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THE UNIVERSITY OF HUDDERSFIELD

**THE PREGNANCY EXPERIENCES OF WOMEN
AGED 40 YEARS AND OVER**

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements
for the degree of Professional Doctorate (Midwifery)

JAYNE SAMPLES

February 2017

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Abstract

Increasing numbers of women are giving birth when older, yet they face being labelled 'at-risk' due to associations between their age and complications in pregnancy. The primary aim of this study was to explore the pregnancy experiences of women aged 40 or over from the perspectives of these women and their community midwives, with a particular focus on risk status and risk communication.

This research used a grounded theory approach underpinned by symbolic interactionism. Research participants comprised ten pregnant women aged 40 to 47 and their ten named community midwives. One antenatal appointment per woman-midwife pair was audio-recorded during the second trimester of pregnancy, followed by individual interviews with each participant. Some women were interviewed again following antenatal appointments with a consultant obstetrician and all women were re-interviewed three to five weeks postnatally. Data were transcribed and analysed using initial and focused coding techniques.

Three concepts were identified from the data. 'Navigating risks' involved women's understanding of their pregnancy-related risks and associated decision-making, from the women's and midwives' perspectives. Decision-making is complex and fluid; it can be emotional and may result in older pregnant women going with the flow of health-professional advice. 'Responsibility' for choices and for balancing their personal, their families' and babies' needs was demonstrated through women's desire to make the right decisions, sometimes within a state of uncertainty. 'Enabling relationships' between older women and their community midwives can contribute to normalising older women's experiences of pregnancy and developing balanced understandings. Community midwives can be instrumental in optimising older women's experiences of shared care, although balancing the demands of their workload to meet women's needs can be challenging. These three concepts are linked and underpinned by the notion of 'doing the right thing', which was evident throughout the data. Women's and midwives' voices and actions demonstrated a determination to do the right things for themselves, for others and for each other, despite the challenges this might pose.

Regardless of experience and efforts to make responsible choices, older pregnant women are likely to have additional needs. Involving them in the development of flexible guidelines to meet these needs could enable care to be more meaningful, supportive and beneficial for older childbearing women and their midwives.

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Glossary of terms

Amniocentesis - a procedure carried out in pregnancy to examine the cells (and their chromosomes) in the amniotic fluid which surrounds the fetus in the uterus. A fine needle is used to draw off the fluid under ultrasound guidance. Most commonly performed to diagnose Down's syndrome.

Aneuploidy – abnormal number of chromosomes

Antenatal – before birth

Assisted reproductive technology – a group name for procedures used to assist women to become pregnant, including IVF and embryo transfer

Birth rate – proportion of live births in a specified population, usually stated as per 1000 population per year

Body mass index (BMI) – a measure of body fat, based on a calculation of height and weight

Breech – position of the fetus where the buttocks are lying lowest in the uterus

Caesarean section / birth – surgical incision into the abdominal and uterine walls to achieve birth of the baby

Chorionic villus sampling – sampling of placental tissue (chorionic villi) under ultrasound guidance

Conception – fertilisation of the oocyte/ovum by the sperm

Diagnostic testing – tests which are intended to confirm the presence or absence of a condition

Direct maternal deaths - maternal deaths resulting from obstetric complications of the pregnancy state, from interventions, omissions, incorrect treatment of from a chain of events resulting from any of the above (International Classification of Diseases (ICD), 2010)

Down's syndrome – a condition caused by an extra chromosome 21 in human cells

Ectopic pregnancy - a pregnancy that develops outside the uterus; for some women this can be a life-threatening condition

External cephalic version - manipulation of the fetus to a cephalic (head-down) presentation, through the mother's abdomen

Fecundity - fertility

Fertility rate – number of births per 1000 women

Fetus – unborn infant from the beginning of the 9th week after fertilisation until birth

Gestation – relating to pregnancy

Gestational diabetes – glucose intolerance that is diagnosed during pregnancy

Gestational trophoblastic disease – a group of pregnancy-related conditions in which tumours develop inside a woman's uterus

Gynaecology – branch of medicine dealing with disorders of the female body, particularly the reproductive tract

Hypertension – elevated blood pressure

Iatrogenic – a condition arising from treatment for a different condition

Indirect maternal deaths – “maternal deaths resulting from previous existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy” (ICD, 2010)

Induction of labour – intervention to stimulate uterine contractions prior to spontaneous labour

Infertility – inability to conceive following 12 months of unprotected intercourse (World Health Organisation, 2016)

Instrumental birth / operative birth – the use of obstetric forceps or vacuum extractor to facilitate the birth of a baby

In-vitro fertilisation (IVF) – a process whereby an egg is fertilised by a sperm outside the body

Low birth-weight – a birth weight of less than 2.5kg

Macrosomic – having excessive birth weight

MAT B1 - maternity certificate enabling pregnant women to claim Statutory Maternity Pay or Maternity Allowance

Maternal death / mortality – “death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (ICD, 2010)

Maternity – relating to motherhood

Midwife Led Unit (MLU) - birthing unit which is managed by midwives

Miscarriage – the most common type of pregnancy loss, affecting around one in four pregnancies

Missed miscarriage - a pregnancy that has failed, but without bleeding or the expulsion of the products of conception

Multiparous / multip - a woman who has given birth to more than one baby

NICE guidelines – guidelines produced by the National Institute for Health and Care Excellence (NICE) and which aim to improve health and social care

Nuchal cord – an umbilical cord which passes around the fetal neck

Nulliparous – a woman who has not given birth

Nursing and Midwifery Council – the nursing and midwifery regulator for England, Scotland, Wales and Northern Ireland

Obstetrician - a doctor specialising in pathological conditions that may occur during pregnancy, childbirth and the postnatal period

Obstetrics – branch of medicine concerning conditions that may occur in pregnancy, childbirth and the postnatal period

Oocyte / ovum – female reproductive cells prior to fertilisation, also known as ‘eggs’

Parous / para – a woman who has given birth to one or more babies at 24 or more weeks’ gestation

Postnatal / postpartum – following birth

Pre-eclampsia – hypertensive disorder in pregnancy associated with proteinuria and systemic dysfunction

Preterm infant – a baby born before 37 completed weeks’ gestation

Primiparous / primip – a woman who has given birth to one baby

Proteinuria – protein in the urine

Screening - a strategy for identifying seemingly healthy people who may be at increased risk of diseases and conditions

Shoulder dystocia – additional manoeuvres are required to assist the birth of a baby whose shoulders are impacted in the maternal pelvis during birth

Stillbirth – babies born after 24 or more completed weeks of pregnancy, who did not, at any time, breathe or show signs of life

Termination of pregnancy – removal of the products of conception from the uterus by surgical or medical means

Trimester – a period of three (or about three) months

Chapter One – Introduction

“Throughout human society childbirth is never just one event in a woman’s life.

It is always momentous, but in different ways” (Oakley, 1979, p9).

This thesis documents an exploration of the pregnancy experiences of women aged 40 years or over from their own and their community midwives’ perspectives. In this introductory chapter I provide an overview of my personal and professional motivations for undertaking this research study, the contextual background to maternity care for older women and introduce the notion of risk and risk-management in pregnancy. I clarify some language-related issues and outline the structure of the thesis.

Personal and professional motivations

As a registered midwife for over 25 years, issues around women’s experiences of pregnancy and health care have played a significant role in my adult life. I have practised in a variety of clinical settings and have supported many women and their families through high-risk and low-risk pregnancies, births and the early transition to parenting. My most recent clinical role was as a community midwife although currently I am a senior midwifery lecturer. Several years ago, prior to working in education I became involved in and facilitated local and national training programmes for dealing with maternity emergencies. This involvement increased my interest in high-risk pregnancies. However, despite a strong focus on mandatory training to ensure that midwives, obstetricians and other maternity care providers could manage emergency and complex situations effectively, minimising the potential for harm to mothers and babies, the psychosocial aspects of complex needs seemed to be afforded less attention. Indeed there appears to be an expectation that women and their families are accepting or grateful for care based on the outcomes of their experiences, regardless of any complications experienced during the process. According to Kitzinger (2006, p26) “women are denied their own definition of birth” and if they express dissatisfaction or questions relating to their experience, they may be expected to accept the experts’ version of events.

Whilst retaining strong links with clinical midwifery practice, stepping away changed my perspectives and I began to see maternity care through the lens of an outsider. Nonetheless this did not give me a neutral perspective; rather it facilitated greater awareness of my biases (Corbin-Dwyer & Buckle, 2009). Reflecting back on my own practices, I identified instances of where I believed I had enabled women with at-risk pregnancies to feel empowered, but also examples of where I might have been more woman- and less

institution-centred. In particular I might have done more to support one woman aged 43 to have a home birth, when she had felt pressured into giving birth in hospital. I wanted to expand my understanding about high-risk pregnancy and birth, but rather than focusing on the effectiveness of different management strategies, I sought to gain a greater insight into women's perspectives. Empathising with and caring for women have impacted on my understanding of their experiences, although I had not examined this in depth. Furthermore, my own pregnancies were straight-forward and my daughters born when I was 27 and 30 years old. Whilst my experiences of pregnancy, birth and becoming a mother have reshaped my own world and perspectives about this, I am conscious that my personal experience is simply that. It cannot be used as a yardstick to interpret the experiences or actions of other women. Similarly my experience as a midwife enables me to empathise with midwifery colleagues, yet I recognise that their motivations to become, and experiences as, a midwife provide a different lens to my own. Observing and exploring professional and practice issues with midwifery colleagues over the years has reiterated the potential for these divergences.

Background to the study

Within the United Kingdom the fertility rate has gradually risen since 2001 (Office for National Statistics (ONS), 2012a). The characteristics and profile of mothers has simultaneously changed with a steady overall increase in maternal age since 1975. Whilst the numbers of births registered to women aged 20 or younger has recently reduced, from 1991 to 2013, live births for mothers aged 40 or over almost trebled from 9,835 to 29,158 (ONS, 2014). Specifically, numbers of new mothers aged 45 or over have increased, whilst births for all other age groups fell slightly in 2013. Overall, ONS (2014) reported the highest numbers of women giving birth aged 40 or over since 1948. Older mothers' characteristics have also changed over time. Previously, many older mothers were multiparous, whereas in recent decades more women are achieving first motherhood in their 40s (ONS, 2016). Various social factors are considered responsible for delayed mothering (Bewley, Davies & Braude, 2005; Tough, Tofflemire, Benzies, Fraser-Lee & Newburn-Cook, 2007; ONS, 2012b; ONS, 2013) and this is discussed further in Chapter Two.

The number of women within the UK with complex pregnancies has also increased over recent decades (Kings Fund, 2008; NHS England, 2016a). This may have helped to sustain maternal mortality and morbidity rates from persistently high indirect causes, in spite of reductions from direct deaths such as haemorrhage (Knight et al., 2015). Wide variations in maternal outcomes exist globally; maternal deaths are 14 times higher in developing nations than in developed nations such as the UK (230 and 16 per 100,000 live births respectively) (World Health Organisation (WHO), 2014). In the UK, variations in the characteristics of women who died are also reported. More deaths occur in older women,

women living in significantly disadvantaged circumstances and those from some minority ethnicities. However the actual risks remain low and for some women improvements in care might have altered their outcomes (Centre for Maternal and Child Enquiries (CMACE), 2011; Nair & Knight, 2015). For most women, giving birth in the UK is “likely to be safe” (Kings Fund, 2008, p xvii), although there are more interventions such as caesarean births, more women with pre-existing complications, more women accessing fertility treatments with a subsequent increase in multiple births and higher numbers of older pregnant women. Additionally, managing deviations may involve interventions which may themselves increase the risk of iatrogenic problems (King’s Fund, 2008) although these must be minimal to remain acceptable (Royal Society Study Group, 1992). Risk reduction forms an essential care component throughout the childbearing continuum (Jordan & Murphy, 2009). However, when this is insufficient for meeting women’s complex needs, the consequences can be dire (NHS Litigation Authority, (NHSLA) 2012; Knight et al., 2015). National guidelines indicate categories of women who may need care that exceeds the expected requirements for women with healthy pregnancies. Women aged 40 and over comprise such a group on account of their increased risk of having or developing complications (National Institute for Health and Care Excellence (NICE), 2008), such as prematurity (Jolly, Sebire, Harris, Robinson & Regan, 2000), caesarean birth (Luke & Brown, 2007) or stillbirth (Salihu, Wilson, Alio & Kirby, 2008; Dhanjal & Kenyon, 2013). (For a more detailed overview of the potential complications associated with older maternal age, see Appendix One)

Most older women have positive childbearing outcomes, despite being more at risk of complications than their younger counterparts (Cohen, 2013). Nonetheless, Bonar (2015) highlighted increased numbers of older mothers as potentially problematic, since these women are more likely to need extra care. In addition, the potential increased demand for care combined with an aging population of midwives (Bonar, 2015) has generated claims of “older mothers placing more strain on midwives” (Booth, 2014) and concerns about future service provision. Whilst Bonar’s report acknowledged that not all older women experience complications, a Finnish National Birth Register-based study found that regardless of medical advances and relative improvements in outcomes for women aged 35 to 39, women over 40 are more likely to have chronic diseases such as hypertension; thus older maternal age can affect health and health service provision (Klemetti, Gissler, Sainio & Hemminki, 2014).

Risk management has played an increasing role within healthcare since the Department of Health (DH, 1997) recommended high quality risk-reduction programmes in ‘The New NHS, Modern Dependable’. The focus on risk and risk management has gained momentum, with midwives and other health professionals becoming increasingly focussed on risk management through schemes such as the Clinical Negligence Scheme for Trusts (CNST) (NHSLA, 2013) and ‘Sign up to Safety: Spotlight on Maternity’ (NHS England, 2016a). Risk

has been described as “the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge” (Royal Society Study Group, 1992, p2) and “the probability that a hazard will give rise to harm” (Mohanna & Chambers, 2001, p3). Thus, the outcomes of risk-related events are perceived as uncertain and negative (Berry, 2004). Encountering risk is unavoidable within daily living (Beck, 2009), although acceptable parameters vary across cultures and societies, influencing people’s unique perceptions (Lupton, 1993). People’s responses to situations affect perceptions of their ‘self’, social actions and their world (Mead, 1934). Furthermore understandings are temporal and responsive to specific circumstances (Kringeland & Möller, 2006). Perspectives may therefore vary during or between women’s pregnancies. For instance, mothers may fear the death of their baby and define time-frames during which the risk of this occurring seems increased; fears around miscarriage during early pregnancy may be replaced by concerns associated with screening and diagnostic testing and later, around birth-related complications.

Policies, initiatives or drivers for change such as the National Health Service Litigation Authority (NHSLA), which aims to minimise harm by studying and gaining insight from claims have influenced risk management approaches to health care. Their ‘Ten Years of Maternity Claims’ (NHSLA, 2012) aims to contribute to the improvement of risk management in maternity care. They report that 49% of the value of claims paid out through the CNST between 1995 and 2011 related to obstetrics and gynaecology cases. A three year review of the NHSLA (DH, 2015a) reported that candour and improved patient safety can reduce the numbers of claims, enabling savings to be fed back into NHS services. Furthermore they suggested that the NHSLA should “better incentivise a sharper focus on better care in the health and care system complementing wider work to drive up care standards” (DH, 2015a, p7). Standards driven by litigation have been criticised previously for failing to provide a clear overview of safety (Kings Fund, 2008) and for focussing on reducing vulnerability to litigation or blame rather than improving safety for women and their families (Jokinen & Silverton, 2009). Avoiding all adverse events is not possible although revisiting and learning from these can improve future practices; failure to do so may strengthen the idea that birth is only normal retrospectively (Scamell & Alaszewski, 2012). Moreover, a focus on risk reduction targets may replace the focus on ‘patient’ needs by prioritising risk avoidance as the primary driver of care (Hutter, 2008) and, consequentially, fear of retribution and defensive practices such as increased interventions may ensue rather than approaches which facilitate empowerment (Shaw, 2010a).

Responding to the Winterton Report (House of Commons, 1992), the Changing Childbirth Report (DH, 1993) recommended women should be the main focus of their care; they should be able to make choices about care after having the opportunity to discuss their options with healthcare professionals. Safety and quality of women’s experience were also

defined as important care constituents. However, over 20 years later, maternity care has still not yet achieved these aims. The Care Quality Commission (CQC) (2015) reported that over 80 percent of women always saw the same midwife for support during their pregnancy. However, almost half of these would have preferred not to, and of those who did not see the same midwife around 60 percent had wanted to. Furthermore only 58 percent of women received sufficient information for them to feel confident about choosing their baby's birthplace and only 30 percent reported having a choice regarding the venue for antenatal care (CQC, 2015). Choice, continuity and control continue to be significant factors in providing woman- and family-centred maternity care. The philosophy of the Changing Childbirth report (DH, 1993) resounds in subsequent publications and policy documents such as National Service Framework for Children, Young People and Maternity Services: Maternity Services (DH, 2004a), Maternity Matters (DH, 2007), Midwifery 2020 (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales (CNOENISW), 2010), Why Choice Matters, (Phipps, 2012) and Better Births: Improving outcomes of maternity services in England (NHS England, 2016b).

The midwife's role as lead professional for women with low-risk pregnancies is well-established and where the expected support and management needs of women exceed the midwife's scope of practice, midwives are responsible for referring to other appropriate professionals (Nursing and Midwifery Council (NMC), 2012). However involving other professionals can interrupt the continuity of care and carer, therefore the Midwifery 2020 programme (CNOENISW, 2010) recommended that midwives continue to co-ordinate care within the multidisciplinary team. Furthermore NHS England (2016b) suggests midwives work within a small team and liaise with identified obstetricians to improve this continuity for women.

Language

Throughout this thesis I use the voices of the women and midwives who participated in my study to illustrate my findings. I have attempted to remain true to their words and be guided by their language; therefore quotations may include grammatical and colloquial idiosyncrasies. Protecting anonymity and confidentiality and conforming to word restrictions has meant that some adjustments were necessary. For example, amendments to names and original conversations are depicted using [alternative words] in square brackets. In particular I was uncertain about what term to use when relating to older women, in order to differentiate between them and other women. 'Older women' or 'older pregnant women' were the terms used most frequently by participants and have therefore been used in this thesis rather than terms such as 'advanced maternal age' used in other literature. Furthermore, I include my own voice to demonstrate my influence on the processes and

outcomes of my work and to demonstrate my accountability for these (Letherby, 2003). I am conscious that technical terminology may detract from some readers' understanding; a glossary has been used to facilitate understanding.

Organisation of the thesis

In this chapter I have explained my personal and professional interests in exploring older women's experiences of pregnancy and I have provided an overview of the context within which women in Britain, including older childbearing women, access care. The following chapter provides a background for this study by exploring current evidence relating to the experiences of women whose pregnancies have been labelled 'at-risk' or 'high-risk' and specifically those women who might be thus labelled due to their older age. Chapter Two identifies five themes from the literature: the timing of motherhood, women's understanding of risk, the notion of being at risk, becoming a mother and the importance of being supported. It justifies the value of the current study and presents the study's aim and objectives. Chapter Three outlines the research methodology and methods used to conduct, analyse and present the findings of my study. It will rationalise the use of a qualitative paradigm and more specifically a constructivist grounded theory approach (Charmaz, 2014). An overview of the theoretical framework, symbolic interactionism, will be discussed and the concept of the 'responsible self' introduced. This will be followed by an account of the methods used in my study, addressing ethical approval, sampling and recruitment, data collection and analysis. The importance of trustworthiness including reflexivity is also incorporated. Transparency enables the reader to make judgements about trustworthiness and appendices will be signposted throughout to facilitate this.

The subsequent three chapters will present my research findings, beginning with a preface which introduces the core concept: 'doing the right thing'. Doing the right thing comprises three concepts: navigating risk, responsibility and enabling relationships. Each concept is explored within a discreet chapter and discusses the focused codes and categories developed from the data. Findings are discussed within the context of policy, theoretical and empirical literature. The final chapter draws together and summarises my findings regarding the pregnancy experiences of older pregnant women from their personal perspectives and from the perspectives of their community midwives. I acknowledge the limitations of this study and make recommendations for clinical practice, education and further research.

Chapter Two – Review of the Literature

Introduction

The purpose of a literature review is to establish what is currently known about an issue, to identify the conceptual frameworks that have restricted or enhanced the progress of knowledge within or about the topic of interest, to identify gaps in understandings and to facilitate the development of research questions (Grbich, 1999). The timing of consulting literature with regards to a grounded theory has been contentious (McGhee, Marland & Atkinson, 2007). Contrasting with Glaser's (1998) view that early literature reviewing contaminates the researcher's understanding of their findings, Thornberg (2012) argues that delayed literature reviewing disregards the researcher's pre-existing insight into the topic area. I fully acknowledge that I do not come to this subject area as a novice and this is discussed further in Chapter Three. In addition completing a research proposal would be difficult without insight into current understandings and might lead to "reinventing the wheel" or repeating others' mistakes (Thornberg, 2012, p245). Reviewing the literature enables researchers to discover what is already known and identify gaps (Henn, Weinstein & Foard, 2009; Flick, 2014). Furthermore early and on-going insight into other literature stimulates theoretical sensitivity. This chapter discusses the literature review methods and findings.

Literature review: design and search methods

Related literature was explored and reviewed prior to beginning the study guided by a structured systematic appraisal process to give the review direction (JBIEBNM, 2001) and enhance the trustworthiness of the findings:

1. Identify a clinical topic
2. Develop an appraisal procedure
3. Find studies
4. Select appropriate studies
5. Appraise the research quality
6. Gather data from individual studies
7. Synthesise and summarise the studies' findings
8. Document methods in a report of the review

The literature was revisited as the study progressed, using the above steps, to enhance my theoretical sensitivity according to constructivist grounded theory methodology and to identify the most significant evidence relating to my findings (Charmaz, 2006).

Review aim and objectives

This thematic review of the research literature aimed to explore contemporary understandings about the pregnancy-related experiences of older women and women labelled 'high-risk'. More specifically it sought to identify, appraise and synthesise research literature relating to the pregnancy experiences of older women and those with an 'at-risk' pregnancy and to identify gaps in knowledge for further exploration.

The main objectives of the literature review were:

- To identify and critically examine the evidence relating to the pregnancy experiences of older women;
- To explore the emotional and psychosocial impact of pregnancy for older women;
- To identify the potential impact of being labelled 'at-risk' for childbearing women;
- To identify areas for further development of understanding about older mothers' needs within contemporary midwifery practice

Locating potential studies

Searches using the electronic databases CINAHL (Cumulative Index to Nursing and Allied Health), Cochrane Library, Medline, National Institute for Health Research (NIHR), PubMed, Science Direct, Summon and TRIP were carried out using the key terms identified in Table 2.1:

Search term	Alternative terms
Woman	Female, lady, maternal, mother, motherhood, women
Experience	Feeling, feel, knowledge, perspective, perception, understanding, view
Pregnancy	Birth, childbearing, childbirth, expectant, pregnant
Age	'Advancing age', aging, aged, elderly, mature, old, older
Risk	'At-risk', complication, danger, 'high-risk', problem

Table 2.1. Literature review search terms

In addition library resources were used to identify and access relevant books and unpublished theses. Criteria for inclusion should incorporate reference to the population of interest (older pregnant women or pregnant women), intervention (being labelled 'at-risk' or 'high-risk'), outcome measures (women's experiences or perspectives) and the optimal research design for addressing the objectives (JBIEBNM, 2001) (see below). Advanced search techniques, such as Truncation, were employed to capture alternative spellings and plural terms: for example, pregnan*, childb*. Boolean operators (AND, OR) were used to link terms and narrow or broaden results. Search terms were combined in accordance with database specific structures. I also undertook manual searches of midwifery and nursing journals and the reference lists of identified or related articles.

Initial searches were restricted to sources written in or translated into English over the previous 10 years (the first search of the literature was conducted in 2010), although where older sources were deemed seminal on account of multiple citations within retrieved data these were also accessed for consideration of their usefulness.

Inclusion criteria for sources to be reviewed in greater detail included: primary research studies; peer reviewed publication or thesis; abstract available; published in English; relevant to the aims of the review. Having conducted preliminary searches it was evident that the age at which pregnant women were classified as older varied; therefore a numerical restriction was not applied. It was my view that this would facilitate inclusion of the views of women who believed that they were relatively old to be pregnant. Papers were excluded when there was insufficient evidence to confirm the trustworthiness of the study or where there was limited applicability to the review, for example studies relating to risk in pregnancy that had been conducted in developing countries with limited healthcare provision. Studies from across the developed world have been included, since early searches suggested that valuable research had been conducted in countries such as Australia (for example, Carolan, 2007).

Selecting relevant studies

Initial searches identified a total of 1915 potential sources of evidence. The title and abstracts were read to determine whether each appeared to meet the inclusion criteria. Those appearing to meet the inclusion criteria were scrutinised further by accessing and proof-reading the full source. After accounting for duplications and excluding papers that did not meet inclusion criteria on further examination, the remaining papers were reviewed in detail. Of these sources approximately half were excluded for one or more of the following reasons: did not meet the inclusion criteria; the findings did not relate to the review aims; the paper did not address specific age-related pregnancy concerns;

older maternal age or risk were not a main focus of the study; the paper did not identify women's views or experience in relation to risk or age; the research concerned evaluations of specific interventions or outcomes rather than women's experience or views. Despite exclusion from the current review, some of these papers were retained for their potential contribution elsewhere and have facilitated development of my overall understanding of this research area.

This process was repeated periodically as the study progressed, to identify new sources or to revisit sources which might have been disregarded at an earlier stage, based on my understanding at that time. Concurrent searches relating to women's experiences of having an 'at-risk' or 'high-risk' pregnancy, unrelated to their age, were also conducted to enhance contextual understanding and to enable points of convergence or divergence to be analysed (Charmaz, 2014). Thus identifying relevant evidence was an iterative process.

Critical appraisal

The evidence gathered was examined for trustworthiness, methodological and subject relevance (EPPI-centre, no date). Using critical appraisal tools can reduce the potential for bias and aid transparency (Dixon-Woods et al., 2007; Popay et al., 2007), although it has been suggested that "the diversity of qualitative study designs and approaches makes it impossible to specify universally agreed a priori defects, equivalent to inadequate randomisation for RCTs, which would indicate that a qualitative study is fatally flawed" (Dixon-Woods et al., 2005, p35). In addition using precise procedures does not align easily with the epistemological foundations of qualitative paradigms and Dixon-Woods et al. (2007) suggest that reflexive researcher judgements may be equally valid. Katrak, Bialocerkowski, Massey-Westropp, Kumar and Grimmer's (2004) review of critical appraisal tools failed to demonstrate inter- and intra-reviewer reliability, with no particular tool being identified as better than others for reviewing literature. However, the Public Health Resource Unit (PHRU) (2007) subsequently published details regarding their tools' development and guidance, emphasising validity evaluation and significance in practice. Furthermore, their Critical Appraisal Skills Programme (CASP) tools are considered concise and effective in addressing the necessary areas for critical appraisal (Nadelson & Nadelson, 2014). A structured approach guided by the PHRU (2007) tools for critical appraisal was employed in appraising the quality of reviewed studies. An example of literature appraisal using one of these tools is presented in Appendix Two.

Whilst richer insights into women's experiences may be developed through qualitative data, legitimate understanding can be acquired from multiple paradigms (Kringland & Moller, 2006); therefore data were reviewed and retained from both qualitative and

quantitative paradigms where it was believed that these could contribute to the overall understanding of the subject matter. Whilst some of the data retained may not be valued highly according to frequently cited hierarchies of evidence (Guyatt et al, 1995), the studies retained to the review were developed through appropriate methodologies for generating relevant data. Figure 2.1 demonstrates the stages of each search undertaken.

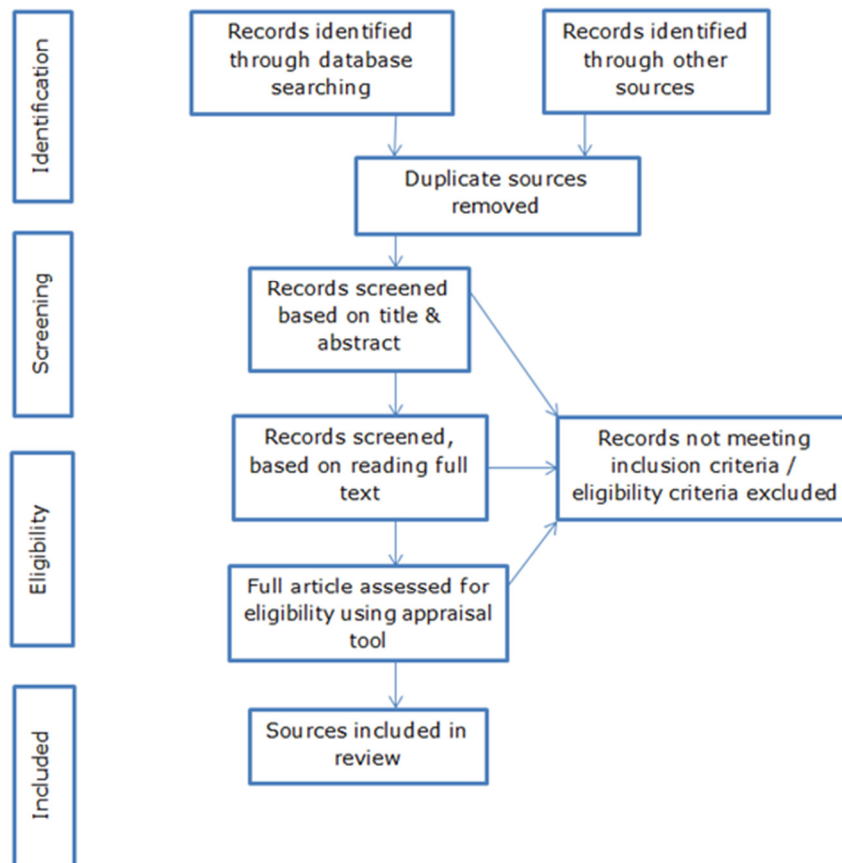


Figure 2.1. Flowchart demonstrating the selection of included sources of literature (Based on Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), 2009).

Data abstraction and synthesis

Once relevant studies had been identified and appraised, a process of manual thematic analysis involved reading each source several times, questioning and annotating the papers. As my research progressed and new insights developed, the existing data were reviewed with fresh eyes and additional data incorporated. Initial codes were applied to the data, then themes and categories were identified, grouping ideas together (Charmaz, 2006, 2014) using Microsoft® Excel spreadsheets to organise and record progress. As new insights developed initially applied codes and themes were revisited and refined. I

have been unable to make direct comparison between the studies' findings due to the differing paradigms and range of methods employed. Therefore a descriptive account of the themes has been presented.

A total of 67 studies were retained: 43 relating to older maternal age and 24 concerning women's experiences of having a high-risk pregnancy. Data relates to studies of women's experiences of pregnancy from 13 countries and regarding a range of specific risk types (see Table 2.2).

Risk type	Study
Multiple high-risk conditions included in study	Dulude et al (2000); Gray (2006); Leichtentritt et al (2005); Lerman et al (2007); MacDonald & Jonas-Simpson (2009); Price et al (2007); Rubarth et al (2012); Simmons & Goldberg (2011); Sittner et al (2005); Stahl & Hundley (2003); Stainton et al (2005); Stainton et al (2006); White et al (2008); Zadeh, Khajehei, Sharif & Hadzic (2013)
High-risk for Down's syndrome following antenatal screening	Georgsson Öhman et al (2006); Heyman et al (2006); Pilnick & Zayts (2012)
Gestational diabetes	Evans & O'Brien (2009); Goldstein et al (2015)
Preterm labour/rupture of membranes	Durham (1999); Hatmaker and Kemp (1998); MacKinnon (2006); Mu (2004)
Pregnancy related hypertension	Barlow et al. (2008)

Table 2.2. Conditions pre-disposing to high-risk status (excludes maternal age)

Following the recommendations of Riesenbergs and Justice (2014) tables were developed to record brief descriptions of the studies included; example pages are presented in Appendix Three. Findings of the review are presented below.

Findings of the literature review

It became apparent early in this project that 'risk' and 'older maternal age in pregnancy' were of significant interest internationally, with research conducted in a number of developed countries such as the United Kingdom, The United States of America, Canada and Australia. Whilst the health care systems and more specifically maternity care systems differ between these countries, I believed that such data could offer valuable insights, enabling convergences and divergences with the experiences of women in the UK to be identified and further explored. Therefore data conducted in developed

countries has been included. Data from 67 literature sources across 13 countries have informed this review. These studies have explored older women’s pregnancy-related experiences using a variety of strategies.

Data analysis initially identified three broad temporal themes: factors influencing the timing of pregnancy; experiences relating to pregnancy and birth and; becoming an older mother. However there were significant overlaps when organised in this linear fashion. Further category refinement resulted in five themes: timing of mothering, understanding risk, impact of being at-risk, becoming an older mother, and being supported (see Figure 2.2). I discuss these themes within this chapter.

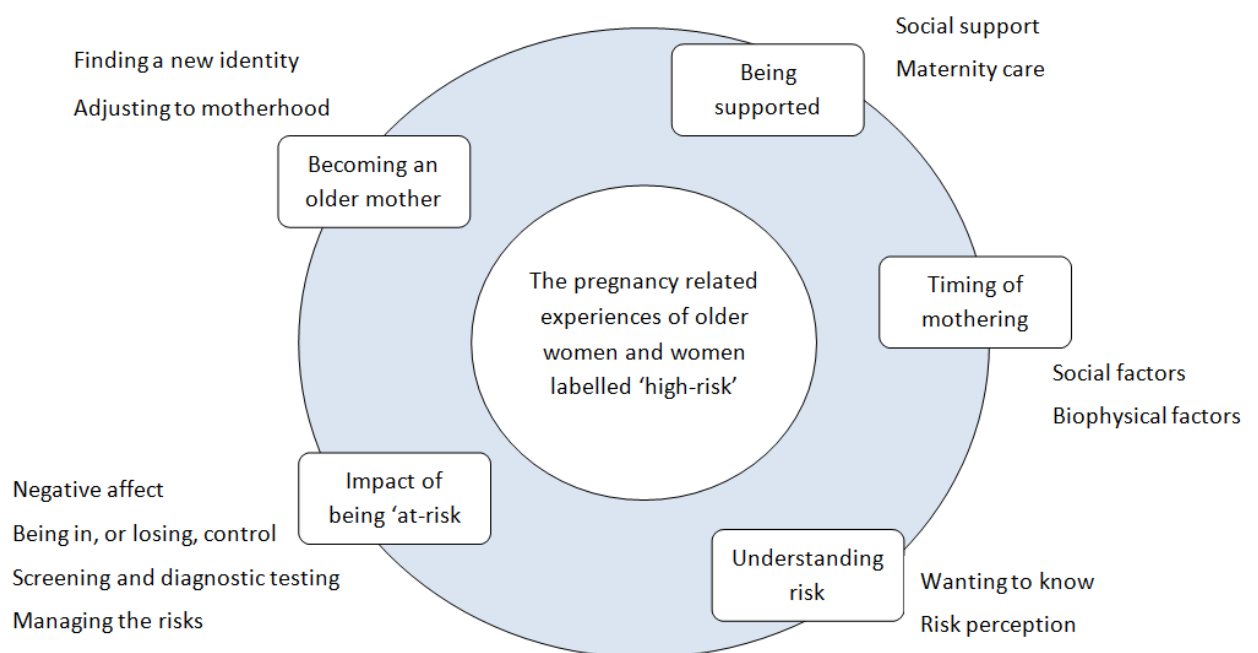


Figure 2.2. The pregnancy related experiences of older women and women labelled 'high-risk'

Timing of mothering

This section draws on empirical literature to discuss the factors influencing older women’s decision-making around childbearing. I discuss socioeconomic factors such as employment and finding the right partner, the roles of society, including the media, and biophysical issues such as fertility problems and understandings about potential complications.

Social factors

Women who give birth to children later in life may feel more ready when they have achieved financial, employment and educational independence and security (Heyman &

Henriksen, 2001; Dobrzykowski & Stern, 2003; Nelson, 2004; Tough et al., 2007; Friese, Becker & Nachtigall, 2008; Mandel, 2010). However career and education are not necessarily the main influences on the timing of pregnancy (Benzies et al., 2006; Carolan, 2007; Cooke, Mills & Lavender, 2012). Cooke et al. (2012) draw attention to the irony of financial security influencing a delay in childbearing since this may contribute to the need for infertility treatment and significant financial costs. For some women, having the right partner can be most significant in delaying childbearing (Friese et al., 2008; Morgan, Merrell, Rentschler & Chadderton, 2012; Cooke et al., 2012; Wiebe, Chalmers & Yager, 2012) although incongruent childbearing motivations can cause further delays (Benzies et al., 2006). If the 'right' partner fails to materialise at the 'right' time older women may view this as a missed opportunity for childbearing (Benzies et al., 2006) or opt for single motherhood if the impact of their biological clock is greater than their need for stability (Mandel, 2010; Tough, Vekved & Newburn-Cook, 2012).

Renewed mothers¹ may have specific influencing factors. For instance, they may feel pressurised to have a baby with a new partner or prior negative experiences may delay future childbearing (Jarvie, Letherby & Stenhouse, 2015). Older women may experience family pressures for grandchildren, although contemporary women have more options regarding parenting than their own parents (Benzies et al., 2006). In addition plans to delay mothering can trigger mixed responses from family (Mandel, 2010), causing some women to perceive that they are weakening generational links, experience tensions between personal and family's aspirations (Perrier, 2013, p81) or feel hurt by negative comments (Kelhä, 2009).

Social acceptability of older motherhood influences some women's reproductive choices. Older motherhood is increasingly common and accepted (Heyman & Henriksen, 2001; Benzies et al., 2006; Cooke et al., 2012) and represented as the '*norm*' through media depictions of celebrity older mothers (Budds, 2013; Mills, Lavender & Lavender, 2014). However, restrictions accompany acceptability and mothering beyond menopause has been portrayed as breaching the reproductive boundaries of nature and social responsibility (Campbell, 2011). Purewal and van den Akker's (2007) exploration of parenthood linked socially idealised parenting norms with selflessness and sacrifice for the child's benefit. However some media portrayals of older mothering fuel images of ambitious, selfish older women who delay childbearing to achieve successful careers, thus risking their personal and baby's health (Dobrzykowski & Stern, 2003; Shaw & Giles, 2009; Cooke et al., 2012; Budds, Locke & Burr, 2013; Locke & Budds, 2013). Such representations can differ from women's actual experiences (Cooke et al., 2012;

¹ Women who become a mother when younger and then again later in life (Jarvie et al., 2015).

Locke & Budds, 2013; Budds, 2013). Women with colleagues or friends who have delayed pregnancy may feel more normal and "in sync with their world" (Dobrzykowski & Stern, 2003, p246), although this may be less significant than women's self-belief as a capable mother. Guedes and Canavarro (2015) report that compared with younger couples, childbearing when older may be less important in enhancing the quality of life, relationships or fulfilling biological urges. Other findings also suggest older parents may already feel self-fulfilled and less likely to view childbearing as essential to their relationship (van Balen, 2005). Furthermore they may be more realistic about potential contributions children can make to their relationship (Purewal & van den Akker, 2007).

Whilst there may be multiple right times for childbearing, attempting to reconcile biological factors, career aspirations and family life means that finding the least wrong time can be more challenging (Budds, 2013; Perrier, 2013). Identifying the optimal time can culminate from intense and lengthy planning (Carolan, 2003a; Nelson, 2004; Carolan, 2007; Mandel, 2010). Indeed Carolan (2007) described older women treating their childbearing decisions as carefully managed projects, although extensive information-seeking could also increase women's concerns about potential problems and feelings of losing control.

Biophysical factors

Older women may be aware of some age-related pregnancy and health risks, and awareness of problems such as Down's syndrome can significantly influence their decision-making (Heyman & Henriksen, 2001; Nelson, 2004; Bayrampour, Heaman, Duncan & Tough, 2012; 2013). Older women may perceive an increased risk of sub-optimal infant outcomes (Tough et al., 2006), although associations between older mothering and caesarean birth or the birth of a low-birth-weight, premature or still born baby may be less well understood (Tough et al., 2007). However, awareness of increased risk does not necessarily increase pregnancy-related anxiety (Bayrampour et al., 2012). Some women reject age alone as a risk factor for adversity, perceiving that younger, unhealthy women may be more susceptible to some conditions (Cooke et al., 2012) or that there is little congruence between their biological age and health status (Heyman & Henriksen, 2001). Conversely, advancing age can trigger serious concerns regarding personal mortality and not surviving to see their children grow (Friese et al, 2008; Cooke et al., 2012) or worrying about their child's upbringing should they die (Dobrzykowski & Stern, 2003).

Declining fertility may limit older women's choices yet some couples have little understanding of the association between increasing maternal age and fecundity. Tough et al.'s (2007) study of factors influencing childbearing decisions revealed 41% of participants being unaware of the extent of fertility problems. Furthermore MacDougall,

Beyene & Nachtigall (2012) found that 48% of women over 40 who had conceived using assisted reproductive technologies had expected fertility to *begin* declining after 40. Several studies have reported women's concerns about their biological clock and time running out (Dobrzykowski & Stern, 2003; Nelson, 2004; Benzies et al., 2006; Cooke et al., 2012; Budds, 2013; Locke & Budds, 2013; Perrier, 2013). In particular, women who have previously experienced infertility can experience a strong desire to become a mother (van Balen, 2005). Infertility can leave women feeling vulnerable and out of control about becoming pregnant (McMahon, Gibson, Allen & Saunders, 2007; Cooke et al., 2012). Earle and Letherby (2007) suggest that having control in preventing pregnancies can lead women to believe that they also have control over becoming pregnant, thus compounding their situation. MacDougall et al.'s (2012) investigation into older women's understandings about age-related fertility found that most women (72%) felt lucky to conceive following IVF. Improved understandings of age-related diminishing fertility might have motivated some older women (23%) to consider pregnancy sooner, whilst others (46%) would have changed nothing; other life circumstances were not right for mothering. Later life pregnancy may result from family or social circumstances or a disregard for the biological clock and having to use assisted reproductive technologies can potentially lead to further delays (Chen & Landau, 2015).

Women's reasons for later life childbearing are complex and can include multiple powerful factors. Not having the right partner or being career-focused can mean that women become vulnerable to infertility and increased risks of medical or obstetric complications when they choose to become a mother. However, they may be unaware of these age-related problems or unable to change their situation even if their understanding is good. Prospective parents could benefit from increased awareness about potential changes to medical, social and economic circumstances during advancing childbearing years in order to optimise maternal and perinatal outcomes (Johnson, Tough & the Society of Obstetricians & Gynaecologists of Canada, 2012).

Whilst women in the current study frequently shared information about their childbearing choices, I have not specifically discussed these in my thesis, due to the wealth of evidence already available. Instead their motivations have informed my overall understanding of their circumstances and enabled me to develop a more holistic view of their experiences.

Understanding risk

Personalising the context of risk-related information can enable women to make appropriate choices for themselves and their families (Lupton, 1993). Prior experiences,

understandings, current circumstances and intuition may carry greater sway than facts or figures, so that choices are “neither completely rational nor irrational” (Zinn, 2008, p439). Personal significance of outcomes, a perceived ability to address problems and trustworthiness of information also contribute to decision-making (Mohanna & Chambers, 2001). Therefore assumptions cannot be made about likely actions (Lupton, 1993; Stahl & Hundley, 2003). This section addresses the complexities of understanding risk for pregnant women. It incorporates women’s understanding about a number of risks including maternal age, Down’s syndrome and preterm labour.

Wanting to know

Older women may actively seek information to feel prepared for all eventualities and may feel a greater sense of responsibility for using this information to improve their health and protect their pregnancy than when younger (Bayrampour et al., 2012). Whilst many (74.6%) older pregnant women might discuss issues such as screening with their midwives, they also access sources such as the internet (88.3%) or pregnancy publications (64.8%) (O’Connor, Doris & Skirton, 2014). Independently sourcing or confirming ‘expert’ information by reading professional texts enables some older women to feel more knowledgeable than simply accessing literature aimed at pregnant women (Carolan, 2003a). Furthermore older women may seek investigations to detect pregnancy-related problems, although continual and extra scrutiny may intensify anxieties (Carolan & Nelson, 2007). Thus, medical models of pregnancy are reinforced (Searle, 1996). Alternatively, women may avoid information-seeking through fearing adversity or disregard potentially irrelevant information (Carolan & Nelson, 2007; Bayrampour et al., 2012). Such behaviours resonate with those of other women with at-risk pregnancies, some of whom seek detailed information, particularly when anxious (Barlow, Hainsworth & Thornton, 2008). Others favour not knowing, filtering out unwanted information (Leichtentritt, Blumenthal, Elyassi & Rotmensch, 2005), despite constant societal messages reinforcing responsibilities about the health of their babies. Risk discourses demand self-control and health-related messages aim to increase knowledge about the dangers associated with specific choices, so that these can be avoided (Gabe, 1995).

Risk-perception

Despite some older women seeking to detect complications, receiving an ‘at-risk’ label can increase surveillance and limit options (Carolan & Nelson, 2007). Some women may be surprised that their age consigns them to an at-risk category. This can be stigmatising (Heyman & Henriksen, 2001) and conflict with women’s self-image of being healthy (Morgan et al., 2012). Some health-conscious older women compare their risks favourably with those of younger women living a less healthy lifestyle (Bayrampour et

al., 2012; 2013). Other factors influencing older women's perception of pregnancy-related risk include their life experiences and insight into other women's experiences, predictability of risks, conception or pregnancy-related problems and perceived control over their health.

Location within an at-risk category can predispose women to feeling fearful about their personal and baby's well-being (Carolan & Nelson, 2007). Such feelings may be compounded by public awareness of these risks increasing pressures on women to make the 'right' choice (Kelhä, 2009), although many women accept that advancing maternal age is associated with more problems relating to their medical history or issues such as birth defects (Heyman & Henriksen, 2001; Georgsson-Öhman, Saltvedt, Waldenström, Grunwald & Olin-Lauritzen, 2006; Bayrampour et al., 2012; Cooke et al., 2012). However, other pregnancy-related risks associated with older age such as multiple pregnancy and preterm birth are less well-known (Mandel, 2010). Whilst some women accept this status quo others resent how potential complications can define them as old (Heyman & Henriksen, 2001), or influence how others view them.

Understanding risk involves making sense of statistical data and applying this to personal circumstances, yet some women are oblivious to potential risks. Some women misunderstand the purposes of screening tests such as ultrasound scans and are thus unprepared for high risk results (Georgsson Öhman et al., 2006). This may be due to ineffective information-sharing or women's interpretation thereof. Women may turn to experts for direction, although they must trust that their advocate has the appropriate knowledge and skills to serve their best interests. Caregivers' honesty, communication skills and women's intuition contribute to their evaluation of trust (Alaszewski, 2003; Zinn, 2008).

Information can be worrying, with some women believing that the purpose of informed choice is to blame them for complications (Sun, Hsia & Sheu, 2008). Studies from the UK (Heyman & Henriksen, 2001) and Hong Kong (Pilnick & Zayts, 2012) have reported health professionals structuring consultations around diagnostic testing based on women's social and economic circumstances and withholding information to avoid concerning women about potentially irrelevant issues. Furthermore inadequacies in carers' ability to explain risks and probabilities and women's ability to comprehend, assimilate or acknowledge a numerically high-risk status can leave women potentially disempowered and frightened (Heyman et al., 2006). Thus, risk-related discussions with health professionals can increase older women's anxieties through repeated reference to risk or judgmental comments (Bayrampour et al., 2012). Such behaviours can result in women avoiding risk-related discussions. Nonetheless, representing numerical risk in an understandable manner is vital, although ways of understanding vary (Edwards & Elwyn,

2001; Keller & Siegrist, 2009) and older women may develop greater risk-related insight from comparisons with family, friends or "stories from real people" (Bayrampour et al., 2012, p12) than from epidemiological statistics.

Risk interpretations differ between women and between women and their doctors or midwives; a lack of consensus between women and health professionals regarding risk-categorisation can increase anxiety and disharmony (Gray, 2006; White, McCorry, Scott-Heyes, Dempster & Manderson, 2008). Personal or organisational perspectives of risk (Williams, Alderson & Farsides, 2002; Schwensen & Koch, 2012) or of women themselves (Pilnick & Zayts, 2012) may hamper health professionals' ability to provide objective, non-directive risk-related information. Whilst health professionals may not openly share personal views, women may deduce these through paralinguistic signals and use this insight in their decision-making. Little risk-related discussion between older women and health professionals may indicate a lack of concern (Bayrampour et al., 2012). Receiving mixed information may exacerbate misunderstandings (Stainton, Lohan & Woodhart, 2005) or prevent women from trusting professionals' guidance (Carolan, 2003a). Women may be particularly vulnerable to direction when they are uncertain (Jordan & Murphy, 2009) and health professionals may strengthen the argument supporting their preferences if women's choices differ from their own (Alaszewski, 2005). Women may fear rejection if they fail to conform (Thompson, 2000), predisposing them to informed compliance (Kirkham, 2004; Jordan & Murphy, 2009), a lack of trust in healthcare and its employees.

Whilst older women may seek awareness about problems, understanding risk-related information is complex; this can be exacerbated by inadequate information sharing. Health professionals may not influence decision-making when women's choices are already made, but their competence in facilitating understanding and decision-making can affect many women's ability to make informed choices (Alaszewski, 2005; Kirkham, 2013). Women may be unaware of some problems and balance what they need to know by accessing a range of sources. Perspectives are likely to differ between women and their midwives and obstetricians since they each use personal (and professional) factors to contextualise their insight. Health professionals' behaviours can enable or disempower older women, although having a mutually respectful relationship whereby one another's beliefs and life experiences are valued can help to build trust (Titterton, 2005; Byrom & Downe, 2010). Being informed plays a significant role in older mothers' experiences of pregnancy and health professional input plays an important role in developing their understanding. However previous research has not examined this issue from the perspectives of older pregnant women and their community midwives, which is a key aim of the current study.

Being at-risk

Risk assessments conducted throughout pregnancy may move women from a low- to a high-risk status, which once applied may not be removed (Handwerker, 1994; Stahl & Hundley, 2003). Women may associate risk with danger and high-risk with significant danger (Lupton, 1993). Whilst health professionals believe their main concerns to be women's and babies' welfare, categorising women, or their pregnancies, as 'high-risk' may be psychosocially detrimental (Stahl & Hundley, 2003) and simultaneously increase iatrogenic risks. This section reviews evidence concerning the impact of an 'at-risk' or 'high-risk' label for pregnant women and incorporates studies relating to risk-related conditions such as older maternal age and Down's syndrome.

Negative affect

Triggers for concerns and women's responses to these vary (Lazarus & Folkman, 1984). Being labelled 'high-risk' may affect women's approach towards information and subsequent actions. Previous experiences of perinatal loss were found to influence women's perceptions of, and reactions to, their current pregnancy and obstetric care. Women felt vulnerable, yet having a high-risk label provided greater access to care and support, which women believed protected their current pregnancy (Simmons & Goldberg, 2011). However, having a high-risk pregnancy, coupled with suboptimal social factors and uncertainties regarding their baby can negatively affect women's mental health (Zadeh, Khajehei, Sharif & Hadzic, 2012), the mother-infant, and other, relationships (Price et al., 2007; Zadeh et al., 2012). High-risk status not only affects pregnant women, but also their families' relationships and functions (Sittner, De Frain & Hudson, 2005; Stainton et al. 2005). High-risk labelling may only benefit women where interventions can eliminate or reduce problems (Enkin, 1994) and for some women this might be unachievable or even unwanted, although awareness might help women to access support. Considering the associated potential psychological consequences, due respect must be applied when using this label.

As a consequence of uncertainty and regardless of preparations, older women may feel unconnected with their pregnancy or baby and worry that this reflects their capacity for mothering (Carolan, 2003b). Engaging in distracting activities, women may avoid emotional investment in their pregnancy in order to deal with uncertainty (Rothman, 1988; 1993; Carolan & Nelson, 2007). Other studies also report emotional distancing from high-risk pregnancies. Women may experience a sense of 'timeout' (Georgsson Óhman, et al., 2006 p64), putting their life (Leichtentritt et al. 2005; Stainton et al., 2005) or their pregnancy (MacKinnon, 2006) on hold. Some women avoid pregnancy-related conversations and others treat their pregnancy like a problem to be managed

rather than a developing infant (Georgsson Öhman et al., 2006). Similarly, Heyman et al. (2006) reported women keeping their pregnancy secret to avoid difficult situations should a diagnosis of Down's syndrome result in termination of pregnancy.

Handling their high-risk status and related adjustments from normality can trigger anxieties and insecurity for women with complex needs. Leichtentritt et al. (2005, p43) reported one woman saying: "pregnancy is not a disease, it's a natural process...but now I'm afraid". Rubarth, Schoening, Cosimano and Sandhurst (2012) describe pregnant women on hospitalised bed-rest as experiencing a "war within" (p400) and labile emotions. Perceived threats to themselves and their baby can mean women with high-risk pregnancies experience greater anxiety and impatience (Leichtentritt et al, 2005; Sittner et al, 2005). Previous life-events and negative experiences contribute to women's concerns and can strengthen their resolve to avoid mistakes in a current pregnancy (MacKinnon, 2006, p704). Positivity regarding risk may lead women to experience fewer pregnancy-related anxieties (White et al., 2008), although women who are worried may be more likely to act on health-related information (Lerman et al., 2007). Even so, such information must be provided sensitively for this to have a positive impact.

Temporality and relativity can influence perceived risk-significance according to whether a threat is believed to be increasing or decreasing. For instance, after experiencing threatened preterm birth, women may feel increasingly positive as their pregnancy advances and risks diminish (Hatmaker & Kemp, 1998). However some women experience difficulties in exiting their high-risk status (Heyman et al, 2006) or believing that problems are passed (Simmons & Goldberg, 2011). Even after a birth of a normal, healthy baby, where women have prepared themselves for complications, anxieties about their baby may persist, with parents expecting new problems (Georgsson Öhman et al., 2006; Heyman et al., 2006). Such findings strengthen an argument for additional and on-going support that continues after early postnatal care.

Being in, or losing, control

Being in control of their life, financial and relationship security may be regarded as important for women of all ages (Tough et al., 2012). Having a high-risk label can challenge women's autonomy and sense of control, compounding their perception of vulnerability (Evans & O'Brien, 2005; Stainton et al, 2005). Studies exploring women's experiences of high-risk pregnancy care describe women feeling unable to plan or bracketing time into manageable chunks to deal with uncertainty (Stainton et al., 2005; Rubarth et al., 2012).

Older women can have increased perceptions of vulnerability, which may prompt regular attendance for antenatal care (Heyman & Henriksen, 2001). However, health

professional anxieties can increase women's perceptions of pregnancy-risks (Morgan et al., 2012) and regular appointments and interventions can reinforce the need to comply (Hatmaker & Kemp, 1998). Pregnancy-related problems are not simply viewed as biomedical concerns, but judged by women according to the impact of that problem (Bayrampour et al., 2012) or related decision-making (Pilnick & Zayts, 2012) on their social and economic worlds. Self-monitoring may offer women greater autonomy, although uncertainties about making the right decisions can increase anxiety and consequently be disempowering (MacKinnon, 2006). Comparisons between hospital in-patient or day-patient care for women with at-risk pregnancies have failed to demonstrate that either management is effective in allaying women's concerns (Hatmaker & Kemp, 1998; Stainton et al., 2005; Stainton, Lohan, Fethney, Woodhart & Islam, 2006). Hospitalisation itself can increase women's perceptions of risk and related concerns may outlast the causative condition (Gray, 2006). In addition hospitalisation has been linked with women's concerns about their family's ability to cope in their absence and treatment side effects (Hatmaker & Kemp, 1998; Sittner et al., 2005; Stainton et al., 2005; MacKinnon, 2006; Stainton et al., 2006; Price et al., 2007). Extra support may be beneficial during a post-hospital phase which might be particularly stressful for women.

Screening and diagnostic testing

Where fetal anomaly screening leads to diagnostic testing, this can be a source of great anxiety for women. The risk of miscarriage associated with diagnostic testing (amniocentesis) may cause more trepidation than the condition itself (Georgsson-Öhman et al., 2006; Sun et al., 2008), although waiting for diagnostic results can feel like a nightmare for women since the results are potentially life-changing (Sun et al., 2008). Negative diagnostic results can lead to women experiencing a more optimistic pregnancy, although older women may be less reassured than their younger counterparts (Lawson & Turriff-Jonasson, 2006). Concerns around screening and diagnosis may be replaced with other fears, resulting in some older women reporting less intense emotional attachment to their unborn infant than younger women (Lawson & Turriff-Jonasson, 2006; McMahon et al., 2007; McMahon et al., 2011; White et al., 2008). Whereas giving birth to a healthy baby might resolve worries for some women (Sun et al., 2008), other women's anxiety persists (Georgsson-Öhman et al., 2006).

Avoiding screening and diagnostic testing for fetal abnormalities enables some women to take control by also avoiding an increased risk of losing a long-awaited child either as a direct (miscarriage) or indirect (termination of pregnancy) consequence of amniocentesis (Morgan et al., 2012). For other women testing provides a means of anticipating and preparing for all eventualities (Sun et al., 2008; Mandel, 2010, p339; Morgan et al.,

2012). In contrast fears about the challenges of caring for a disabled child lead other women to terminate their pregnancy; although where this is the case, older women may fear that their age and any conception difficulties might prevent any future pregnancies (Georgsson-Öhman et al., 2006). Amniocentesis is worrying for women and related discussions and decision-making around termination following amniocentesis can be emotionally challenging (Kelhä, 2009), leading to some women being unable to consider themselves pregnant and experiencing what Rothman (1993) described as a 'tentative pregnancy'. The negative effect of risk-labelling and discourse on women's experience requires sensitivity particularly where older pregnant women may already be conscious of being different or vulnerable.

Managing the risks

Pregnant women may feel insecure when they are unable to comprehend the severity of risks (Mu, 2004) or where reality differs from expectation (Leichtentritt et al., 2005). Nonetheless women may attempt to minimise their personal and baby's risk by whatever means possible. MacKinnon (2006) identified women who were at risk of preterm labour ceasing their usual activities to commence their new role of "keeping the baby in" (p705). Similarly accepting interventions can be difficult for women who feel well. Barlow et al.'s (2008) study of 12 women hospitalised with pregnancy related hypertension revealed women struggling to accept their situation. Some women berated themselves for worrying, whilst also sensing a loss of control since their condition occurred irrespective of previous responsible behaviours. Thus, acting responsibly does not always avoid complications, which could fuel further uncertainties.

Having a high-risk label gives pregnant women greater access to health-care providers which may be viewed as affording them greater power in relationships with obstetricians. Availing themselves of high-risk care enables women to do what they can to optimise outcomes (Simmons & Goldberg, 2011). Conversely, when a high-risk condition has been identified and health professionals or family assume responsibility, women can feel a greater sense of disempowerment. In Evans and O'Brien's (2005) exploration of women's experiences with gestational diabetes mellitus (GDM), women described "living a controlled pregnancy" (p71) and unrelenting assessments from health professionals and family. Furthermore, some women seemed to be disempowered by management regimes and attempted to regain some control through non-compliance. For other women, diagnosis with GDM incentivised healthier lifestyles, thus empowering women to take control rather than being controlled (Evans & O'Brien, 2005). Whilst women with GDM may recognise the benefits of following medical advice (89%) or making lifestyle changes (96%) for their future health, translating this understanding into action can be challenging (Goldstein, Gibson-Helm, Boyle & Teede, 2015).

Older mothers may have greater resilience, which may develop as a strategy for handling age-related pregnancy risks (McMahon et al., 2007) or as a consequence of greater socioeconomic stability (Hammarberg et al., 2013). Some older women are proactive, employing their prior skills and experience to achieve a sense of control (Carolan & Nelson, 2007). For instance, Heyman et al. (2006) reported women seeking to actively manage potential health threats by paying to reduce the period of uncertainty rather than waiting for screening results. However social circumstances can prevent some women utilising services. Durham (1999) found that even where women knew that resting might reduce the risk of preterm labour, conflicting family needs prevented them implementing this advice. Therefore women prioritised what they did, slowly increasing their activity – testing the advice they had been given or “cheating” (Durham, 1999, p498). Providing advice alone is insufficient to change people’s behaviours.

Older women may invest time and effort in preparing for mothering: producing detailed birth plans as well as plans for parenting (Carolan, 2003b; Carolan, 2007; Kelhä, 2009). They may be conscious of, and worry more than younger women about, possible childbirth risks (Windridge & Berryman, 1999; Yang, Peden-McAlpine & Chen, 2007). Windridge and Berryman (1999) reported that increased awareness of age-related risks did not appear to disadvantage older women during childbirth and, when complications did occur, older women were more likely to express satisfaction with how these were managed. Furthermore they were less likely to blame carers for negatively affecting their birth or its outcomes. However, older women can be more self-critical about their birth with adverse events, such as a caesarean birth, or loss of control being perceived as personal failures, particularly when this deviates from prior expectations (Carolan, 2003b; Kelhä, 2009). Aasheim Waldenström, Rasmussen and Schytt (2013) agree that older women might experience a more negative experience of spontaneous birth than younger women, possibly as a result of increased interventions such as induction of labour. Nonetheless, their findings also suggest that older women are more accepting of instrumental or caesarean births. Older women may have a greater awareness of the potential for this type of birth and are therefore better prepared if it happens.

Having a high-risk label such as being older can impact on women’s social, emotional and mental health as well as influencing their biophysical well-being. As a result women may avoid emotional engagement with their pregnancy or baby. Resolution is possible for some women when the perceived threat fades, although the fears and anxieties continue beyond the period of threat for others. Thus a threat during pregnancy can continue to impact on a woman’s life beyond the birth. Conversely older women may seek to actively reduce their risk by developing their knowledge and accessing care. The current study explores care provision from the perspectives of women and midwives with

the intention of gaining feedback on recommendations for practice so that an effective and practical model of care might be recommended.

Becoming an older mother

The following section relates to becoming an older mother and will discuss evidence around the ways in which women accommodate this important new role through adapting their identity and lifestyle to address new challenges.

Finding a new identity

Older motherhood encompasses private and public identities which are handled through women's interactions with others as they attempt to preserve their rightful status as a mother (Friese et al., 2008). People perceive and negotiate their position according to sociocultural norms and, where older parenting complies with social norms, women are more likely to feel included (Friese et al., 2008). Furthermore, being pregnant when older can be viewed as advantageous on account of associated emotional and social maturity (Bayrampour et al., 2012). However, some women feel stigmatised by their new position within society as an older mother (Carolan, 2003b) or, even more so, as a single older mother (Mandel, 2010). After becoming a mother at 50, Crowley (cited in Roberts & Forster, 2015) writes: "There's a level of shame attached to saying "I really want to be a mother", especially as you get older". Some women view media stereotyping of older mothering as potentially detrimental for the mother and child (Dobrzykowski & Stern, 2003; Nelson, 2004; Budds, 2013), yet other representations perpetuate misunderstandings that pregnancy and mothering at any age is possible (Campbell, 2011; Mills, Lavender & Lavender, 2014; Yasa, 2014).

Friese et al (2008) observed older women negotiating their status by normalising their position or being extraordinary. Normalisation involved women reinforcing their position as a good and normal parent or drawing attention to increasing numbers of older mothers. Older women may be particularly conscious of other people's views and adopt differing strategies to conform. Some women attempt to appear younger to moderate others' responses to their age and minimise self-consciousness (Heyman & Henriksen, 2001; Yang et al., 2007), to avoid negative comments or embarrassment about women's relationships with their children (Dobrzykowski & Stern, 2003; Friese et al., 2008; Chen & Landau, 2015; Jarvie et al., 2015). Other women normalise their position through disassociation with weakening attributes such as being unable to cope (Heyman & Henriksen, 2001) and not informing work colleagues about their pregnancy for as long as possible (Carolan, 2003a). Pregnancy can therefore be isolating, particularly for older

women who feel unable to discuss pregnancy-related concerns with peers, or share concerns with younger women who lack insight into their age-related concerns (Yang et al., 2007). Whilst normalising appears to be a common strategy, there is less evidence of older women setting themselves apart from the other mothers, reflecting Friese et al.'s (2008) findings.

Adjusting to mothering

Women with complex needs are likely to prioritise their baby's needs above their own (Leichtentritt et al., 2005; Evans & O'Brien, 2005; Stainton et al., 2005; MacKinnon, 2006). Sociological factors influence women's child-bearing choices and drive to become a good mother, although pregnancy-related risks can intensify a sense of pressure (Leichtentritt et al., 2005) and indeed increase the risk of iatrogenic problems (Bayrampour et al., 2012). In the presence of risk, women can feel challenged in their potential to be a good mother (Mu, 2004) or fearful that worrying could harm their infant (Georgsson Óhman et al., 2006). Moreover, women may avoid attachment to their unborn baby when the future appears uncertain although hearing the baby's heartbeat can provide transient reassurances (Simmons & Goldberg, 2011). Nevertheless, similar attachment levels have been found for high- and low-risk parents where babies are born generally healthy (Dulude, Wright & Belanger, 2000). In addition 'high-risk' new parents may feel more successful than their low-risk counterparts. It is possible that adaptations made to avoid risk in pregnancy mean that fewer changes are required following birth. Alternatively, gratitude for a healthy baby may incline these parents to general optimism (ibid, 2000).

Becoming a mother is a life changing event (Morgan, Merrell & Rentschler, 2015) with some women believing that older maternal age poses unique challenges and advantages. Even where women are happy about becoming pregnant, concerns about their physical capacity for pregnancy and their infant's health may lead them to experience significant ambivalence (Yang et al., 2007; Sun et al., 2008). Longer term concerns about lower energy levels and weakening health may be perceived as manageable through socioeconomic advantage (Heyman & Henriksen, 2001). Moreover, while older pregnant women may prepare extensively for becoming a good mother, the reality and commitment this entails can be surprising (Carolan, 2007; Morgan et al., 2012; Morgan et al., 2015). High self-expectations of mothering, limited understanding of baby cares and adaptations needed to balance the logistical, emotional and social demands of combining mothering and working, can give older mothers a reality shock (Nelson, 2004; Morgan et al., 2015). In addition, older mothers may have to balance managing the potentially conflicting needs of their baby and elderly dependent parents (Morgan et al., 2012) or older children (Jarvie et al., 2015).

Experiencing a challenging transition to mothering does not mean that mothers do not love or want to love their baby (Gatrell, 2005). New babies can trigger feelings of overwhelming responsibility (Carolan, 2003b; Carolan 2007) yet some older women are reluctant to seek guidance, anxious that this positions them as failing (Carolan, 2003b; Nelson, 2004; Carolan & Nelson, 2007). According to Gatrell (2005), older middle class women expecting their first baby may be most receptive to expert opinion about parenting; such advice can imply that, as a good mother, women should be emotionally resilient, temporarily disregarding their intellectual and sexual identities in favour of their identity as a mother. Budds (2013, p117) agrees, suggesting that these are "notions which are central to contemporary definitions of 'good' motherhood."

Male partners may share childcare responsibilities, although mothers often act as "central caregiver" (Morgan et al., 2015, p485) and, whilst difficult adjustments are not unique to older mothers, adapting may appear more intense due to previous independence. However becoming a mother can provide a real sense of achievement with the benefits outweighing any challenges (Mandel, 2010). In addition, after initial adjustments, many women can utilise pre-existing organisational skills to manage childcare-related decisions (Carolan & Nelson, 2007), although if this fails to create a sense of competence, older women can feel inadequate (Carolan, 2003a).

Fitting-in as an older mother depends on sociocultural norms and women's ability to position themselves as a good and normal mother. According to Ridgeway and Walker (2001, p311) "cultural beliefs that attach status value to a characteristic also unite it with implicit expectations for competence". Thus where older mothering is accepted there may also be expectations that women can fulfil this role, yet for some older mothers this is challenging, particularly where they have additional or competing responsibilities. Some older mothers underestimate the demands of becoming a new mother, although life experience may afford transferable skills which can ease adjustment to their new role. The current study builds on this understanding by focussing on responsibility in the transition to older mothering and draws on the experiences of first-time and parous women in addition to the views of their community midwives.

Being supported

"How mothers feel about their health care has become an inseparable part of having and rearing a baby" (Oakley, 1979, pp274-5).

It is difficult to anticipate feelings about an event until this becomes a reality (Nord, 1999) and prior experiences provide one lens through which events are viewed. In previous generations, mothering skills and support were shared between female networks, yet contemporary older mothers may have little social support; understanding what makes a good mother does not make this easier for women to achieve (Kitzinger, 1995). This section explores evidence relating to social, spiritual and professional support for older women and suggests that regardless of former life experience and skills, support can make a difference.

Social support

Older women may use their life experiences to deal with their world but mothering is challenging and, as for younger women, support is advantageous. Partners, family members and friends can provide valuable help for women experiencing at-risk pregnancies (Sittner et al., 2005; Barlow et al., 2008). However, whilst Zadeh et al. (2012) found that family or spouses in Iran supported women with high-risk pregnancies well, these women were unlikely to feel well-supported by both. Partners' support and encouragement are valuable in decision-making although a lack of empathy can leave women feeling unsupported (Heyman & Henriksen, 2001; Georgsson Óhman et al., 2006). In addition, high-risk pregnancies may be associated with more relationship problems and women's negativity towards partners (Zadeh et al., 2012). Some women worry that providing this support could place loved ones, and their relationship, under considerable strain (Georgsson Óhman et al., 2006; Mu, 2004), with mothers of teenagers expressing specific concerns about not taking advantage of older children (Jarvie et al., 2015). Experiencing an at-risk pregnancy may be "much more than a medical diagnosis" (Stainton et al., 2005, p19) since it can be challenging and traumatic for women and their families, although mutual empathy can moderate such problems (Sittner et al., 2005). Indeed in some cases being 'at-risk' enables women to access help that would otherwise have been unavailable; where women have little or no family support, their means of assistance may be limited (Sittner et al. 2005; MacKinnon, 2006). Turning to pre-existing resources or identifying new ones can provide alternative support.

Spirituality may play an important role in supporting women through difficult times (Leichtentritt et al., 2005; Sittner et al., 2005). Price et al., (2007) reported the pregnancy-related concerns of hospitalised pregnant women leading them to reflect or pray more than normal to feel calmer and more confident. For one woman religion provided "a sense of empowerment in a situation where you have little or no power over what's going on" (ibid, 2007, p67). Similarly Bayrampour et al. (2012) report that faith

enabled older women to deal with their anxieties by knowing that they were not alone and helping to relieve the burden of responsibility for decision-making.

Whilst older mothers might have significant financial and experiential adaptability, their need for support is no less than for younger women (Yang et al., 2007). They can feel unable to relate to peers who do not have babies and unable to discuss age-related concerns with mothers of young babies (Dobrzykowski & Stern, 2003; Yang et al., 2007; Morgan et al., 2012; Chen & Landau, 2015). Such incongruity can result in older women having a "thin network of support" (Morgan et al., 2012, p160). In addition, becoming a new mother can signify the end of relationships with non-mothers, compounding the problem (Brunton, Wiggins & Oakley, 2011). Being aware of other women's pregnancy-related problems can exacerbate concerns, but using other women's experiences as a benchmark against which to judge their own situation enables some women to feel hopeful (Barlow et al., 2008; Rubarth et al., 2012) particularly where their usual support networks are inadequate. Support from women in similar circumstances can facilitate the transition to older mothering (Dobrzykowski & Stern, 2003; Laminpää & Verviläinen-Julkunen, 2012) and the development of support systems can facilitate adaptation to this new role (Yang et al., 2007; Mandel, 2010; Morgan et al., 2012).

Maternity care

The quality of professional support for women with complex pregnancies appears to vary. Some women report insensitivity and concerns being disregarded by health professionals (Carolan & Nelson, 2007). This may manifest through health professionals highlighting women's age in their pregnancy records or using euphemisms to avoid calling women 'old' (Heyman & Henriksen, 2001). Other women perceive discordance between their own and doctors' understanding and acceptability of risk. Values and decision-making are likely to be influenced by women's cultural and spiritual context, partners, friends and family (Sun et al., 2008); nevertheless, effective information-sharing and compassion from health professionals are important in enabling women to negotiate their pregnancy experiences (Mandel, 2010). Frequent antenatal appointments can provide a greater sense of safety, and in Finland, where women have more routine antenatal appointments than British women (11-15 and 7-10 respectively), women aged 40 or over did not want these to be reduced. Furthermore, they wanted additional information, specifically regarding screening, labour and birth (Laminpää & Vehviläinen-Julkunen, 2012). O'Connor et al. (2014) report many UK older pregnant women rating pregnancy care as generally high, yet their findings echo Heyman et al.'s (2006) reports of insensitivity and insufficient time for midwives to provide adequate support or good continuity of care. In addition, women reported feeling frightened by midwives' language or believing that midwives prioritised personal agendas above women's

interests. A lack of confidence in midwives and obstetricians can lead women to consider changing (O'Connor et al., 2014) or wishing that they could choose their care provider (Laminpää & Vehviläinen-Julkunen, 2012). Almost 20 years ago Lee (1997, p18) suggested that women prioritised good care above continuity, yet some older women are still disappointed.

Women value being involved in decision-making (Laminpää & Vehviläinen-Julkunen, 2012). Taking control may be viewed as acting responsibly and this may be particularly significant for older women who are deemed to be already at-risk on account of their older body (Kelhä, 2009). Midwives can however assume that older women are knowledgeable based on their childbearing experiences or because of their age (O'Connor et al., 2014) which can limit information sharing, leaving women and their infants vulnerable. Such assumptions may seem valid where women readily conform to medicalised processes so as to be regarded as a "competent social actor" (Kelhä, 2009, p97).

Pregnant women who are categorised as being at-risk may require extra professional support. Frequent appointments with midwives and obstetricians and technology such as ultrasound scans can be reassuring for women experiencing high-risk pregnancies subsequent to perinatal loss (Simmons & Goldberg, 2011). Midwives can enhance women's independence by enabling them to manage their condition through new knowledge and skills (Evans & O'Brien, 2005), familiarising them with neonatal care provision (Sittner et al., 2005) or generally providing support and information in a way that women can understand to facilitate decision-making (Georgsson Óhman et al., 2006; Heyman et al., 2006; Lerman et al., 2007). Insufficient information and inconsistency between carers make it difficult for women to understand their situation, creating anxiety and fear about seeking clarification (Barlow et al., 2008). Uncertainty or incomplete understanding impairs women's capacity for making the 'right' decisions and the complexities of some women's lives confound this further. Providing individualised care can facilitate understanding and enable women to incorporate interventions to improve their health if they wish (Durham, 1999). Medical discourses about pregnancy may imply that women who fail to engage in risk-reduction strategies are irrational or failing; although women may not feel able to discuss their potential for risk with health professionals (Keenan & Stapleton, 2010). Mutual respect is important although vulnerability can create dependence (Sittner et al., 2005; Leichtentritt et al., 2005) which may provide initial reassurance but disempowerment in the longer term.

Older pregnant women may have limited support networks, yet they may also be reluctant to seek support on account of wanting to be accepted as a good mother. Health professionals can support older childbearing women, although current provisions do not

appear to meet women's needs. Having little capacity to engage with health professionals seems to be significant in determining the quality of support provided to older women during pregnancy and preparations for mothering. Previous literature does not provide an in-depth account of older women's experiences of current pregnancy care in the UK from women's or midwives' perspective. Such an exploration, as provided in the current study, can contribute to the growing body of evidence around this increasingly common issue.

Summary

Although many older women may wish to be in the right physical, financial and relationship place to have a baby, the timing of pregnancy and motherhood is not always within their control. Women's reasons for becoming pregnant in later life result from a complex combination of social, emotional and biological factors, and can differ from the stereotypical representations of older mothers as portrayed in the media (Campbell, 2011; Budds et al., 2013) or deemed culturally acceptable (Lupton, 1993). Women can experience difficulty negotiating their role as an older pregnant women and mother particularly where older mothering deviates from the social norm. Despite extensive planning and preparation for this transition, many women are surprised or overwhelmed by the realities that this new identity entails. For women who are used to independence adapting to pregnancy and mothering may be challenging. Older women may have high self-expectations and are likely to be self-deprecating when reality fails to meet their hopes.

Extensive information seeking enables some women to feel more in control; for others increased knowledge increases concern. Older women face an array of potential pregnancy-related complications although labelling them as high-risk in an attempt to minimise problems can increase feelings of vulnerability. Much risk related information is based on epidemiological data, which are not always helpful in enabling women to make choices (Nettleton, 1997a; Lupton, 1997; 2003). The effects of labels such as 'high-risk' have been previously discussed and Enkin (1994) suggested that labelling may only be beneficial where interventions can eliminate or reduce the problem. When women feel uncertain they may be more susceptible to clinical direction and, consequentially, informed compliance (Jordan & Murphy, 2009). All women are unique and their perceptions are likely to be influenced by cultural and temporal issues. Assessing women's individual cultural context may enable carers to support women in dealing with their position (Stahl & Hundley, 2003), although it is important to avoid making

assumptions based on characteristics such as perceived knowledge and organisational abilities (Pilnick & Zayts, 2012).

The findings from this literature review provide insight into the issues facing older women regarding pregnancy and becoming a mother. However, the majority of literature exploring the older women's experiences of pregnancy relates to women aged 35 or over, with few relating to women aged 38 or more (McMahon et al, 2007; 2011; Perrier, 2013). Studies which address childbearing issues concerning women aged 40 or over describe their knowledge relating to fertility and advancing age (MacDougall et al, 2012), the psychosocial implications of risk of first childbirth following assisted reproductive technologies (Chen & Landau, 2015), becoming a mother (Morgan et al., 2012; Morgan et al, 2015) and women's views of maternity care in Finland (Laminpää & Vehviläinen-Julkunen, 2012). However, current literature does not provide an in-depth exploration of the pregnancy experiences of UK women aged 40 and over with a particular emphasis on risk, nor does it compare women's with midwives' perspectives: key aims of the present study. Binfa, Pantoja, Gonzalez, Ranjö-Arvidson & Robertson (2011) revealed that Chilean midwives recognised the special needs of older mothers and believed that they were well-positioned to meet these, but their work focussed on women's biophysical rather than psychosocial needs. There appears to be little evidence relating to midwives' perspectives on the experiences of older women during pregnancy. O'Connor et al (2014) identified this as an area for future research. Further insight into women's and midwives' views of the pregnancy experiences of older women in the United Kingdom could contribute to a growing body of literature around this increasingly common life-event and may enable training and development issues for midwives, or improvements in service provision, to be identified.

Study Aim and Objectives

The aim of my study was to explore women's experiences of higher risk status which is conferred wholly or partially as a consequence of advancing maternal age.

More specifically the preliminary objectives were:

To explore women's perspectives of pregnancy in relation to their age, with particular reference to perceived risk status.

To gain insight into the views of midwives regarding maternal age, risk status and risk communication.

To examine the ways that risk is communicated in consultations between midwives and women.

To obtain feedback about any proposals for improving practice based on the findings of the study.

In this chapter I have identified and discussed empirical evidence relating to women's experiences of having a high-risk pregnancy and the issues facing women who become pregnant when 'older'. I have stated the aim and objectives of my study and have outlined the contribution my research could add to existing knowledge. The following chapter addresses the research methodology and methods used in conducting the study.

Chapter Three – Methodology and Methods

Introduction

This chapter describes the methodology, theoretical framework and methods used to underpin and conduct this research study. The first part will justify the use of a qualitative, constructivist paradigm for investigating older women's experiences of pregnancy, the choice of grounded theory following Charmaz (2014) as a research methodology and symbolic interactionism as a theoretical framework. In this chapter I will also discuss the notion of 'the responsible citizen' since this is strongly associated with perceptions of the 'self' and the identified core concept of 'doing the right thing'. The second section of the chapter discusses issues around trustworthiness, authenticity and triggers for action, including the use of reflexivity. Ethical issues and ethical approval, the specific methods and strategies employed in conducting this study are then explained. These discussions are supported with reference to documents within the appendices to enhance transparency and trustworthiness.

Methodology

There are multiple pathways to good research and the strategy chosen should be feasible, ethical and suitable for the specific project (Denscombe, 2010). Lincoln, Lynham and Guba (2011) describe five research paradigms: positivism, post-positivism, critical theory, constructivism and participatory. A broader categorisation is provided by Polit and Beck (2008), who suggest that both positivist and naturalist or constructivist paradigms have legitimacy in health and social research. They suggest that whilst positivism and post-positivism are closely aligned with the objectivity of quantitative research, naturalistic inquiry is more strongly associated with the subjective and narrative nature of qualitative research.

Qualitative, constructivist paradigm

"Childbirth is a social and personal as well as a medical experience"
(Oakley, 1983, p106).

Whilst it is important to recognise women's medically orientated needs, gaining insight into their social and personal needs is important too (Oakley, 1983). Qualitative

(naturalistic) research facilitates the exploration of people's experiences to gain insight into how their truths are formed within and because of their cultures. It recognises that individual participants' 'reality' is multi-faceted and constructed (Corbin & Strauss, 2008) and that perspectives influence and are influenced by socially and historically constructed frames of reference (Lincoln & Guba, 1985). Naturalistic inquiry allows researchers to examine phenomena from multiple perspectives (Lincoln et al., 2011) thus facilitating an understanding of "the meanings and interpretations that they give to behaviour, events or objects" (Hennink, Hutter & Bailey, 2011, p9). In contrast, the positivist paradigm views knowledge as concerning 'facts', and 'reality' as external to the researcher (Denzin & Lincoln, 2000), an approach aligned with quantitative research. Naturalistic research recognises numerous truths or realities for given situations. It recognises, incorporates, and values the researcher's subjective experiences and the impact of these at each stage of research processes (Lincoln et al. 2011). As a woman, registered midwife and mother I recognise that my prior and current understandings about pregnancy and childbearing have impacted on my research throughout. Lincoln and Guba (1985) outlined the characteristics of naturalistic research and Appendix Four demonstrates how these relate to the current study.

This study did not aim to quantify relationships nor to test causal relationships, rather the objectives of the study seek to identify "patterns of interconnected themes and processes" (Polit & Beck, 2008, p62) so that the pregnancy experiences of women aged 40 years and over could be explored holistically. Recognising that perspectives have no absolute truth or validity, rather they are subjective and based on individual context, my ontological position is relativist and my epistemological perspective subjective. My research is thus located within a qualitative paradigm.

Grounded theory

Employed widely within social sciences (Guba & Lincoln, 2005), grounded theory (GT) respects personal experience in uncovering theory through theoretical sampling (Strauss & Corbin, 1990, 1998; Corbin & Strauss, 2008; Charmaz, 2008a; 2014). It offers "systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories from the data themselves" (Charmaz, 2014, p1) using iterative, comparative strategies which move between the data and analysis and which involve the researcher interacting with the data as findings emerge. Grounded theory enables researchers to explore everyday situations focusing on events, connections, interpretations and people's decision-making (Grbich, 1999). It encompasses a specific

qualitative methodology, which is “no better or worse than any other methods” (Glaser, 2010, p2).

Glaser and Strauss (1967) first described the grounded theory method, although a divergence in specific techniques became apparent when Strauss (1987) individually published detailed guidance. Both Glaser and Strauss emphasize the discovery of new meaning, the identification of a core issue, which incorporates significant elements or categories, and acknowledge the researcher’s prior life experiences, although there are differences in their specific methods. Glaser’s (1998) stance is that early understandings about the subject matter should be broad, with targeted reading occurring only to contextualise the emergent theory. According to Glaser (2012a) researchers should remain objective with a view to allowing the findings to emerge solely from the data and he criticises deviations from these principles (Glaser, 2010; 2012b). Data is collected through “passive, non-structured interviewing or listening of the GT interview-observation method” (Glaser, 2012b, p30). In comparison Strauss and Corbin (1998), Corbin and Strauss (2008) and Charmaz (2014) acknowledge the value of the researcher’s self and pre-existing literature in providing theoretical sensitivity. Charmaz (2014, p161) describes this as “the ability to understand and define phenomena in abstract terms and to demonstrate abstract relationships between studies’ phenomena”. Grounded theory researchers can thus identify understandings from emerging data patterns and outline the specific characteristics of the categories they construct.

All variations of grounded theory methodology incorporate concurrent data collection and analysis, the dissection of data to challenge what is accepted as ‘real’, development of emerging themes through early analysis, theoretical sampling, identifying social practices and inductively constructing categories to clarify and combine these practices (Conlon , Carney, Timonen & Scharf, 2015). The methodologies developed by Glaser (1998) and Strauss and Corbin (1998) incorporate the iterative processes of data collection and analysis as stated above with coding on multiple levels. Strauss and Corbin’s (1998) intermediate level ‘axial coding’ requires a specific framework of questioning which may be deemed restrictive (Charmaz, 2014), distracting from the main focus of the data or artificially distinguishing the primary (open) coding from subsequent coding (Corbin & Strauss, 2008). Axial coding has been criticised for resulting in a final core category that is “created rather than creative” with potential loss of sensitivity and insight (Heath & Cowley, 2004, p146).

Constructivist grounded theory includes: researcher-participant reciprocity which facilitates the development of jointly constructed insight; researcher-participant relationships which acknowledge and seek to minimise imbalance; researcher transparency about their biographical position and how this impacts on their work (Mills,

Bonner & Francis, 2006). It rejects the objectivist position associated with Glaser's framework, embraces reflexivity and acknowledges impacting factors such as power and individuality (Conlon et al., 2015). Furthermore transparency and appropriateness of 'divergent' grounded theory may be viewed as more important than adhering to rigid step-by-step protocols (Amsteus, 2014). Charmaz (2014) presents constructivist grounded theory methods as a group of flexible principles rather than prescriptive rules. These principles include: gathering rich data which are suitable and sufficient for revealing the area of investigation and enabling the development of core categories; at least two phases of coding – initial and focused, with the possibility of axial coding and theoretical coding; identification of in-vivo codes; testing codes with extensive data; constant comparison of data with data and codes with data; memo-writing; theoretical sampling and reflexivity. Heath and Cowley (2004, p149) recommend that novice grounded theory researchers should not concern themselves with "doing it right", but observe the principles of constant comparison, theoretical sampling and emerging data. Constructivist grounded theory recognises temporal and contextual influences, and as such cannot produce a generalisable 'truth' (Larkin, 2014). Rather, it seeks to generate one version of truth which can facilitate understanding and the potential for action within the subject area.

Grounded theory techniques have been used previously in midwifery research (Sittner et al., 2005; Lalor, Begley & Galavan, 2008; Levy, 2006; Koehn, 2008) to reveal a sense of women's experiences with a growing body of evidence using constructivist grounded theory techniques in relation to health care (Barnett, 2012; Williams & Keady, 2012; Larkin, 2014; Chen & Landau, 2015; Tapley, Jack, Baxter, Eva & Martin, 2015; Templeman, Robinson & McKenna, 2015) (See Appendix Five). Charmaz's (2014) constructivist grounded theory principles have been used to guide this study. The methods used will be discussed in a later section.

Symbolic interactionism

Grounded theory's foundations lie within symbolic interactionism, a theoretical perspective derived from pragmatist traditions (Charmaz, 2008b; 2014). According to Mead (1934, p202) individuals' behaviours within any given culture are reflective of the "relational pattern of organized social behaviour which that society or community exhibits". Individuals modify their behaviours according to their understanding of how others perceive them. Subsequent actions and the perspectives of others impact on the perceived situation with consequential further refinement of perspectives (Charmaz, 2008b; 2014). Thus perceptions are fluid, dependent on time and context. Indeed my

own perceptions of pregnancy and maternity care have been affected by my professional and personal experiences and in the findings chapters I describe how numerous factors influence the views of women and their community midwives.

Symbolic interactionism is described as a “dynamic theoretical perspective that views human actions as constructing self, situation and society” (Charmaz, 2014, p262). Social interactions are evolving and unlimited and rather than being static, people’s lives comprise process and change. Interactions contribute to the shaping of society through common understandings and in this way influence the behaviours of individuals (Heath & Cowley, 2004) generating a cyclical, reciprocal process. Symbolic interactionism aims to demonstrate that many everyday beliefs are human constructs, although these may be considered ‘normal’ or taken for granted (Branaman, 2001). Interactions are crucial to understanding and resultant actions (Charmaz, 2014). Prior interactions create a social order which precedes the individual and creates the conditions in which actions and interpretations occur. Symbolic interactionism recognises the researcher’s contributions to their understanding of the explored phenomena (Heath & Cowley, 2004).

Theories relating to symbolic interactionism are inductive (Klunklin & Greenwood, 2006) with the ‘self’, the ‘world’ and ‘social action’ as the key concepts (Mead, 1934). The ‘self’ is developed through interactions with others and incorporates two aspects: the ‘I’ and the ‘me’ (Mead, 1934). The ‘I’ interprets, reflects on and synthesizes events; it is the “principle of action and impulse; and in its action it changes the social structure” (Morris, 1934, pxxv). The ‘me’ is the object of self-reflection that can be defined to others and the self. Each person has multiple ‘mes’, such as ‘mother’, ‘wife’, ‘midwife’ and ‘patient’ which are interchangeable and evolve in response to context and others. The ‘self’ results from the impulsive ‘I’ developing through a complex social order and in turn contributing to the organisation of a “distinctly human society” (Morris, 1934, pxxv). Each ‘self’ reflects a unique combination of characteristics resulting in peculiarities between people and their behaviours (Mead, 1934). Validating others’ responses develops self-concept, and feedback from widening social circles, including family, religion, the law and cultural norms becomes meaningful in determining behaviours (Klunklin & Greenwood, 2006).

The ‘world’ refers to the world of symbols (Blumer, 1969). Language and symbols are significant in determining and sharing meanings. Human worlds incorporate symbolic objects; personal and others’ actions shape these objects and as a result perceptions may change (Charmaz, 2014). According to Bowers (1988) only objects that have been assigned meanings are symbolic; these objects may be concrete such as a home, or abstract such as culture, they may also include verbal and non-verbal behaviours. Meanings originate from the ways that people react to objects symbolically through

actions and communications. These behaviours are shared with other people who consequently adapt their response to the object. Feedback from other people determines how further adaptations are shaped. As a consequence of such adaptations perceptions have a temporal element and symbolic interactionism facilitates an analysis of how current events evolve and influence perceptions of the past (Charmaz, 2014).

'Social action' and interaction involves 'actors' attempting to gauge another person's potential responses to an object and interpreting feedback about their own responses from the other person. Meanings are thus developed as social products and vary depending on the perspectives of the person with whom someone interacts (Klunklin & Greenwood, 2006). The 'actor' is the focus of symbolic interactionism; they are influential rather than influenced and society is constructed from interactions between individuals and groups.

Benzies and Allen (2001) summarise Blumer's (1969) assumptions underpinning symbolic interactionism. Firstly, people's responses to things depend on their perception of these; symbols or names are used to interpret their world. Secondly the meaning of things is influenced by interactions with other people in how they respond and thirdly meanings are managed and adapted by using familiar interpretive processes. Whilst this involves some freedom of choice, societal and cultural norms provide constraints. Each actor presents a face which they hope to have accepted, although acceptance relies on other people's responses (Ridgeway & Walker, 2001). Where circumstances are familiar and habits have formed actions become routine. However where there are difficulties in employing familiar strategies, increased consciousness demands alternative responses to be considered (Shibutani, 1986 cited in Charmaz, 2014).

In describing the meaning of reality as being socially constructed, Branaman (2001, p9) cites Thomas's (1928) theorem: "if men define situations as real, they are real in their consequences". However people do not have total freedom in defining situations, these are socially constructed based on inequalities in power relating to factors such as age, gender, class, educational and occupational status. Furthermore definitions of reality may pre-date the existence of an individual; therefore it is that individual's culture, family and community which influence primary definitions (Branaman, 2001). Systems such as health care are likely to embody social order and predate those who play roles within them, and although formal features of these systems limit individuals to some degree, continuously evolving understandings, patterns of working and organisational agents such as midwives and doctors mean that such order is fluid to some degree (Bryman, 2012). Researchers should to aim to view understandings from the perspectives of those concerned including temporal and local contexts (Lincoln et al. 2011) and qualitative research is concerned with gaining insight into participants'

perspectives and the meanings that they assign to their experiences (Flick, 2014). Perceptions may result from self-fulfilling prophecies in that people's beliefs determine their behaviour and impact on their experience and interpretation thereof. Events are understood according to pre-conceptions; perceptions about other people can determine specific behaviours towards them and this may in turn trigger a response which confirms their beliefs (Branaman, 2001).

There may be expectations that other people think and behave as we do. However different cultures and societies behave differently with some behaviours perceived as strange or unusual to others (Branaman, 2001). Whilst people's views and perspectives influence their lives and society, this is rarely entirely self-determined. Powerful structures exist although some people navigate these organisational conditions to meet their own needs. Where existing institutional values and behaviours limit behaviour by restricting options, responses to these options vary (Charmaz, 2014). Status structures reflect interactional disparity developed from one person's value of themselves in relation to their value of others; this is based on shared values about attributes, possessions or positions. Higher status confers the capacity to influence others, creating an informal hierarchy of power (Ridgeway & Walker, 2001). Higher status individuals have the power to demand compliance from lower status individuals where this compliance fits with social or cultural norms. However it may be unnecessary for them to exert this power since normatively appropriate instructions are likely to be complied with voluntarily (Thompson, 2000; Ridgeway & Walker, 2001). Lupton (2003) argued that power between patients and doctors is based on legitimate authority that has been accepted by society due to the potential achievement of collective goals (healing and well-being). Claims to status based on dominance may be met with collective resistance, and result in the dominant individual failing to achieve the desired status through a "normative control process" (Ridgeway and Walker, 2001, p304). As a result people may refer to shared goals in an attempt to prove themselves more worthy of superior status.

Defining and naming concepts facilitates understanding, although naming is rarely neutral (Charmaz, 2014). Strauss and Corbin (1998) stress the importance of contextualising names to facilitate understanding. For example: women who repeatedly miss antenatal appointments are labelled as 'non-attenders' which may be negatively interpreted as 'time-wasting'. If such women are prevented from attending by a controlling and abusive partner, a new label - 'victim of domestic violence' - may trigger a different understanding.

Charmaz (2014) suggests the label ascribed to oneself demonstrates self-concept, feelings and behaviours and renaming signifies change. In terms of my 'self', adapting from my familiar label 'midwife' to an unfamiliar label as 'researcher' has been an

iterative process. Similarly changes in perceptions of 'self' amongst the women in this study have been observed and will be discussed in the findings chapters. The meaning of people's behaviours can be examined through studying their interactions with other people (Edgely, 2003) and although people may stage their actions, aspects of their behaviour (for example, clothing and paralinguistic cues), rather than what is said, may reveal insight.

Symbolic interactionism and grounded theory

Charmaz (2008b) suggests that representing a fair and faithful picture of participants' explored world requires researchers to view their own meanings as tentative and the basis for further development. Thus researchers do not enter the research field as a blank canvas, since prior understandings influence interpretations of what is encountered. Researchers develop a secondary analytical role as they analyse the behaviours of others who are interpreting their own worlds (Forte, 2008) and in doing so attempt to see the world from the perspective of research participants and establish a more intimate and accurate understanding (Jeon, 2004).

Grounded theory is an open-ended theoretical perspective and as such aligns with symbolic interactionism's emphasis on process and change. Whilst there may be a perception that symbolic interactionism is unable to address 'macro' concepts such as inequality and power, Dennis and Martin (2005) argue that symbolic interactionism studies can focus on the ways that power relationships can be discussed in terms of power differentials, developing at 'micro' levels, with real people contributing to the way that societies are structured.

Glaser (2005) suggested that symbolic interactionism is inappropriate for Glaserian methods of grounded theory due to a number of tensions. Narrowed researcher perspectives and restricted emerging concepts may be cited as reasons for rejecting symbolic interactionism (Newman, 2008). However, Charmaz (2014, p277) suggests that using symbolic interactionism within a grounded theory methodology enables researchers to combine "theory and method into a coherent, unified whole without forcing their data and ideas into a prescribed set of concepts and may enhance rather than restrict the conduct and impact of the study". Furthermore symbolic interactionism can enable researchers to justify their findings in relation to different value systems as well as specific events (Klunklin & Greenwood, 2006). A strong focus on language ensures that participants' words are valued and also that the researcher considers how their own use of language shapes and informs what is said or understood. Using codes which reflect the language used by the women and midwives in the study aims to more

accurately reflect their meanings rather than my own, although I acknowledge that my personal and professional meanings have impacted on my interpretations of the data.

Symbolic interactionism and exploring the pregnancy experiences of women

Understanding how people behave and the factors that influence these behaviours is important within midwifery practice. Gaining insight into older women's experiences of pregnancy and how these experiences are influenced by women's worlds involves gaining an understanding of their individual perspective as well the factors that may have influenced this perspective. Researchers must have an understanding of any pre-existing assumptions and remain sensitive to the lives and situations of the people they study. Symbolic interactionism enables research to sensitively explore the lives of individuals in a variety of social settings, by acknowledging individuality and cultural differences (Benzies & Allen, 2001). It may not provide specific research techniques, although Blumer (1969) proposed this as a philosophy rather than a method. Furthermore, symbolic interactionism was criticised for insufficient emphasis on emotion (Meltzer, Petras & Reynolds, 1975), although emotions and affect are increasingly explored using this theoretical underpinning (Benzies & Allen, 2001). Since the current study aims to explore pregnancy for older women within the world of maternity care and the social interactions that may predispose to and result from such experiences, symbolic interactionism is an appropriate theoretical framework to use. In addition adopting a reflexive approach through being mindful of my own 'self' and the impact of my understandings and interactions on the research processes and participants has enabled me to be critical of the ways that meanings have developed.

Responsible citizens

Socially and culturally determined processes regulate which behaviours are deemed acceptable and contribute to preserving cultural unity (Lupton, 1993). This viewpoint supports Foucault's (1991) theory of 'governmentality', whereby societies seek to retain control through managing the behaviours of individuals within it by determining responsible behaviours. Political economy is facilitated by institutional use of a "complex form of power" (Foucault, 1991, p102) and self-governing strategies (Holmes & Gastaldo, 2002). Since societal norms provide benchmarks against which individuals are judged, oppressive and direct interventions are unnecessary (Flynn, 2002); cultural norms and rules are generally accepted without question through socialisation (Thomas, 2003).

Governmentality treats risk thinking as a means of social control through which people are expected to use scientific evidence such as epidemiological findings to self-regulate and behave responsibly (O'Malley, 2008; Heyman & Titterton, 2010). However such evidence based risk estimations are insufficient alone to determine risk-selection, with multiple social forces interacting to influence risk-related priorities (Heyman, 2010a). Detecting common characteristics leads to classification, and pregnancies may be labelled high-risk when allocated to a category in which adverse outcomes occur often enough to trigger "collective concern" (Heyman, 2010b, p43). For instance, women aged 40 or over may be considered to be at increased risk of pregnancy complications on account of their age.

Risk-selection may be based on the greatest perceived benefits to society, with priorities often determined by formal authorisation through bureaucracies such as the Department of Health (Heyman, 2010a). Healthcare falls under the umbrella of governmentality through promoting health as advantageous; as such it shapes society for economic purposes (Holmes & Gastaldo, 2002). Similarly, neoliberalism whereby free-functioning of market forces can improve resource use and thus economic development prioritises individual and family responsibility for managing well-being through ethically, morally and socially acceptable behaviours (McGregor, 2001; Connell, 2010). Midwives and obstetricians reinforce societal norms and expectations by informing women about pregnancy-related choices, risks and risk-reduction strategies (Samples & Heyman, 2015); such information may be driven by national or local agendas. Lipsky (1980; 2010) uses the term 'street level bureaucrat' to describe public service workers such as midwives and obstetricians who represent the state in their face-to-face work with citizens. Street level bureaucrats have some discretion in implementing policies. However, differences between bureaucratic and professional responsibilities may be problematic and the extent of their workload can mean they develop routinised ways to work more efficiently. They rarely need to exert any control since society determines responsible health-related behaviours (Hoyle, 2014).

Governmentality and neoliberalism make individuals responsible for managing their lifestyle for the good of themselves, their family and the state (Nettleton, 1997b; McGregor, 2001). However, familiarity with risks does not guarantee that it is possible to circumvent or minimise these (Lupton, 1993). The nature of risk is complicated (Beck, 2009); its meanings are individual and subjective (Searle, 1996; Alaszewski, 2005; Zinn, 2005). Failing to implement responsible life choices or those advocated by health professionals can lead to people being labelled as deviants (Thompson, 2000, p279). Such labelling may seem more justifiable where choices contribute to negative outcomes (Lupton, 1993). However, when medical experts confirm complications, the person is

relieved of responsibility for self-management (Thompson, 2000). Instead, they become responsible for accessing and following expert advice (Hugman, 1991).

People's right to self-determination may be waived more readily during emergency situations or to avoid confrontation (Levy, 2006); indeed depending on others can be useful for avoiding the emotional costs of responsibility (Alaszewski, 2010). Lipsky (1980; 2010) suggested that street level bureaucrats may respond best to people who cooperate, since this makes best use of resources. Thus, people who fail to conform, because they are unable or choose not to may receive inferior care. Blameworthiness may be attitude- rather than outcome-dependent making risk-takers more susceptible to blame than those who are risk averse (Cholbi, 2014). Pregnant women may be stereotyped as unwilling to listen by health professionals if seen as non-conforming. Health professionals may also provide limited information or do this in an unclear fashion, thus reinforcing their power and control (Kirkham, Stapleton, Curtis & Thomas, 2002). Being labelled may predispose to further deviance or attempts to right the perception (Thomas, 2003), although some women find it logistically difficult to do the 'right' thing on account of their social or physical circumstances (Thompson, 2000).

Trustworthiness, authenticity and triggers for action

No research method "can deliver an ultimate truth", although researchers must question whether their findings are "sufficiently authentic" to trust these in guiding actions (Lincoln et al., 2011, p120). The quality of qualitative research is judged by its trustworthiness, authenticity and potential to be a catalyst for action (Lincoln et al., 2011). Schwandt (2007, p14) suggests that Lincoln and Guba's (1986; 2007) strategies for assessing qualitative research's credibility and truthfulness are "an extension of the ways we support the truthfulness, honesty, correctness and actionability of our interpretations in everyday life". These research qualities are discussed below.

Trustworthiness

To be deemed trustworthy, research findings must reflect the meanings shared by participants as closely as possible (Lincoln & Guba, 1985; Lietz, Langer & Furman, 2006) and must reflect credibility, transferability, dependability and confirmability (Lincoln & Guba, 2007; Schwandt, 2007; Sandelowski, 2015). However bias during research processes and reporting pose threats to its trustworthiness (Lietz et al., 2006). Strategies to minimise such threats include prolonged engagement, member checking, triangulation, peer debriefing, negative case analysis, audit trail recording and reflexivity (Lincoln & Guba, 2007). In addition Morrow (2005) describes three categories for

judging trustworthiness: integrity of the data, balance between subjectivity and reflexivity and, clear communication of findings.

Member checking and prolonged contact

Since interpretations are vulnerable to researchers' own understandings, member checking is a key approach in ascertaining research quality (Lincoln & Guba, 2007). Whilst Kornbluh (2015) agrees, she argues that guidance to facilitate this is sparse. Nonetheless, periodically asking for participant feedback throughout research processes can enhance the collaborative nature and trustworthiness of research (Williams & Morrow, 2009). Informally engaging women and midwives prior to commencing the study enabled me to discuss the feasibility and value of the study and using a longitudinal approach to data collection enabled me to discuss tentative categories with women and midwives as data collection occurred. However, I attempted to present a range of perspectives so as to minimise the potential impact this might have on future disclosures. Participants were all sent a copy of the study recommendations and invited to comment on these prior to completion of the study.

The value of member checks as determining trustworthiness has been challenged (Morrow, 2005, Rolfe, 2006); imbalances in researcher-participant power may lead participants to defer to researcher's views if they perceive those views to be superior to their own (Kleinman, 2007). Whilst researchers do not have intellectual superiority over research participants, they must acknowledge their intellectual privileges, for example, analysing data from their perspectives and making ultimate decisions about the outcomes (Letherby, 2003). Findings that differ from a participant's personal experiences may be rejected (Kornbluh, 2015) and since naturalistic inquiry values multiple and constructed realities (Lincoln et al., 2011), variations between participants' and between the researcher's and participants' perspectives are likely. Therefore achieving a generalised consensus may not be possible (Sandelowski, 1993). I attempted to minimise power differentials through being honest about my position and the aims of the research, reflecting participants' language and being conscious of my appearance, spending time in the setting and using informal conversation to build trust.

Triangulation and negative case analysis

Triangulation or cross-checking data was achieved by gathering data from pregnant women at different times during their childbearing experience, their community midwives and listening to audio recordings of antenatal appointments. Constant comparison of data and codes within the grounded theory procedures enabled me to identify commonalities, differences and negative cases. Identifying negative cases contributed to the processes of coding, theoretical sampling and sufficiency.

Audit trail

Recording an audit trail demonstrates evidence of decisions and actions and contributes to transparency (Lietz et al., 2006). Integrity involves adequacy and dependability of data which have been gathered through clearly articulated processes; these should be illustrated by including protocols and audit trail extracts (Williams & Morrow, 2009); I indicate where such evidence has been included in appendices. Regular meetings with academic supervisors and senior midwifery clinicians were valuable in determining the quality and sufficiency of data. Achieving redundancy² or theoretical saturation³ can be difficult due to the disparate nature of people's experiences and understandings (Williams & Morrow, 2009). However, theoretical sampling ensured diversity of participants as far as possible.

Reflexivity

All research is subjective regardless of methodology and researchers make political decisions throughout the research process either consciously or subconsciously based on social interactions (Harrison, MacGibbon & Morton, 2001; Denzin, 2007; Letherby, 2003). Denzin (2007, p458) states that the ground in grounded theory "is a function of the researcher's shifting relationship to the world" and that interpretation involves different approaches to present people's worlds. Attempting to clarify participants' perspectives and meanings by contextualising these is "an essential, if not the essential component of good qualitative research" (Williams & Morrow, 2009, p579). Furthermore, ensuring that participants understand the researcher's role and the purpose of the research is vital (Miles & Huberman, 1994). In retelling participants' stories, researchers present *their* understanding and in this way qualitative research presents multiple perspectives and multiple layers of perspective (Ferguson, Ferguson & Taylor, 1992).

Qualitative researchers are not neutral in their observations (Altheide & Johnson, 2011) since their research links with their own lives (Charmaz, 2014); they inevitably influence and are influenced by this (Rubin & Rubin, 2012). Reflexivity helps to define qualitative research and aids researchers' consciousness of their role in co-constructing understanding (Finlay, 2002a; 2002b; Hall & Callery, 2001). It enables researchers to monitor (Wasserfall, 1993) and incorporate sensitivity to their own cultural, political and social contexts and create knowledge which acknowledges these (Robson, 2011; Bryman, 2012). Reflexivity recognises how pre-understandings re-model throughout the research process (Forbes, 2008). For instance, new insights gained as a consequence of

² The point at which no new information is discovered from additional data

³ Themes are fully developed, reflecting the intricacy of people's lives

changing personal circumstances enabled Berger (2013) to revisit and reshape her research findings in relation to marriage and parenting.

Procedural ethics alone are unable to address all ethical issues in day-to-day research practice (Guillemin & Gillam, 2004). Achieving a humane, non-abusive response whilst working within the boundaries of research roles is challenging. Through reflexivity researchers try to anticipate potentially difficult situations and strategies for responding to these (ibid, 2004). I recognised that I could be exposed to difficult or upsetting situations whilst listening to women's and midwives' accounts and remained mindful that my emotions may be detected, potentially leading participants to subconsciously modify their viewpoint or openness (Corbin & Strauss, 2008). In practice settings reflexivity may incorporate emotion work whereby conscious effort is required to moderate inappropriate actions (Della Fave, 2001). Rather than relying on specific guidance for the most appropriate response, reflexivity may "enable ethical practice to occur in the complexity and richness of social research" (Guillemin & Gillam, 2004, p278). I have drawn on my knowledge of the subject matter and communication skills to enhance my ability to use emotional intelligence in my interactions. Whilst familiarity with the subject area facilitates understanding of participant meanings, researchers must remain mindful of their knowledge and biases since these can influence the research at every stage (Letherby, 2003; McAuley, 2004; Berger, 2013). Indeed I acknowledge, as Finlay (2002b) suggested, that other researchers may have developed different relationships with, and prompted different responses from, the women and midwives.

Self-exploration may enhance developing awareness, but do little to empower or alter participants' positions. Consequentially, reflexivity may be construed as self-indulgent. Furthermore self-referential discussions can muddy the original research focus (Flick, 2014) and may be dismissed as "woolly, unscientific bias" (Finlay, 2002b, p543). However, Finlay (2002b) argues that subjectivity, sometimes mistakenly labelled as bias, enables multiple understandings of the same event to be acknowledged. According to Letherby (2003, p143), whilst there is a fine-line between "situating oneself" and self-indulgence; reflexivity goes beyond simple "naval gazing". Self-scrutiny is essential and omitting this can indicate a failure to acknowledge the impact of the researcher's self on others and the research processes. Throughout this study I have attempted to consider how my different 'selves' and my pre-existing perspectives about pregnancy, mothering and maternity care have impacted on my decisions, understandings and the responses of participants as an on-going process. As a result I have developed new ways of knowing. Thus reflexivity has facilitated cyclical, iterative research processes and insights (see Figure 3.1).

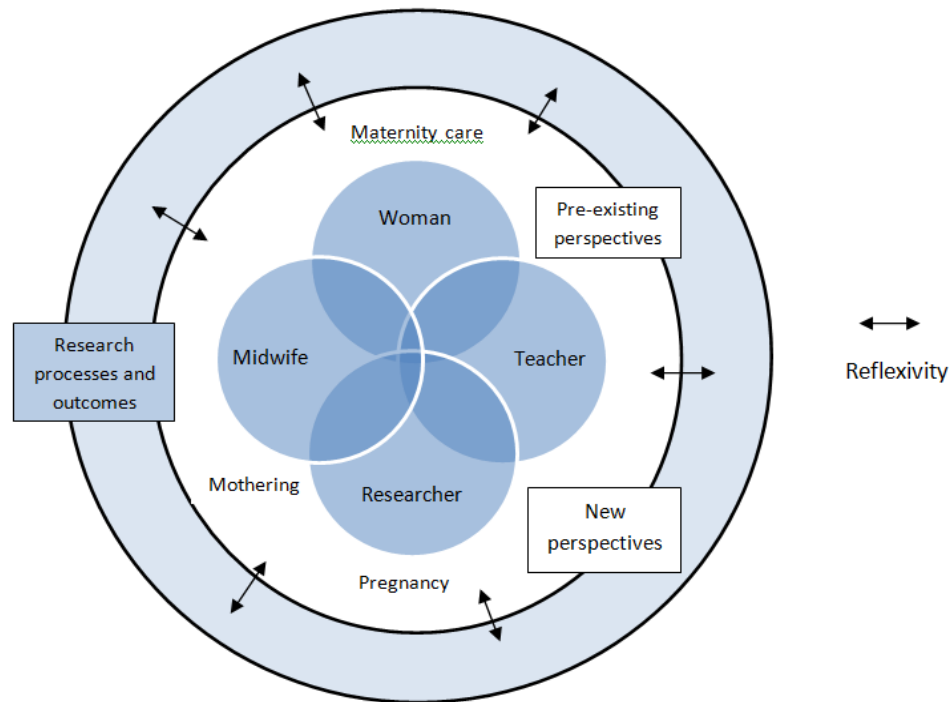


Figure 3.1. Diagram to illustrate the relationship between my life experiences, pre-existing and new insights and the research processes resulting from a reflexive approach

Insider-outsider continuum

Burns, Fenwick, Schmied and Sheehan (2012) suggested that qualitative researchers have a fluid position on a continuum between being an ‘insider’ and an ‘outsider’. Such fluidity enables them to “draw on their multi-layered identity to facilitate familiarity whilst maintaining an analytical degree of distance” (ibid, 2012, p59) as well as responding to the diverse social interactions that occur during the research process (Ritchie, Zwu, Blignault, Bunde-Birouste & Silove, 2009). It has been suggested that reflexivity can enhance sampling and data collection (Gardner, 2006; Neill, 2006). Acknowledging my different ‘selves’, I recognised that I might be perceived as both ‘insider’ and ‘outsider’ when recruiting midwives and women and collecting data. As an ‘insider’ I have utilised my knowledge of midwifery practice, the processes within maternity care and the local trust to facilitate access to older pregnant women and their midwives and to develop my research. I have understood the clinical and contextual topics discussed by women and midwives and it seemed that being a midwife was important in influencing women’s participation. However, it has been necessary to actively remember my position as an ‘outsider’. For instance, asking for clarification when midwives and women seemed to assume that I understood what they meant and when I believed that, based on my experience as a midwife, I *did* understand. Reflexivity enabled me to recognise that through failing to seek elucidation, my personal lens of

meanings and truths could obscure valuable insights as experienced by the women and midwives who were sharing their stories. This was particularly challenging initially when I felt less comfortable as a researcher and on reflection I recognised that I was not only attempting to make the women and midwives feel comfortable during interviews but also trying to make myself comfortable too. As a registered midwife it was challenging referring women back to their community midwife when I was asked questions that as a clinical midwife I could have answered easily, yet in my role as a researcher I was not in a position to do so. Being unable to be with (Byrom & Downe, 2010) or be professionally available for women (Pembroke & Pembroke, 2008) challenged my self-perceptions as a good midwife. Budds (2013) stated that being a non-midwife created difficulties when she was seeking access to study maternity care. I argue that being a midwife insider provides its own professional and ethical challenges.

Whilst I built temporary relationships, which can increase participants' willingness to share (Young, 2003), occasionally it was difficult to negotiate and maintain middle, non-clinical ground: to be honest and transparent whilst maintaining professional and researcher boundaries. Maintaining boundaries can cause emotion work in clinical midwifery practice (Hunter, 2005). I found this to also be the case in conducting my research. Using critical internal dialogue has enabled me to monitor my biases, understandings and actions (Berger, 2013); as a midwife I wanted to be able to help, reflexivity enabled me to appreciate that by giving these women and midwives a voice, I may be helping in an alternative way.

Initially I felt uncomfortable as a researcher, viewing my 'self' as a novice within an unfamiliar culture. At times felt that I was presenting a face which masked my own and I recognise that in the early stages I occasionally deferred to a more comfortable position as a midwife, an 'insider'. Through my developing understanding and repeatedly presenting myself as a researcher I was becoming the researcher that I had been trying to portray (Branaman, 2001). Charmaz (2014, p165) states that in writing about their own professions some grounded theorists "idealize them in remarkably uncritical ways that suggest an entrenched and unexamined value stance". To minimise this, the impact of my understandings on my study has been acknowledged at each stage through reflexive memos, a reflective journal and discussion with my research and midwifery supervisors. As recommended by Rolfe (2006) a reflective journal extract relating to my developing understanding of the insider-outsider continuum is included in Appendix Six.

Authenticity

Authenticity of naturalistic research may be determined using a number of criteria (Lincoln et al., 2011). These criteria include fairness, ontological and educative authentication, catalytic and tactical authentication. Good quality research represents

the voices of all participants by handling their stories fairly and without prejudice. Fairness is achieved by identifying, exploring and communicating different beliefs and values and negotiating any recommendations with stakeholders (Lincoln & Guba, 2007). Theoretical sampling enabled differing perspectives to be explored and recommendations for practice and further research have been shared with participants.

Ontological and educative authenticity involves research participants and people who have social or organisational relationships with them having the opportunity for increased awareness as a consequence of the research findings (Kvale, 2002). Research reports may provide valuable learning resources and enable policy holders to gain insight into their clients' perspectives, but cannot dictate how practitioners behave. However awareness of "the intended and unintended consequences of actions can provide the basis for thoughtful dialogue" (Silverman, 2013, p321). Catalytic and tactical authenticities demonstrate the study's ability to prompt action for the benefit of research participants, which may involve the researcher providing training where this is appropriate or desired. Rather than simply understanding participants, research should attempt to make a difference (Letherby, 2003): training needs will be discussed with midwives following completion of the study.

Lincoln and Guba (2007, p24) acknowledged that their authenticity criteria may not be comprehensive although this forms "part of an inductive, grounded and creative process that springs from immersion with naturalistic ontology, epistemology and methodology". Furthermore I have throughout attempted to be true to myself, my profession, to the women and midwives who have participated in, and those whose experiences may be touched by this research.

Clear communication and application of findings

Research findings must be clearly communicated and demonstrate "social validity" (Williams & Morrow, 2009, p580), for example through recommending alternative ways of working to address identified limitations to current practices or making recommendations for further research. Findings should be easily understood by the reader, supported with examples of participant voices and enable the reader to contextualise findings using current understandings and literature. In addition reports must be honest, accurate, unplagiarised and understandable (Denzin, 2011). I have practised with professional and academic integrity throughout this research. Extracts from data are used to illustrate my findings and discussions around my findings are contextualised by relating these to other sources of literature. Rolfe (2006) questioned the value of pre-determined criteria for assessing the quality of naturalistic inquiry and suggested research quality is judged by readers' impressions of the report rather than the research per se. In addition, Sandelowski (2015) suggests that interactions between

the reader, writer and text play an equally important role in determining quality as procedural aspects of the study.

Research methods

This next section describes the research methods used in conducting this study. It will include ethical issues, access to potential research participants, recruitment, sampling and consent to participation, data collection and analysis.

Ethical approval

Since this study involved collecting data from NHS employees and women accessing NHS provisions it was necessary to gain ethical approval from the relevant bodies. Ethical approval was sought and provided by the University of Huddersfield's School Research and Ethics Panel (SREP) in July 2012, the National Research Ethics Service (NRES) in November 2012 and the relevant NHS Research and Development Office in January 2013 (see Appendices Seven, Eight and Nine). Recruitment and data collection began in May 2013. Ethical decision-making and actions will be discussed in the following sections of this chapter.

Inclusion and exclusion criteria

Whilst some studies exploring the experiences of 'older mothers' relate to women aged 35 years or over (for example, Carolan, Davey, Biro, & Kealy, 2011; Cooke et al., 2012; O'Connor et al., 2014), current national guidelines for antenatal care (NICE, 2008) suggest women aged 40 years and over may have additional needs requiring supplementary care. Being 40 may therefore impact directly on women's pregnancy care and their experience of pregnancy regardless of other biophysical or psychosocial factors. An age limit of 40 has therefore been set for inclusion.

Inclusion criteria – women

English speaking pregnant women aged 40 years or more at the time of birth
Booked to give birth within the host Trust
Had at least one antenatal appointment with their community midwife after providing informed consent to participate

Exclusion criteria – women (based on the judgement of their community midwife)

Inability to provide informed consent under the Mental Capacity Act (2005)

Evidence of mental illness or major complications existing or developing

Inclusion criteria – midwives

Community midwives working within the host trust

Had identified at least one woman in their caseload who met the study's inclusion criteria and who was willing to participate

Gatekeepers

In addition to formal approval for conducting research, access is mediated by gatekeepers who can facilitate or obstruct access to participants based on their understanding of the researcher's motives, the effect of the study on the organisation and its staff (Bryman, 2012). Whilst gatekeepers normally restrict what can be studied (Silverman, 2013), my prior and current relationships with the host organisation facilitated early and continued contact with gatekeepers. This ensured that my motives and proposed methods were understood and enabled identification of potential barriers prior to seeking ethical approval. Ways of accessing midwives and women were suggested, which I might have been reluctant to suggest as an outsider and ongoing support from senior midwives was encouraging. For instance, discussions with the consultant midwife, who became my link within the trust, were able to reassure me about the value of my work:

Extract from research diary

"[consultant midwife] is meeting and supporting a 42 year old (postnatal) woman who was disappointed with her care and felt that her age negatively affected the way that she had been treated [...] [consultant midwife] said that she would tell the woman about the study [...] to demonstrate that older age is recognised as a real issue for women and that there are midwives who want to do something about this... made me feel that I am doing something worthwhile"

As the study progressed, familiarity within the trust enabled me to negotiate access with other gatekeepers who facilitated my access to the community midwifery teams. Letherby (2003) suggested that studies involving gatekeepers (in this case senior midwives) can discourage participation since it can be perceived that these gatekeepers might have access to information that participants have shared. Whilst I reinforced issues around confidentiality, anonymity and stressed that participation was completely optional for midwives and women, as a midwife myself I empathised with some midwives' anxieties about personal and women's vulnerability.

Recruitment and sampling

Initial contact was made through group meetings with community midwives in the three geographical areas within the host trust. I provided written and verbal information about the study purpose and design and what would be expected if they consented to participate (see Appendix Ten). Mindful of community midwives' daily pressures, I realised that identifying potential research participants for my study could easily be forgotten. Therefore after initial discussions, and in agreement with senior midwives, I sent monthly reminders and asked the community midwifery managers to remind the midwives about my research. In addition I took advantage of opportunities to gain face-to-face contact with midwives since this seemed to have a more powerful impact than indirect communication. Individually, I could address specific concerns better, although I was careful not to apply pressure to participate. Direct contact resulted in some midwives trying to recall suitable women within their caseloads and others recommending that I approach particular midwives who were deemed to have caseloads with higher numbers of older pregnant women.

Midwives interested in participating were asked to provide written information about the study to women who met the inclusion criteria so that they could contact me if they were also interested (see Appendix Ten). Several women contacted me by e-mail or telephone; others asked their community midwives to forward their contact details so that I could contact them. The first participants recruited were a purposive convenience sample since they were the easiest for me to access within the resources available (Patton, 2002). However as the study progressed tentative categories identified from initial coding of earlier data were used to guide theoretical sampling. Theoretical sampling enables data to be collected to maximise the development of concepts, relationships to be identified between the different concepts and variations to be revealed (Corbin & Strauss, 2008).

In attempting to include an appropriate sample of participants with the greatest insight into the research focus (Bowen, 2008; Breckenridge & Jones, 2009) I selected women with specific characteristics to explore tentative findings. For example, women recruited in the early stages were mainly multiparous, some of whom discussed differences between themselves and women experiencing their first pregnancy. Therefore nulliparous women were specifically recruited. Inclusion criteria were broad to avoid restricting the authenticity of developing theory in line with grounded theory principles (Punch, 2006; 2014). Theoretical sampling of midwives was more difficult; the majority of community midwives at the time of data collection were experienced in community practice although it would have been useful to have explored the views of less experienced midwives. However self-selection for participation recruited only one

midwife with less than five years' experience in the community setting. Nonetheless, the longitudinal nature of the study enabled me to explore developing categories and concepts with midwives in later interviews.

To avoid overburdening any midwife or over-sampling any practice area, it was agreed that midwives should approach no more than four women who met the inclusion criteria. For each midwife who participated in the study only one woman from their respective caseloads was included. A total of 11 women and 11 midwives were initially recruited to the study, although one woman subsequently booked for birth within a different trust and was therefore excluded. Of the ten women and midwives retained there were participants from each of the three geographically based community midwifery teams. (See Tables 3.1, 3.2 and 3.3 for an overview of the participating women's and midwives' characteristics)

<u>Summary of women's attributes</u>	<u>Summary of midwives' attributes</u>
Parity at recruitment Multiparous: 3 Primiparous: 4 Nulliparous - 3	Age 30-40 - 1 40+ - 9
Multiple pregnancy - 1 Assisted conception - 2*	Ethnic origin White British / Irish / other - 10
Ethnic origin White British/Irish - 8 Black African - 1 Black Pakistani - 1	Length of time qualified as a midwife < 5 years - 1 5-10 years - 1 10+ years - 8
Site 1 - 3 Site 2 - 4 Site 3 - 3	Length of time as community midwife <5 years - 1 5-10 years - 2 10+ years - 7
*one additional woman had previously used IVF unsuccessfully on a number of occasions and then conceived naturally	Mother Is a mother: 9 Is not a mother: 1

Table 3.1. Overview of participant attributes

	Women's pseudonym	Age at birth of baby	Age at first birth	Parity at recruitment	Assisted conception	Site	Type of birth	Midwife
1	Liz	40	20-30	4	No	1	Elective caesarean	Margaret
2	Cath	47	40+	1	Yes	2	Elective caesarean	Debbie
3	(Excluded)							
4	Louise	40	35-40	1	No	1	Normal birth	Fiona
5	Miriam	45	20-30	6	No	2	Normal birth	Kirsty
6	Carol	45	40+	2	No	3	Elective caesarean	Ruth
7	Jenny	45	20-30	1	No	1	Emergency caesarean	Helen
8	Karen	41	40+	0	No	3	Normal birth	Anne
9	Clare	40	40+	0	Yes	2	Normal birth	Chris
10	Heather	40	35-40	1	No ⁴	2	Elective caesarean	Sarah
11	Wendy	42	40+	0	No	3	Elective caesarean	Lynne

Table 3.2. The women

	Midwife's pseudonym	Age	Length of time as qualified midwife	Length of time as community midwife	Is a mother herself
1	Margaret	30-40	<5 years	<5 years	Yes
2	Debbie	40+	>10 years	5-10 years	Yes
3	(Excluded)				
4	Fiona	40+	>10 years	>10 years	Yes
5	Kirsty	40+	>10 years	>10 years	Yes
6	Ruth	40+	>10 years	>10 years	Yes
7	Helen	40+	>10 years	>10 years	Yes
8	Anne	40+	>10 years	>10 years	No
9	Chris	40+	>10 years	>10 years	Yes
10	Sarah	40+	>10 years	>10 years	Yes
11	Lynne	40+	5-10 years	5-10 years	Yes

Table 3.3. The midwives

⁴ Heather had previously been unsuccessful in conceiving using assisted reproductive technologies and then conceived without assistance for both pregnancies

Qualitative studies aim to facilitate contextual concept transferability rather than widespread generalisability (May, 2002; Sandelowski, 2008; Kvale & Brinkman, 2009). Identifying the ideal sample size and episodes of data collection to achieve theoretical saturation within grounded theory is complex (Charmaz, 2014). Mason's (2010) analysis of 560 PhD studies identified samples ranging from four to 87 participants in the 174 grounded theory studies reviewed. Complete saturation may never be achieved as everyone's unique experiences mean that there are always new insights to discover (O'Reilly & Parker, 2012). However, 'sufficient' sampling may have been achieved when "considerable depth and breadth of understanding about a phenomenon, and the relationships to other categories have been made clear" (Corbin & Strauss, 2008, p149) or when no further dimensions emerge (Holton, 2007). Including women with diverse social, reproductive and health backgrounds facilitated insight into a broad range of issues affecting older pregnant women and has facilitated the development of codes and categories from women's and midwives' perspectives. Recruiting midwives with varying caseload demographics enabled the perspectives of midwives with differing experience in supporting older pregnant women to be included. Recruitment continued until no new categories were being identified and the identified categories incorporated depth and breadth of information (Bowen, 2008): "sufficient data to account for all aspects of the phenomenon [had] been obtained" signifying saturation (Morse, Barrett, Mayan, Olson & Spiers, 2002, p12). Ethical approval to recruit up to 15 women and 15 midwives to the study was granted and although some researchers recruit more participants than necessary "to be on the safe side" (Mason, 2010, p15), this wastes participants' time and may thus be unethical (Francis et al., 2010).

Informal conversations with midwives revealed that women recruited to the study were mainly those whom the midwives thought would be most interested in taking part and, supporting the work of Shue (2011), who would provide interesting data. However, some midwives' personal reluctance to participate may have prevented other women's perspectives from being heard. There may be a number of reasons why some eligible midwives and consequently some eligible women were not recruited to the study. For example, busy workloads can prevent clinicians from volunteering as participants (Broyles, Rodriguez, Price, Bayliss & Sevick, 2011; Shue, 2011; Scourfield, 2012; Høyland, Holland & Olsen, 2015) or studies may be viewed as having little relevance to practice (Broyles et al., 2012). Furthermore potential midwife participants may have experienced difficulties in remembering to share information with women, or may have had concerns about their own or women's eligibility (Kristensen & Ravn, 2015). Some midwives may have worried that participating could reveal areas of professional weakness. Certainly some midwives who did participate seemed to want reassurance that they were saying the right things. Wanat (2008, pp203-4) suggested that anxious

gatekeepers might use resistance tactics such as “controlling communication” about the proposed study or “forgetting” to arrange a time for data collection and that their busyness might be deemed a feasible reason for such omissions. Indeed, midwives’ busy workloads were very evident during my observations in the practice setting and in the accounts of women and midwives. Whilst I was able to discuss issues with women during our initial and subsequent conversations, I had little control regarding what or whether midwives told women, who might meet the inclusion criteria, about the study. Thus in addition to formal access and the approval of managerial gatekeepers, a third tier of screening or gatekeeping became evident in the form of the community midwives themselves. As a result some women were excluded from recruitment because midwives selected either themselves or the women out.

Consent to participation

Community midwives indicated initial interest in participation by referring women from their caseload. Following initial contact with women who expressed interest in participating I arranged to meet them immediately prior to their next antenatal appointment with their community midwife. This enabled me to introduce myself, discuss the information sheet, clarify queries, obtain informed consent or give women the opportunity to decline to participate. Women were all reassured that they could decline to participate or withdraw from the study at any time without providing a reason and that their non-participation would not affect their care or their relationships with their care providers. Midwives were reassured that non-participation would not affect relationships they or the trust had with the university or me. All the women that I discussed the study with consented to participation although three women who provisionally agreed to participate were then unable to do so either due to pregnancy loss (two) or booking for their maternity care within a different trust.

Women were offered a £20 gift voucher as a thank-you for taking part and the host trust was offered £500 towards training for midwives. Funding was provided by the University of Huddersfield. Whilst compensation for research participants is common, ethical concerns may be raised regarding the potential for coercion to participate (Silverman, 2013). However Largent, Grady, Miller and Wertheimer (2012, p500) argue that “because payment is an offer, rather than a threat, payment is never coercive”. Furthermore payment may contribute to balancing relational differentials between the researcher and participants (King & Horrocks, 2010). Some participants agreed to participate in principle prior to reading the information sheet or meeting with me, suggesting altruistic rather than monetary motivation to participate.

During recruitment and the immediate pre-data collection stages gaining informed consent and reassuring participants of confidentiality and anonymity is fundamental. However personal information may emerge during data collection, placing researchers in a potentially ethically exploitive position (King, 2004; Nunkoosing, 2005; Guba & Lincoln 2005). Gaining specific consent to record interviews is essential (King, 2004; Hennink et al., 2011) and offering transcriptions for participants to review is good practice (Nunkoosing, 2005). Whilst participants did not wish to review transcripts, most said they would be happy to read and comment on recommendations for practice.

Information and consent sheets provided details about confidentiality and anonymity and were developed using National Research Ethics Service (NRES, 2009) guidance. Written consent was gained from women and midwives prior to audio-recording the antenatal appointment (see Appendix Eleven). Since there were multiple episodes of data collection for each participant a process consent approach was adopted (Polit and Beck, 2008); consent was re-affirmed prior to and at each point of contact.

Confidentiality and anonymity

Researchers are responsible for developing and adhering to protocols to minimise the risk of personal data being inadvertently disclosed (Rubin & Rubin, 2012). Protocols developed to maintain confidentiality and anonymity of personal data followed guidance from the Department of Health (DH, 2003; 2008), the Data Protection Act (1998), the Human Rights Act (1998), The Nursing and Midwifery Council (NMC, 2008), the Royal College of Nursing (2009) and the Social Research Association (2003). Data were collected and retained following Caldicott principles (NRES, 2009). Pseudonyms were allocated prior to data collection and used to ensure anonymity when travelling to and from data collection sites. Audio recordings were stored in a password-protected format for transporting, transcribing and reviewing. Information regarding identity and contact details has been stored separately and securely. This was necessary to link data with individual midwives and women and to ensure that identities would be known only to me. To eliminate possible identification through inference, potentially identifying details were withheld or amended slightly. Transcribed data and documentation used to facilitate and record processes utilized pseudonyms, dates have been changed or omitted and, for women participants, job details amended. Data is therefore confidential to me and reported anonymously.

The potential for a serious risk of any participant being identified was considered and plans to deal with this in a timely and appropriate manner included consultation with my

research supervisors and reporting to my nominated link within the host trust. No such concerns arose.

Data collection methods

I conducted field work over an 11 month period, from June 2013 until April 2014. Data collection methods comprised audio-recording one antenatal clinic appointment per woman-midwife pair, followed by individual interviews with the women and midwives. Where women had not already had an obstetric appointment at the time of their first interview, a second antenatal interview was arranged to capture any significant experiences resulting from that appointment. All women consented to an additional interview after their baby's birth. The purpose of this interview was to allow their retrospective perspectives of pregnancy and birth to be explored. These interviews were conducted within two to five weeks of birth to enable women to recover from birth whilst minimising loss of recall.

For each woman there were a total of three to four data collection episodes and for each midwife two episodes. A total of 44 episodes of data were collected. I recorded detailed memos immediately following data collection, whilst listening to recordings, transcribing and coding data in order to develop a significant aspect of the grounded theory approach and demonstrate transparency and reflexivity throughout the study (Punch, 2006). (See Figure 3.2)

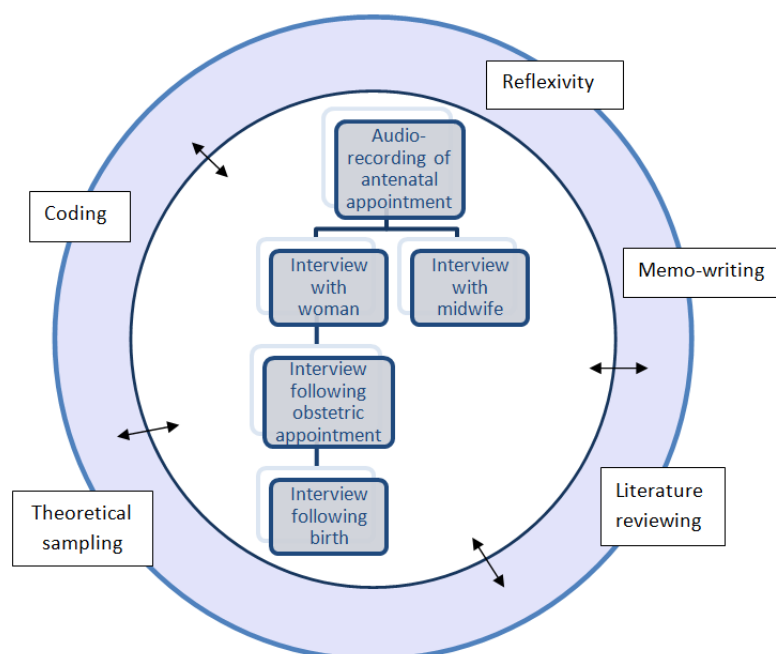


Figure 3.2. Diagram to demonstrate data collection methods

Audio-recording antenatal appointments

Audio-recording women's antenatal clinic appointments with community midwives permitted me insight into the social interaction within this out-of-hospital setting. Recording interactions facilitates a naturalistic account of events which is free from the researcher's influences at the time the data is collected (Flick, 2014; Silverman, 2013). To minimise any impact I might have on the interactions, after switching on the recorder I withdrew from the room. I acknowledge that in doing so I may have missed significant non-verbal cues and several women and midwives were surprised that I would not be remaining in the room with them.

A discreet recorder was used to reduce participants' concern with this and facilitate more naturalistic exchanges; it was placed so that the woman or midwife could stop the recording should they wish. Awareness of the recorder may have influenced interactions to some extent (Flick, 2014) and during some recordings direct reference was made to 'that' (the recorder). However awareness may have enabled participants to check their words (Peräkylä, 2004); and reduce the likelihood of anyone later requesting to have information excluded. In accordance with professional codes and standards (NMC, 2008, 2012, 2015) midwives appeared to be mindful of the potentially intrusive nature of the recorder. During one recording the midwife offered to make the woman an additional appointment in case the recorder had inhibited her ability to communicate anything sensitive (the woman declined).

Antenatal appointments were recorded between 13 weeks and 22 weeks gestation and lasted from six to 35 minutes. I had hoped to record appointments early during women's pregnancies, but women seemed generally reluctant to participate until they perceived greater pregnancy security. At times there were additional people present, such as a partner, student midwife or maternity support worker. Additional people were reassured that any contributions to the recordings would be excluded from the transcription and analysis. All recordings were listened to and transcribed as soon as possible after the appointment had taken place. Observations of the interactions between women, their midwives and me were documented at the end of each transcription as an aide memoire.

Interviewing

Interviewing as a data collection method is effective and popular particularly within social sciences (Nunokoosing, 2005; Silverman, 2013). All interviews are somewhat structured since interviewers have topics of interest and all prompts guide interviewees to some degree (Kvale, 1996; 2006; Brinkman, 2013). Standardised questions and interviews facilitate easier comparisons between participants although responses may be narrow and passive (Oppenheim, 1992). Conversely, loosely structured interviews can

stimulate more spontaneous and unexpected answers which can facilitate a stronger understanding of the interviewee's viewpoint and context (King, 2004; Miller & Glassner, 2004). Topic guides were developed using potential and preliminary questions and probes (see Appendix Twelve). As a novice researcher being able to refer to these guides enabled me to manage my role within the interviews more effectively and avoid neglecting significant issues. However, I sometimes worried that I could have managed the interviews better. Language plays a significant role within interviews and although research questions may be developed using theoretical language, embedding interview questions and prompts within interviewees' everyday language stimulates interpersonal relationships and knowledge production (Kvale & Brinkmann, 2009). I observed and listened closely to the midwives and women, drawing on my pre-existing communication skills to reflect their verbal and non-verbal communications in an attempt to make them feel more comfortable. Some midwives seemed to perceive their involvement as a test, asking questions such as 'did I say the right things?' when interviews were complete. Therefore I was careful to try to balance questioning with accepting what I had been told. To avoid abrupt or difficult endings to our conversations, I guided final discussions towards future developments (King & Horrocks, 2010); this was normally part of the general departing conversation.

Oakley (1983) suggested that building trust with research participants involves sharing of the self. However, I was careful to avoid my own experiences and feelings becoming central to discussions.

Extract from research diary

"I have observed that discussions prior to and following conversations often include questions about my views/experiences (sometimes forming part of the recorded conversations). I need to be honest about my own experiences whilst being mindful not to portray an image that could undermine women's or midwives' perceptions of their own experiences e.g. 'have you got children?' As my own children are older I am conscious that I made a decision about my own parenting which differed to the decisions/circumstances of the women I am talking to... this difference in choice might be perceived as my preference over the choices that they are making. Sharing advantages and disadvantages may help to demonstrate my non-judgemental perspective."

In addition, although I recognised that talking about experiences can be therapeutic for participants (Drury, Francis & Chapman, 2007), I remained conscious of my role as non-clinical and the ethical boundaries that I must uphold. Drawing on my underlying knowledge about women's experiences of pregnancy and maternity services may have enabled me to stimulate responses that the interviewees may not have previously considered whilst simultaneously remaining open-minded to develop my own

understandings and avoid making assumptions (Nunkoosing, 2005). According to Nunkoosing (2005, p702), "when we seek to find what we already know in interviews, we learn little to advance our knowledge". Concentrating closely on verbal and non-verbal cues and remaining responsive to narratives enabled me to explore individual insights and levels of meaning at appropriate times. Occasionally it was necessary to return to a previously discussed topic as I had not wanted to interrupt the stories as they were being told, although I was conscious that sometimes I missed important cues as a result of not interrupting. Having multiple opportunities to speak with women facilitated an excellent opportunity to revisit issues that, on reviewing the data and emerging codes, I could have developed further. In addition, issues can spill over the interview, emerging after the recorder has been turned off (Parker, 2005). Audio-recording memos immediately following an interview or antenatal appointment recording meant that I could follow up significant issues. For example 'being lucky' was identified as an in-vivo code. Heather mentioned this as I left her home after her first interview and I was able to revisit this during our next conversation:

Antenatal interview with Heather (9) (sections377-382)

JS: when I was leaving last time, one of the last things that you said to me just as I was walking out, was about that you felt lucky

Heather: yes

JS: can you tell me what you meant by that? I didn't want to ask you at the time because I was leaving and you'd got people around

Heather: yeh, I just felt quite lucky in the fact that, you know, we'd, we'd gone through having IVF, it didn't work... and I think we were kind of resigning ourselves to the fact that we weren't gonna have kids...

JS: mmm

Heather: felt totally blown away when I was pregnant with my first one naturally and that was just... we always thought it would be nice to have another child, but I just really didn't think it would happen

Through collecting and coding data simultaneously and iteratively an inductive process was achieved; questions and probes could be adapted according to current insights as the study progressed.

Individual interviews with women and midwives were arranged for a time and venue that were convenient to them, following the recorded antenatal appointment. Rather than attempting to interview either directly after this appointment, interviews normally occurred within one month of the recorded antenatal appointment so that I could listen to the content of their conversations and draw on this insight to ask meaningful

questions. In addition I was mindful of midwives' busy schedules and wanted to avoid compounding this.

The venue for collecting data is important when dealing with issues that are potentially emotive or sensitive and respondents may feel more or less comfortable according to where this takes place (Letherby, 2003). Interviews were conducted as privately as possible at a venue selected by the respondent; this was either their home or place of work. All participants made me feel very welcome and in most cases women introduced me to family members. Developing a 'temporary closeness' with respondents may not be unusual when listening to people's stories (Letherby, 2003, p109) and this may be more evident where there are multiple episodes of contact. I recognised this closeness throughout data collection and again I was able to draw on my midwifery skills to build and end these temporary relationships. However because of my on-going indirect contact with participants through data analysis, reflexivity and future dissemination of my learning, for me, elements of these relationships will be long-lasting: a notion identified previously by Harrison et al. (2001). I experienced a profound sense of privilege through being trusted sufficiently for these women and midwives to share sometimes extremely personal and sensitive aspects of their lives with me. I also felt a strong sense of responsibility for being an honest and good-enough conduit for their stories. Brinkman (2013, p28) suggests that researchers rarely reflect on this 'magic' aspect of interviewing: strangers willingly sharing aspects of their lives in the name of research. He highlights the importance of de-familiarising with this phenomenon of openness and trust in order to appreciate its significance in developing scientific knowledge. As a novice researcher this 'magic' was very apparent and an emotional aspect of my work.

Interviews with women lasted between 25 and 85 minutes. Interviews with midwives lasted between 10 and 35 minutes. As stated above, after each episode of data collection I audio-recorded my initial feelings and observations so as not to lose these early insights and the emotional impact of disclosures. Memos and a reflective journal have aided the development of this study through recording my evolving understandings.

Transcribing

Data were transcribed as soon after collection as possible to facilitate better recollection of non-verbal communication and other non-audible data, thus improving retention of the "embodied transaction that took place" (Brinkman, 2013, p28). As I intended to explore the content of the exchanges recorded rather than using linguistic or conversational analysis, rigorous attention to the length of pauses and so on was

unnecessary. Therefore a recognised system of transcription was not used, although each section of speech was allocated a numbered code to facilitate transparency and locating data at a later time. The 'section' numbers are used in illustrative extracts within the findings chapters. According to Strauss (1987) it is necessary only to transcribe the data required exactly by the research question, since precise transcription requires time and effort that could be better spent on data analysis. Indeed I underestimated the time that transcription would take, with each ten minutes of recording taking approximately one hour to transcribe. Since I was unsure which data would be relevant to findings that would emerge later in the study, all recordings were transcribed as truthfully as possible using processes which enabled me to understand and analyse each record. I attempted to portray accurately what was said, although sometimes it was difficult to portray tone and other paralinguistics. Each transcription was checked against the recordings for accurateness and anonymisation of data (Flick, 2014); this also provided enhanced familiarity with the data.

Coding

Charmaz (2014) suggests that two major threads develop as coding occurs in grounded theory. The first incorporates generalisable theoretical statements which exceed specific places or times and secondly a thread of contextual analysis of actions and events. In addition there are at least two main phases of coding. The first involves initial coding whereby each word, line or phrase is coded and the second phase involves focused or selective coding with the most significant or common initial codes are used to organise, synthesise and interrogate large amounts of data.

Initial coding

Initial coding is particularly appropriate for early career researchers who are learning how to code. It facilitates "analytical leads for further exploration" (Saldaña, 2013, p101), involves reading the data closely and remaining open to potential trends. Prior to beginning coding, I read each transcript carefully whilst listening to the recording; this also enabled me to consider the most relevant codes. According to Corbin and Strauss (2008, p170) although it is impossible for researchers to fully understand the experiences of another person "the more he or she works with the data, thinks about them, and mulls over them, the more the data take on meaning and the researcher starts to understand". This is an important stage in familiarisation with the data (Clarke, 2005).

Gerunds or process coding using the words and actions as described by respondents were used for initial coding as this is associated with adhering closely to the data and

beginning analysis from the perspective of the participant (Charmaz, 2011; Charmaz, 2014). There are many ways to code data, including word-by-word, line-by-line or paragraph-by-paragraph and although these are time-consuming forms of coding they enable the analyst to generate categories quickly (Strauss & Corbin, 1998). I initially attempted to code line-by-line, but this fragmented the meaning and context of the narrative. Therefore in accordance with Saldaña's (2013) view that data need not be coded at a pre-determined frequency; codes were applied phrase-by-phrase according to the data, reducing the potential for me to impose any pre-existing understandings and keeping the codes grounded within the data.

In-vivo codes were used to prioritize and honour participant voices, or as described by Charmaz (2014, p135) to "anchor your analysis in your research participants' worlds". As data were read or listened to particular words and phrases stood out as significant for example 'being lucky', 'going with the flow' and 'doing the right thing'; these were highlighted as in-vivo codes.

Emerging codes were listed and reviewed frequently as analysis continued to enable me to visualise my work in progress. Initially I felt that I was simply restating what had been said, but after re-reading and listening to the data I began to recognise codes such as 'panicking about test results' and 'being like other women'. Reflecting on and discussing codes applied to early data within supervision increased my confidence and understanding regarding coding and data analysis. Lee (2009, p79) suggests that supervision can enable researchers to cope with the sense of "drowning in a mass of data": a sentiment I can identify easily with. At times I felt that the amount of data I had collected was overwhelming and unmanageable.

Focused coding

Focused coding enables researchers to identify and develop the most prominent or frequently occurring codes and then test these with large sets of data (Charmaz, 2014). Saldaña (2013) refers to this as a modified version of axial coding. This stage condenses and refines codes already emerging through analysis, without needing to consider the impact of their relative importance or characteristics. These codes are more conceptual than those initially used to label data and take the analysis through a comparative process: comparing codes with data and distinguishing the most meaningful. Categories may lack common features or lack sharp boundaries and therefore there are "different degrees of belonging" (Dey, 1999, p69). Through constant comparison of data and codes, this blurring of boundaries became apparent with many codes belonging within more than one category resulting in fewer and increasingly conceptual categories. As categories were being identified and assembled initial codes were revisited to determine whether the most appropriate codes had been applied, to recode some data and merge

some codes. Infrequent codes were re-evaluated and some eventually deemed redundant.

Using prompts such as 'what?', 'why?', 'where?' and 'with what consequences?' to examine how different codes and categories related to one another, data that had originally been fractured through coding were brought back together. Strauss and Corbin (1998) refer to this process as 'axial coding'. However Corbin & Strauss (2008, p198) suggests that the distinctions between axial and open, or initial, coding are "artificial and for explanatory purposes only", since the processes overlap. The transition from initial to focused coding is not linear (Charmaz, 2011; 2014); as data were collected over an 11 month period some preliminary focused codes were developed prior to completion of data. Where potential focused codes were identified later in the data collection early data were revisited with new insight. Constant comparisons were made between data and the codes applied to these, enhancing the development and refinement of concepts. As issues emerged these were incorporated into subsequent data collection either through additional questions or through theoretical sampling to develop or concentrate the categories previously identified (Strauss & Corbin, 1998). As data collection and analysis progressed, existing literature was reviewed and employed to facilitate thinking and development. In making these links I have been able to reconstruct the fractured data and understand the value of using a grounded theory approach. Charmaz (2014) does not use the formal procedures recommended by Strauss and Corbin (1998) preferring to develop categories and subcategories with explicit links to represent how sense is made of the data.

Summary

This chapter has justified the use of a qualitative approach, a constructivist grounded theory methodology and a symbolic interactionist theoretical framework to explore the pregnancy experiences of women aged 40 years and over. The strategies used to ensure that the research has been conducted in a trustworthy way have been described and ethical approval for the study demonstrated. I have provided an account of the methods used for recruiting participants to the study and for maintaining their confidentiality and anonymity in accordance with recognised processes. Methods of data collection, transcription and analysis have been justified and supported with extracts from the data. Throughout the research process I have maintained a reflexive journal and memos which have enabled me to record my insights, my personal journey and the impact of my 'self' on the research processes and outcomes. Reflexivity has enabled me to recognise and negotiate my position on the insider-outsider continuum.

Following a brief introduction to the findings, the next three chapters will discuss the concepts generated as a result of these processes.

Preface to the findings - The pregnancy experiences of women aged 40 years and over: 'doing the right thing'

As data were analysed and initial then focused codes identified, categories were developed and defined, with the most significant theoretical categories being made into concepts. "Concepts provide understanding of the studied phenomenon and are situated in the conditions of their production in time, place, people and the circumstances of the research process" (Charmaz, 2014, p342). Three concepts were identified; these were 'navigating risks', 'responsibility' and 'enabling relationships'. However as the study progressed it became apparent that an *in-vivo* code 'doing the right thing' linked and underpinned the identified concepts and categories therein. It was thus elevated to core concept. The choices and actions taken by these older pregnant women demonstrated their determination to do the right things for themselves, their babies and their families, although balancing the needs of each was not always easy. Similarly the midwives were positioned wherein they needed to balance doing the right thing for the women, themselves, their profession and their employers.

The following three chapters demonstrate my research findings in relation to the three concepts. Chapter Four reveals how the women in this study navigated the risks associated with being pregnant aged 40 years or over, through developing their understanding and ability to make decisions that best suited their personal circumstances. It also includes insight into their community midwives' understanding of older women's feelings about risk in pregnancy. The following chapter relates to the sense of responsibility expressed by women in their efforts to balance life's daily tasks with their personal, baby's and family's well-being. The final findings chapter demonstrates the importance of effective relationships between older pregnant women and their midwives and obstetricians in enabling these women to make decisions and take actions that were 'right' for them. It addresses some of the challenges faced by women and health professionals in developing and maintaining enabling relationships.

Grand theories claim to explain wide, generalisable human experiences; in contrast my grounded theory of the pregnancy experiences of women aged 40 years and over focuses on a small aspect of human life with limited generalisability and as such represents a middle-range theory (Polit & Beck, 2008). Theories demonstrate the relationships between concepts, although these relationships may be complex and difficult to encompass. However diagrams can help researchers to explain their findings

to others in an organised manner (Corbin & Strauss, 2008; Charmaz, 2014). The relationships between the concepts and categories within them are demonstrated in Figure 3.3.

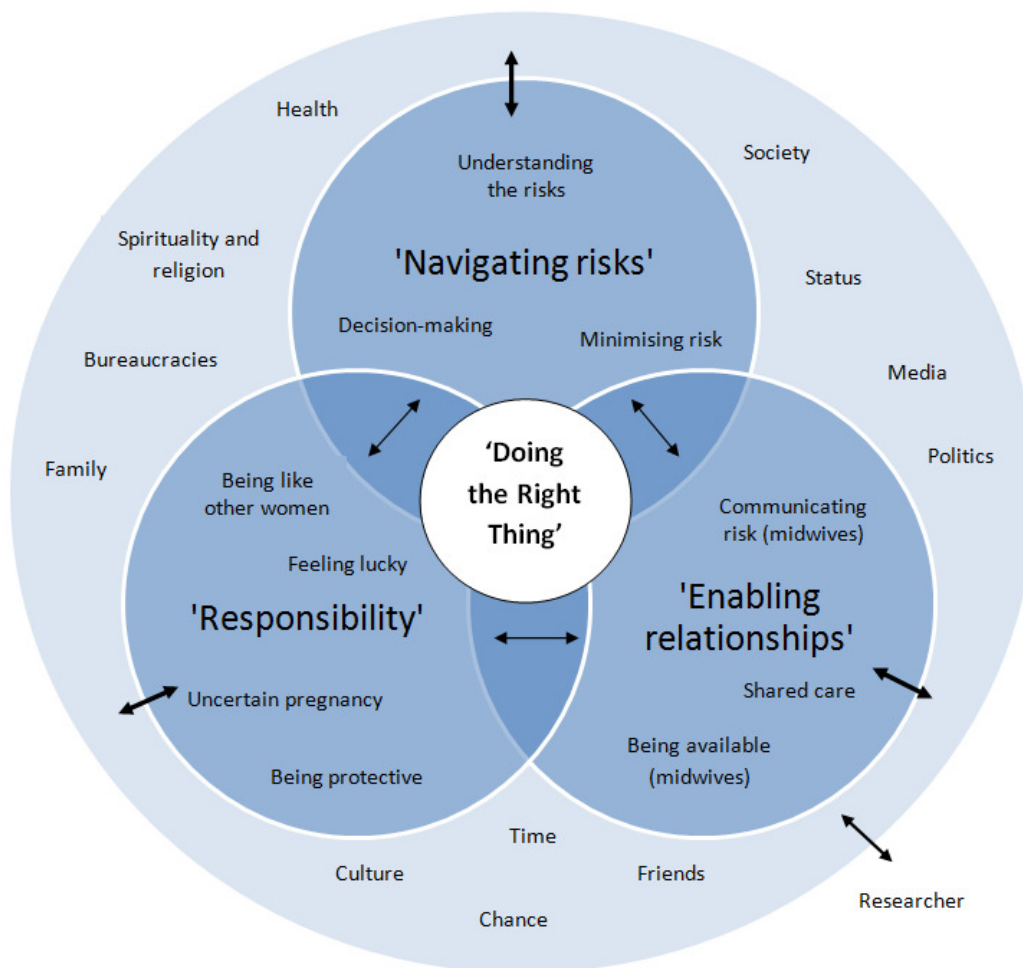


Figure 3.3. Diagram of the grounded theory: the pregnancy experiences of women aged 40 years and over: doing the right thing

The overlap and arrows between the three concepts (navigating risks, responsibility and enabling relationships) represents the mutuality between these. The concepts have been located within a larger circle which represents women’s ‘worlds’ and the aspects of their lives which influence their experiences of pregnancy. In accordance with symbolic interactionism, people and their worlds create shared meanings (Ridgeway & Walker, 2001); therefore double arrows have been used to represent this reciprocal affect. Circles have been used to represent the fluid and cyclical nature of older pregnant women’s experiences, and the lack of an outer border represents their worlds’ vulnerability to change. Diagrams will be used within each findings chapter to illustrate the relationships between concepts, categories and focused codes.

Chapter Four – Navigating Risk

Introduction

This chapter focuses on the first of three concepts derived from the data: navigating risk (see Figure 4.1). It relates to the women’s understanding of their pregnancy-related risks and subsequent decision making. Navigating the risks in pregnancy involved three categories: understanding the risks; decision making; and minimising risks (see Figure 4.2). Narratives revealed two main areas of risk-related decision-making for the older women in this study: Down’s screening and labour and birth. The analysis will therefore focus principally on these topics and draws largely on data from women’s interviews. However, midwives’ insights into older pregnant women’s views and choices impact on women’s experiences, therefore data from midwives’ interviews have also been used to inform and illustrate the categories included in this chapter.

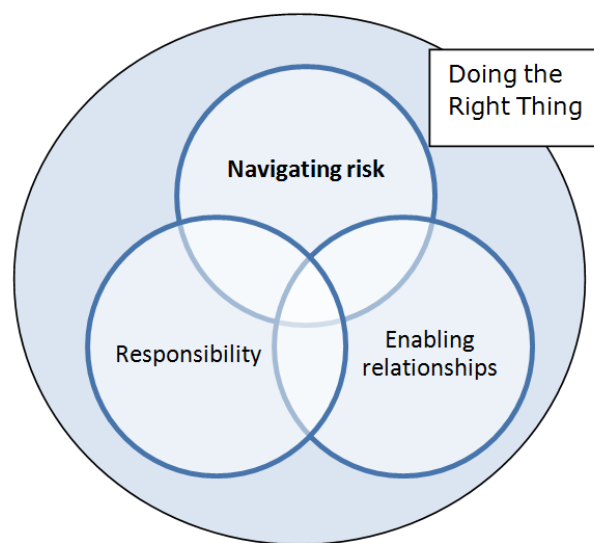


Figure 4.1. Relationship between the concept 'navigating risk', the other concepts and the core concept 'doing the right thing'

The first category I explore will be 'understanding the risks' and will incorporate women’s perception of their risks as an older pregnant woman. The factors which influence this perspective and the ways in which these women can develop the necessary knowledge to contextualise and understand their choices with regard to their pregnancy, will also be explored.

Category two addresses women’s ‘decision-making’ strategies with regards to getting the best outcome for themselves and their families. Down’s syndrome testing and labour and birth are discussed in separate sections since these emerged as specific and important decision-making issues for the women in this study. The third section addresses the ways in which women sought to minimise any risks to themselves and their babies. Findings will be discussed in relation to other research and theoretical evidence.

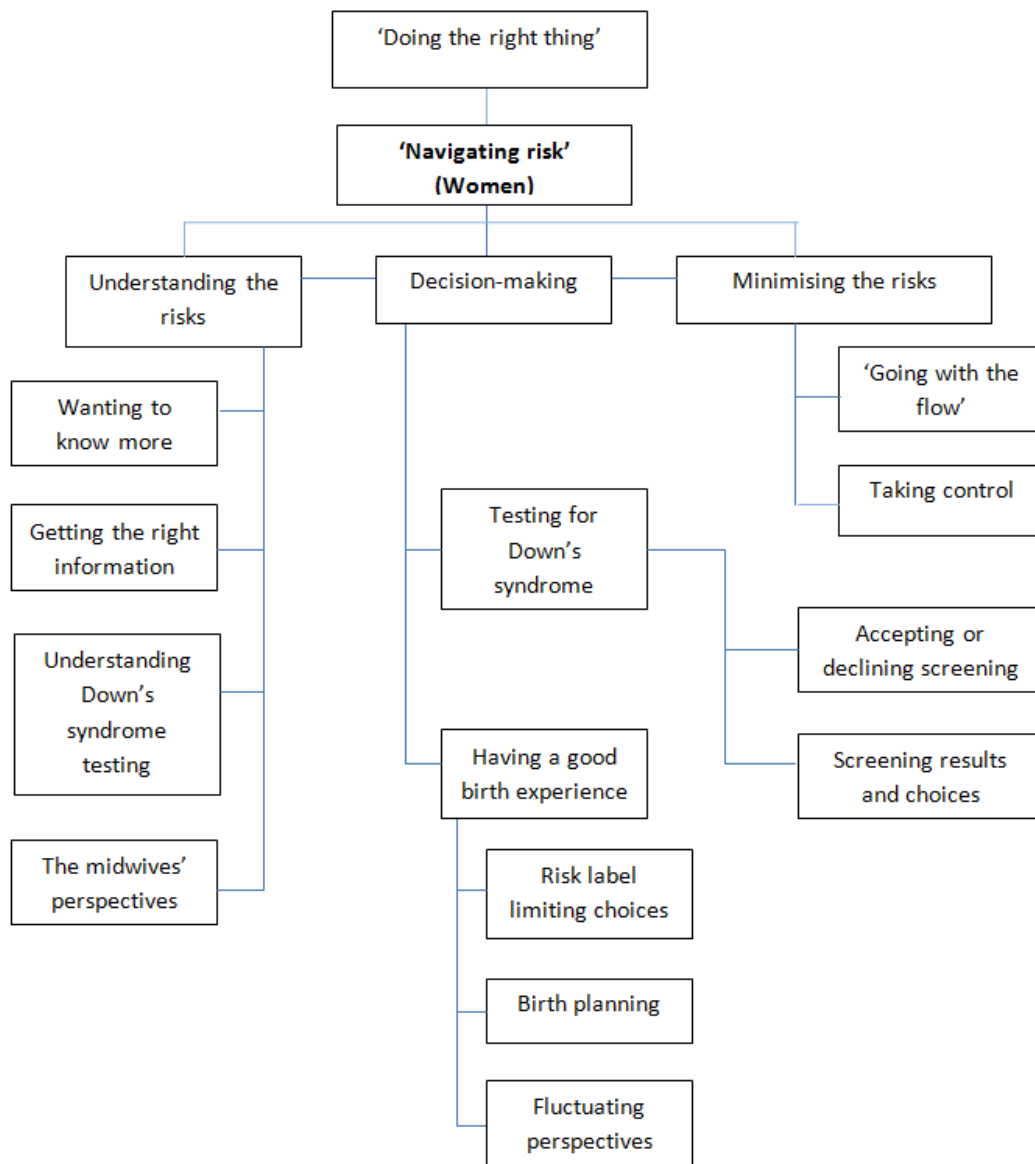


Figure 4.2. Diagram to illustrate the relationship between the core concept (doing the right thing), 'navigating risk', its categories and focused codes

Understanding the risks

“It is not just a matter of ‘real risk’ versus ‘perceived risk’ as risk-theorists (too) often describe it. This is rather an intelligent balancing of risks, weighing of risks and contextualising of risks” (Rothman, 2014, p6)

Pregnant women appear to be bombarded with information encouraging them to take extra care, shifting the focus from a normal to a potentially hazardous course of events (Kringeland & Möller, 2006). As such they become caught up with monitoring, investigations and advice all of which require co-operation (Lupton, 2013). The words of the older pregnant women in this study suggested a general understanding that their age increased their pregnancy-related risks with some women stating that their age also enabled them to accept this status.

Antenatal interview with Jenny (7) (sections 57-59)

Jenny: ...and I think when you're older you're a little bit more educated and you've had a little bit of life experience, so that you know that things aren't always as you....

JS: as you would like?

Jenny: yeh, yeh....

Some women accepted that they would feel more tired and, supporting Mandel's (2010) findings were aware of their age-related increased risk of having a baby with Down's syndrome. Other pregnancy-related conditions were less well-recognised or understood. As a result of personal experiences several women appreciated the increased risk of miscarriage or diminishing fertility associated with advancing age, although they had been unaware prior to being affected personally. In addition, regardless of parity, there was a general lack of clarity about why older age constituted a risk and why referrals were made for shared care. Several women described feeling disappointed, thinking that they would receive an explanation about 'the risks' at their obstetric appointment although these appointments generally failed to make women's position any clearer:

Antenatal interview with Carol (6) (sections 322-324)

Carol: ...and I just think 'what is the risk with age?' cos they don't go through it - what risk, additional risks there is - with age [...] they just tell you you're at risk, and every pregnancy the risks increase - the list! (laughs)

This section explores older pregnant women's understanding of pregnancy-related risk.

Wanting to know more

Despite repeated drivers as discussed on pages 16-18 to ensure that women are able to make informed decisions about their pregnancy, birth and beyond, having insufficient information, an incomplete or incorrect understanding about information was a recurrent issue in the data. Several women expressed uncertainties about whether their concerns were justified. Although Miriam (para. six) had been warned about the potential instability of her baby's position within her uterus due to her high parity she perceived that she might have been given a clearer explanation about what this meant:

Antenatal interview with Miriam (5) (sections 77, 146)

Miriam: well she [consultant] confused me a bit, when she said about the more children you have there's more space in the uterus for the baby to move around: I don't know if that poses a risk because the baby's moving [...] I have to research it otherwise your mind goes wild doesn't it [...] I don't like to be in the blind about things, no, so it would be nice for her just to explain, yeh, as long as I know and then just let it go

Miriam explained that her sister-in-law's baby had been stillborn with a nuchal cord and she feared that this could happen to her baby as a result of the mobility. Despite saying that she would not worry about something that was in 'God's hands' and researching the issue herself, having a lack of understanding did cause anxiety; she lacked understanding about the nature and extent of the risk and what, if anything, could be done to address this. Miriam's words suggested that she felt personally responsible for her anxiety since she had not considered the potential implications until after the consultation and had therefore not asked for clarification. For Miriam, and other women in the current study, becoming more knowledgeable through reading was a strategy to facilitate more meaningful discussions within antenatal appointments. Reading and research could facilitate a better understanding about what was being said or not said and helped women to consider a broader range of perspectives.

In accordance with recently published guidance suggesting that induction of labour at 39-40 weeks gestation could decrease the risk of stillbirths for women aged 40 years or over (Royal College of Obstetricians and Gynaecologists (RCOG), 2013), women reported being 'told' that their pregnancy 'should not' continue beyond the expected date of birth, and for those who were not scheduled to have an elective caesarean section, that their labour would be induced at term. However, the women's stories suggested that the rationale for this proposed intervention had not been clearly communicated. For instance, Karen was told that this was due to her age but when she wanted more clarity she had been made to feel guilty for putting her baby at risk because of her age:

Postnatal interview with Karen (8) (section 85)

Karen: ...there was so much urgency about this, we was under the impression, cos we are a little bit to blame here aren't we? The way the consultant spoke to us was that: 'we don't want you to go over 40 weeks because it is putting a risk on the baby'

When Karen was later admitted to the labour ward for induction of labour, she described feeling confused, because no-one mentioned her age, and inadequately prepared for the induction process' unpredictable nature. She was also surprised when a labour ward midwife explained that giving birth beyond her expected date posed no risk to her baby:

Postnatal interview with Karen (8) (sections 136-140)

Karen: it confused us a bit didn't it really? She says I can completely understand your panic if that's what you have been told, you know because it's like 43 days now, well 40 weeks and 3 days [...] she goes: 'I can understand that' and so we was like: 'well that's what we've been told all the way through because of my high-risk, you know side of things' [...] she went: 'no, no, you're no risk whatsoever, I've read all your books, your details', she goes: 'you're no risk whatsoever, you could literally go home and have this baby in another 2 weeks' time and there'd be no problem'

Karen's perception of information being inconsistent, due possibly to a lack of health professional understanding about current guidance regarding older pregnant women or the failure to communicate this effectively, caused her confusion, upset and anger. Issues relating to the importance of effective relationships between older women and their carers are addressed further in Chapter Six.

Where older women are labelled 'high-risk', for example, because of their age (Karen) or associated conditions such as high parity (Miriam) this may be accompanied by uncertainty about potential consequences, although availability bias (increased awareness of an adverse event) can predispose to vulnerability (Mohanna & Chambers, 2001). Decision-making regarding risk-related matters is complex; this is compounded by limited understanding and societal messages which remind women they are responsible for their baby's health and thus responsible for making the right choices. Since childbearing in later life may be viewed in some societies as voluntarily risk-taking, older women may experience a greater sense of pressure to demonstrate responsibility. Fear of death or harm to one's self or the baby influences the decision-making of women and their families and health professionals. However such 'shroud-waving' (Murphy-Lawless, 1998) as demonstrated above eclipses a more holistic assessment of families' needs, their social and emotional considerations. This can lead to informed compliance rather than informed choice (Jordan & Murphy, 2009) and incline women to lack self-

confidence and mistrust health professionals (Alaszewski, 2010). The relational aspects of information sharing are discussed further in Chapter Six.

Getting the 'right' information

Being better prepared for problems was perceived as desirable although some women correctly believed that health professionals might withhold information that could create negative feelings. Indeed having the right amount and type of information was important. Too much information was viewed as causing unnecessary worries, supporting the findings of Mander and Melender (2009), and untimely information potentially disregarded as irrelevant. These older women therefore only sought information that was directly relevant to them at any given time lest additional understanding about their age-related risks caused increased worries:

Antenatal interview with Louise (4) (sections 46, 230)

Louise: ...I didn't feel the need to go and look into it, the things about what could happen at 40, cos sometimes you, you start thinking about it and you become more anxious anyway about the little things [...] I'm not gonna get side-tracked by thinking 'what if', I don't think that makes sense

Some women were surprised at developing problems that they had been unaware of, such as gestational diabetes, leading those women affected to question whether the condition was age-related or, more worryingly, unique to them. Developing a better understanding about conditions and their implications through searching on-line reduced some concerns and enabled some women to minimise complications. However being able to access that information quickly was important in reducing anxiety rather than having to wait for the next planned appointment. In addition some women wanted to know about potential problems so that they could avoid becoming too blasé and feel better prepared:

Antenatal interview with Miriam (5) (section 223)

Miriam: So it's good to have that little, little worry instilled in you to think: 'yes, there is more of a risk, but I should take those factors', I mean if the risk is there then you should take them into context and think about them

Regulating or filtering information has been reported previously with women actively seeking useful information or avoiding irrelevant, untimely information in order to avoid unnecessary concerns (Leichtentritt et al., 2005; Levy, 2006) and this appears to be true for women aged 40 or over. Women are generally committed to ensuring the best outcome for themselves and their baby. Not wanting to be given all the information

about everything need not be perceived as a lack of interest or concern. However, “within the horizon of modernity, non-knowing is viewed as a short-coming or failure” (Beck, 2009, p124), potentially leading women to feel guilty about not wanting to know or failing to recall information that has been shared at a time when this was deemed irrelevant. Whilst people have the right to be informed of risks, they should also have the right not to be informed of risks or not to take action in response to information should that be their preference (Lupton, 1993). Achieving the right balance and ‘being non-directive’ are challenges for health professionals, necessitating excellent communication with women. These issues are explored further on page 137.

Understanding Down’s syndrome testing

In accordance with national and local guidelines all the older women in this study were offered combined screening for Down’s syndrome apart from one woman who booked for antenatal care too late to access this. As stated previously, the women in this study were aware of their age-related increased risk of carrying a baby with Down’s syndrome. Screening for Down’s syndrome was a key issue and is therefore discussed specifically rather than in terms of screening generally.

Several women believed that they lacked sufficient understanding about screening tests, the results and subsequent diagnostic tests. Irrespective of parity, and even where these older women perceived that they already had a good understanding or had no intention of accepting screening or terminating their pregnancy, being advised to read about the tests prior to decision-making was considered less helpful than being given the opportunity to discuss concerns with a knowledgeable health professional and gain a balanced viewpoint. However, supporting the findings of Pilnick (2007), not all women sought clarification prior to accepting testing, possibly as a consequence of accepting that health professionals know best (Heyman & Henriksen, 2001). Alternatively, using Beck’s (2009, p126) typology of non-knowing, rather than being “wilfully ignorant” and neglectful, these older women were perhaps “unconsciously non-knowing” and unable to seek further information. For example, Karen lacked understanding about her risk score of one in 120 for Down’s syndrome, and blamed herself for not asking enough questions:

Antenatal interview with Karen (8) (sections 456-462)

Karen: but, I think 1 in 120 people, it’s quite low risk is that... it’s not a high risk that, but I don’t know, this is what I mean, I don’t know whether it is a low risk or not, because I’ve not been given that information, that’s the thing [...] but I think if they’d have said; ‘Karen it is quite high, we’re looking at 1 in 1000 to be normal’, that might have made me look at things a little bit different [...] I don’t

even know what higher risk is, I don't even know what low risk is, I don't even know that

Discussing her results with an appropriate health professional might have enabled Karen to consider the implications of statistical data within her personal framework and develop a clearer perspective. Nevertheless, where women were able to discuss screening and diagnosis with health professionals this was not always helpful, since some information was deemed confusing. The difficulties of effective screening-related risk communication have been documented by others (for example, Siegrist, Cousin & Keller, 2008; Gillespie, 2012). Women may experience difficulty relating statistical information to their personal context and health professionals can experience difficulties understanding and explaining this (Mohanna & Chambers; 2001; Keller & Siegrist, 2009; Shapiro, 2009; Alaszewski, 2010). In addition, as confirmed by data within this study, health professionals may withhold information that could cause unnecessary alarm (Heyman & Henriksen, 2001) or because they believe that older women 'know' that they are at higher risk; this does not mean that these women understand what that increased risk represents to *them*. However, being able to make the 'right' choices depends on women understanding and contextualising the risks and benefits of all options. It is unethical for health professionals to restrict information based on assumptions about older women's perceptions and feelings derived from their history or social context. Furthermore, risk assessments and categorisation represent average groups of women rather than individuals, and even when risk factors, such as older maternal age, have strong associations with adverse outcomes, they do not predict how or which women or babies will be affected, since this is determined by the woman's biographical, social, personal and cultural context. Understanding risk is therefore a complex process and maternal age is just one factor affecting this.

The midwives' perspectives

Midwives acknowledged that all women, regardless of their age, could have some pregnancy related concerns. However, reflecting the findings of Bayrampour et al. (2012; 2013), the types of concerns that women experienced varied. Some midwives in the current study believed younger women were more concerned about changes to body image and social life whereas older women's primary concern related to wanting a healthy baby. Older women were perceived as recognising that advancing age increased pregnancy-related problems although not necessarily having a good understanding of these. Some older women were deemed to accept a high-risk label. Conversely, some midwives words suggested that some women perceived a disproportionately negative

view of their pregnancy-related risks and this could be perpetuated when women were given a specific high-risk label, for example, on account of their age or having a multiple pregnancy:

Interview with Chris (midwife 10) (sections 46-50)

Chris: I think they actually feel that they're more at risk than it turns out at the end, really. I think they are more worried than they need to be, cos if it's a planned pregnancy and they're older, they're often quite healthy anyway

JS: what do you think makes them feel more at risk than they need to?

Chris: just the label of being over 40

Labelling women as 'high-risk' may contribute to negative psychosocial implications (Stahl & Hundley, 2003). Midwives seemed to believe that they reinforced older women's perceptions of risks by drawing attention to these. Therefore they did not inform women about all age-related risks, only the risks that they themselves perceived as being significant for individual women. According to Mohanna and Chambers (2001) factors influencing perception of risk include significance for the person involved and the trustworthiness of the information source. Furthermore, to elicit a positive response the person must believe that they can address the risk. These midwives attempted to act in the best interests of older women and their babies by sharing 'relevant' information, so that the women could act to minimise their risks. However the midwives also recognised the potential for harm as a result of the nocebo effect "whereby negative effects result from suggestions of negative outcomes" (Symon, Williams, Adelasoye & Cheyne, 2015, p1519).

Some midwives' accounts suggested that although referral for consultant care could increase women's perception of risk, older women's life experiences, social status and intelligence were viewed as increasing their acceptance of a higher-risk status and subsequent obstetric referral. As Kirsty's words indicate, being labelled high-risk and having additional appointments may be viewed as advantageous rather than inconvenient particularly for older pregnant women:

Interview with Kirsty (midwife 5) (sections 75-78)

Kirsty: I think some of them quite like it because they get extra care [...] I think they think: 'I'm gonna get extra scans, extra care'...: yeh, I don't think they mind being told...especially the age-related ladies

In addition extra attention from obstetricians or midwives was considered to make some older women feel safer or more special. However, removal of the risk label, resulting in less intensive support might lead women to feel vulnerable, since they would no longer

be able to depend as heavily on the organisation for reassurance. This is illustrated in Chris' narrative below:

Interview with Chris (Midwife 10) (sections 51, 84)

Chris: I think they expect to be consultant [led care] because I think that they think they're more at risk cos they're pregnant and they're older in general, unless it's a woman who's had lots of babies before and they're not bothered [...] I couldn't generalise cos I think some women like to be 'high-risk' sometimes, they like to feel special, and then some just don't bother do they, they don't bother at all (laughing), but erm, yeh, sometimes you can see that you're bursting a bubble when you say that your fine now...

Medical investigations and interventions such as ultrasound scanning may be welcomed by some older women as enabling them to feel safer. However women's responses to such interventions are likely to depend on their situation at given specific times and may therefore vary (Lupton, 1997) requiring health professionals to revisit and reaffirm women's views regularly. In addition when women are informed that their pregnancy is no longer considered to be at-risk and regular or intensive investigations are withdrawn this may result in a greater need for support and reassurance (Heyman et al, 2006).

The midwives' narratives demonstrated uncertainty about how older pregnant women compared themselves with other pregnant women. Several midwives identified older age as being associated with greater anxiety particularly for first-time mothers:

Interview with Fiona (Midwife 4) (sections 31-35)

Fiona: sometimes they are more anxious because they are older, especially if it's a first time mum because you do get some first time mums at 40. I think they are a little bit more anxious and worried about their pregnancy and things that might go wrong, cos sometimes they're a little bit more clued up, you know when they've waited all that time to start their family [...] I do think they're a little more anxious, *they want to do everything right*

Whilst this perception of first-time older pregnant women as experiencing greater anxiety than other women reflects the findings of some (Carolan, 2003a; Aasheim et al., 2013; Li et al., 2015), Bayrampour et al. (2013) found that even where older nulliparous women understood their pregnancy related risks to be increased, this understanding did not result in higher levels of risk-related knowledge, pregnancy related anxiety or perceived control. Echoing the findings from data collected during women's interviews Fiona's words above suggest that older women are perceived as 'wanting to do everything right' to optimise outcomes for themselves and their babies. This includes attending for frequent investigations as discussed above and thus self-regulating as

responsible patients in accordance with neoliberalistic principles (Brown & Baker, 2012). In this respect older women may be no different to 'responsible' younger women.

Some midwives felt unsure about women's understanding of potential risks including the possibility for poor outcomes when given a low-risk factor. Despite encouraging women to think about statistical information in terms of what it might mean for them, midwives perceived women's responses to risk-related information as unpredictable, ranging from being upset and emotional to calm and confident, although being prepared for potential outcomes was believed to enable older women to view information more positively. 'Being switched on' or being a mother already were perceived as improving older women's abilities to manage pregnancy-related complications and information about these, reflecting the perspectives of these women. However midwives also recognised that older pregnant women may need greater support on account of their perceived risk.

Decision-making

Two main categories of concern relating to decision-making arose during interviews with the older pregnant women in this study: Down's syndrome screening and labour and birth. This section will therefore focus on decision-making in relation to these two issues.

Testing for Down's syndrome

Women's narratives reflected a generalised sense of respect for mothers of children with Down's syndrome, but locating this 'challenge' within the context of their own lives resulted in varying attitudes towards this condition and towards related screening and diagnostic testing. Discussions regarding Down's syndrome involved these older women expressing strong emotions about this topic, with several women expressing concerns about moral difficulties in decision-making around screening and the impact of their beliefs on this. Four women declined and one avoided screening. Five accepted screening because they either wanted to prepare for parenting a child with Down's syndrome or so that they could have a termination of pregnancy if their baby was affected. Parity did not appear to impact on decision-making, probably because this is just one of many factors influencing women's individual context and perspective.

Accepting or declining screening

The older women in this study responded to being offered Down's syndrome screening in one of three ways:

Declining screening – accepting whatever happens

Accepting screening – wanting to be prepared

Accepting screening – avoiding a child with Down's syndrome

Declining screening was a strategy employed by some older women to avoid difficult decision-making and related to personal and cultural beliefs. Cath and Clare had used donor eggs to conceive and understood that this lowered the chances of their babies being affected by Down's syndrome. However, both women declined screening since they would have continued with their pregnancy regardless of screening test results:

Antenatal interview with Cath (2) (section 240)

Cath: I chose not to have the Downs test, I just thought when we talked about it [partner] and myself, we said even if the baby had Down's syndrome we'd still have the baby, it wouldn't change anything, it wouldn't...our lives might be a little bit different but we'd still do the same things and still love the child and we'd still have the child

Cath acknowledged that her life could be different to the one she anticipated if she had a child with Down's syndrome, although that child would still be an important family member. Decisions around screening and living with the potential consequences of these complex choices (loss of their baby) were unthinkable for some women. Cath perceived this as an emotional roller coaster similar to the difficult journey she had experienced in coping with IVF. Clare expressed similar sentiments but was also strongly influenced by her beliefs that the lives of people with disabilities have the same value as any other person's. Thus their prior experiences impacted on their views and choices. Becoming and being pregnant at an older age are both laden with difficult and potentially life-changing decisions, some of which may be 'just too difficult'. For instance, while Jenny had *some* difficulties in arranging early antenatal appointments, *not trying hard* meant that she could avoid uncomfortable decisions by being too late for early screening:

Antenatal interview with Jenny (7) 165-175)

Jenny: I'm not very good at playing God [...] I suppose really Jayne it is my choice, cos I've let things go on, I mean I should've been... I'm not very demanding, but I should have said: 'please can you get me in early, cos I'm really worried about this test and that'... and I didn't, did I? So it's my own fault if anything...it in't my own fault is it? It's just what you are given

Beck (2009) refers to not wanting to know as denial, suggesting this may offer self-preservation. Jenny's father had recently died and this appeared to play a significant role in contextualising her position. She did not want her choices to be responsible for the loss of another family member. Conscious that others might deem her irresponsible for

not accessing Down's screening, Jenny expressed some feelings of guilt, initially suggesting that she would be responsible for any adverse outcome, but then reconciling her position by stating that ultimately a child having Down's syndrome was beyond her control.

As well as emotional and personal beliefs, faith was important in decision-making for a number of women. Miriam's religion provided boundaries such as prohibiting abortion in the absence of significant risk to maternal life. Religion removed the burden of responsibility for making the 'right' choices and for the outcomes of screening-related decisions, thus facilitating a comfort zone for Miriam:

Antenatal interview with Miriam (5) (section 295)

Miriam: ...it probably wouldn't rest easy with me if, you know, if I took that decision on myself and I'm glad God just took it off me [...] it's a relief cos I don't have to make all the decisions

Accepting and dealing with the consequences of not screening was preferable to facing difficult screening-related decisions for several older women in the study regardless of what other people said or what they had read. As demonstrated above, perceptions of an increased risk of miscarriage or trusting to fate can deter women from Down's screening and diagnostic testing (Pilnick, Fraser & James, 2004; Godino, Turchetti, & Skirton 2013), although women may fear being blamed for failing to accept screening and this may result in women failing to access care. This may be particularly significant for older women who believe that their increased age-related risk already makes them blameworthy for adverse outcomes.

Alternatively, being able to anticipate future challenges could be an advantage of Down's screening. Louise and Heather underwent screening to enable them to prepare psychologically and socially for mothering a baby with Down's syndrome; a child that they anticipated would be 'different'; neither believed in termination of pregnancy. Thus screening provided a valuable means to facilitate understanding and avoid being side-tracked by thinking about 'what-ifs':

Antenatal interview with Heather (9) (sections 84-86)

Heather: I had always made the decision that I would have wanted the test, the nuclear [*sic*] test, not necessarily because I would have thought of a termination, but I, er, you know, it's to prepare you because, you know, I had friends, I had a friend who was 28 and wasn't offered the test, she just thought: 'I'm young, I'm...' and they had a little girl with Downs [...] they weren't prepared, she said: 'it's not the fact that, that... it was just that we didn't have time to prepare and that came as a shock', so I was just always of the opinion: 'well if we know, we know how to deal with it and get the support that's out there'

These women knew other families that had been affected by Down's syndrome which confirmed the possibility of this situation as real, rather than abstract. According to Nord (1999), people who have not encountered a particular challenge cannot comprehend what that means. Relating to the experiences of others may enable older women to gain a clearer perspective and make choices regarding their future.

For those women who had screening with a view to terminating their pregnancy if the baby had Down's syndrome, decision-making seemed to focus on personal and others' perceived quality of future life rather than the nature of the condition itself, supporting Heyman and Henriksen's (2001) work. Being older triggered longer term considerations relating to personal mortality and morbidity, influencing several women's understanding about the implications of having a child with Down's syndrome:

Antenatal interview with Liz (1) (sections 111-115)

Liz: I admire the women that do that, it's just it's, it's a difficult thing for me to have to go through that it's not just... it's harder being in your forties having a [child with] Down syndrome than what it would have been 10 years ago when I were only in my thirties [...] when you're younger you don't worry about that because you just think: 'oh I'm alright'

Liz worried about the effect on her family if she were to die. Whereas most women expressed some concerns about their age negatively affecting their ability to care for a child with disabilities, having a younger partner or older children who might ultimately be responsible for caring for this child seemed to reinforce their concern. However this did not always lead to women opting for screening.

As older women have greater life experience and are likely to have a wider range of responsibilities than younger women, their choices, for example relating to Down's screening, may be influenced by a more extensive range of factors, making it particularly important to avoid making assumptions about their likely views or choices. Screening uptake may comply with normative expectations of the responsible good citizen to look after their body (Armstrong & Eborall, 2012), with an additional 'moral' obligation for pregnant women to consider the health of their unborn child. This responsibility may be further exacerbated by statistical data placing older women and their babies in a high-risk zone. Irrespective of results, screening itself can increase women's anxiety (Kringeland & Möller, 2006). Understandings about Down's syndrome can influence older women's perceptions in various ways, with some perceiving that this was something that they could not accept and many perceiving that a baby with Down's syndrome would bring 'mixed blessings'; their life would just be 'different'. Dabrowska and Pisula (2010) and Gilmore and Cuskelly (2012) found that parents of children with Down's syndrome were satisfied with their parenting and their ability within that role. However the parents

in these studies had already adjusted to their child's needs whereas women planning a child do not yet have that insight, attachment to the child or understanding of their ability to adjust. Comprehending an abstract situation is difficult without experience or insight.

Children with Down's syndrome may not be universally welcomed into societies prioritising achievement and appearance. Therefore news of a child with Down's syndrome may be received somewhere between "positive acceptance to vehement rejection" (Heyman & Henriksen, 2001, p121). Discussions about this were never value neutral for the older women in this study and involved justification for decision-making. For some women having a child was more important than not having a child with Down's syndrome. Older women's views are formed from a complex web of factors, which may include concerns about limited opportunities for future childbearing on account of their advancing age. Ensuring that these women and their partners feel supported in their decision-making and its consequences is an important midwifery role.

Assumptions that 'everyone knows' about older women's increased risks of carrying a baby with Down's syndrome may have contributed to the midwives specifically recognising Down's syndrome screening as being important for older women. Some midwives suggested that older women may have developed opinions about these issues either before becoming pregnant or in early pregnancy, and would have researched this subject prior to accessing midwifery care. Although midwives demonstrated understanding about the ethical dilemmas associated with screening, particularly for older women, some expressed concerns regarding women's abilities to cope with the processes and consequences of this. Some older women were perceived as naively supposing that all would be well once they had conceived, and not fully understanding the consequences of screening related decisions.

Screening results and choices

In accordance with other studies (Heyman & Henriksen, 2001; Mandel, 2010) the women in this study were aware that older age placed them into a higher risk category for having a baby with Down's syndrome. However, supporting Dahl et al.'s (2011) findings, not all understood that their situation could escalate involving further difficult decisions around diagnostic testing. Women who received low-risk results all expressed relief that 'everything was okay' despite acknowledging that their 'low-risk' category did not equal no risk.

Two women received high-risk screening results, reflecting the increased likelihood of this for older pregnant women. Liz was given a risk of 1 in 33 for having a baby with Down's syndrome and Karen a risk of 1 in 120. Both received results by telephone (in

accordance with NHS screening programmes (2015a) guidance) at a time when they were busy, felt unprepared for and shocked by the news. Both women perceived this as inappropriate for sharing sensitive and unsettling information and were unable to digest what was being said to them:

Antenatal interview with Liz (1) (section 215)

Liz...I'm not saying the lady on the phone, she wasn't that she wasn't sympathetic, it wasn't that – she was trying to explain, it was just I heard the one in 33 and my mind went blank and I wasn't really listening to her, so it wasn't her that was doing her job wrong, it was just me, I went into panic mode and I wasn't paying attention

Both women deemed that face-to-face contact with someone they knew explaining the test results to them at an appropriate time would have allowed them to deal with the shock better and develop a better understanding of their situations. Finding the right way and time for communicating risk-related results can be challenging for health professionals, but could benefit from personal, face-to-face interaction and time to digest the information being shared (Heyman et al., 2006). Ensuring that older pregnant women are aware that they are more likely than younger women to receive a high-risk screening result and how this information is likely to be shared, might enable them to feel more prepared for this possibility.

When a vague, population-determined risk becomes more likely, this casts a new light on perceptions. Karen and her partner initially agreed to diagnostic testing based on a high-risk screening result and a fear of being unable to care for a child who might become a 'burden' and interfere with their comfortable lifestyle. However, as diagnostic testing loomed Karen became more acutely aware of her uncertainty. Influenced by her family's strong belief about not interfering with nature she cancelled the amniocentesis. When faced with this 'real' dilemma, Karen recognised that she hadn't really understood the implications of screening and eventually her emotions overruled the more detached perspective she had held when the threats to her family were abstract:

Antenatal interview with Karen (8) (section 217-219)

Karen: what will be, will be... and you're blessed with this in any case, and don't mess with what mother nature's given you [...] I couldn't stop thinking about it and my dad going through my mind, saying: 'listen, it's a child, you know, God's given you a child, don't be injecting and don't be putting needles in any of its bits and bobs, you know', then I think the final straw was, I watched that thing, that YouTube piece on child growth – it was 9 months into 4 minutes and it was there you know, in the womb to being born and I watched [...] and I thought: 'I don't think we should mess with what we've got; I think we should let it be'

Women may be able to rationalise their decisions, but may be unaware of the potential consequences of their choices. Confirming Carolan's (2008) findings, the older women in this study expected expert reassurance rather than the potentially unanticipated and frightening chain of events that can follow high-risk screening results. Perspectives are responsive to social and emotional contexts; an imminent threat to Karen's expectations led to a shift in her risk appraisal and a greater respect for her family's traditional beliefs. Spirituality may help to decrease stress by putting concerns into perspective (Price et al., 2007), with God's will or fate providing alternative ways of understanding (Crawford, 2004).

Emotions and instinct can significantly influence decision-making; women expressed sentiments of 'feeling' that they had made the right choice. Emotions may act as an "advisor in decision-making" (Zinn, 2005, p445); they are linked with an individual's life experiences and can trigger alarms when choices based on rational thought could be 'wrong'. It is possible that older women may be more responsive to emotions and intuition due to their greater life experience. Supporting the work of others (Marini, Sullivan & Naeem, 2002; Kupperman et al., 2006), Karen's situation above demonstrates that high-risk screening results for Down's syndrome may not result in diagnostic testing due to the related uncertainties and psychosocial factors. A clear understanding of the implications may only develop at pre-diagnostic counselling (Simms, 2004). Thus, greater clarity may facilitate greater foresight into potential implications and lead to renewed priorities for women and their families.

Having a good birth experience

Once women's pregnancies had progressed beyond concerns around early pregnancy and screening, their attentions seemed to turn towards labour and birth. This too emerged as a major aspect of decision-making, although being older restricted the options available.

Risk label limiting choices

"Some midwives are skilled at using the rhetoric of choice while persuading women to make what they see as the correct choices" (Kitzinger, 2005, p95).

Several women reported that 'risks' associated with their age limited their pregnancy and birth choices. While some women recalled being offered some choices regarding type of birth, these choices appeared to involve some degree of compromise. Consequently, some of these older women experienced disappointment about being

unable to birth their baby at their preferred location. Having experienced a problem-free labour and birth with her previous child, Louise discussed the options of home-birthing or birth at a local midwife-led unit with her midwife. However she was upset when the midwife revisited these options considering Louise's age, stating that she should give birth in an obstetric unit instead. Louise later reconciled herself with the prospect of a hospital birth after being warned by the obstetrician about the potential hazards of alternatives:

Antenatal interview with Louise (4) (sections 32-36)

Louise: ... I thought 'oh, I could have it at home' I really started to tell myself I could do it and I got excited about the idea. Then I got excited about the midwife unit, they said I have to see a consultant and everything, so I got upset because ...upset isn't the right word ... yeh, kind of upset, because I thought I could have had it in the midwifery led place. Instead when I go to see them [obstetricians] they say 'oh, because you're 40 we don't want anything to happen'

Doubts and worries about threats to personal or their baby's safety may be used to manipulate the amount of control women have over choices. In requesting options, such as home-births, which deviate from experts' preferred choices, women such as Liz and Louise may be judged as irresponsible. However rather than completely disregarding risk, women's desire to birth at home may be driven by awareness of "clinical, social and cultural iatrogenic risks inherent in the birthing environment" (Scamell, 2014, p923), rather than risks associated with inadequacies of the older female body as implied through the advice Louise received. Exploring older women's perceptions of risks in a non-directive way may enable health professionals to support their needs more effectively.

Risk management thresholds can create binary parameters for the "virtual presence of a risk" (Heyman, 2010b, p50-51), implying that the likelihood of an event is 'black or white'. Such parameters can be applied through policies and guidelines without accounting for the wider context and some women questioned why they were considered to be 'at-risk' aged 40 or more when they might have been treated like 'other women' at 39. Louise employed her understanding of health to challenge some obstetric decisions. Nevertheless, implicit threats to her personal and baby's health, through high-risk labelling, steered her into choosing a hospital birth against her prior wishes and thus conforming to the system (Thomas, 2003). High-risk categorisation of older women can act as micro-regulation through guiding them into accepting medical advice or interventions because risk is communicated as unpredictable (Lane, 1995) and through restricted choices within a framework of policy-centred, rather than family- or women-centred, care (Hugman, 1991; Edwards, 2004).

Birth planning

In contrast with some other aspects of their pregnancy and Carolan's (2007) findings that women aged 35 and over treated having a baby as a project, none of these older women wrote birth plans. Some women believed these were unnecessary for a caesarean birth and others were happy to 'go with the flow'. Louise (previous normal birth), Cath and Carol (previous caesarean births) believed there was little point in writing a birth plan because they doubted it would change their actual birth experience. In contrast with her usual behaviour, Cath had decided to relinquish control so that she wouldn't be disappointed:

Antenatal interview with Cath (2) (section 97)

Cath: ...I just thought it's something to be disappointed by if it doesn't go according to plan. I love a plan, I really love a plan, and I'm very organised, but I never bothered with any of that I just thought let's go with the flow

Carol believed that she would not be 'allowed' to realise any choices because of her risk status and that she would be told what to do rather than having a choice:

Antenatal interview with Carol (6) (sections 374-376)

Carol: ...you go in that room and you're armed with stuff and you might want this and you might want that and they'll just say 'no - no you'll have to do this and you'll have to do that'. So that's just it - birth plan? What I want and what you get...are two different things I think

When women are afraid they may be more inclined to comply with medical advice, although feeling in control may also increase the tendency to comply (Brown and Baker, 2012). Based on her previous experiences Carol appeared to perceive little control regarding her upcoming birth. Whilst she expressed reluctance to accept the passive and impersonal birth she anticipated, Carol attempted to regain some control by amending her expectations so that she would be less likely to be disappointed, hoping "just once to have a nice birth experience" (antenatal interview with Carol (6), section 405). Experienced mothers sometimes expressed trepidation about labour and birth, with fears of reliving negative experiences influencing perspectives of birth for their current pregnancy. Similarly women who had experienced normal births previously recalled aspects thereof which they wished to avoid repeating: for example, fears about their baby's health and not feeling supported. Thus for some older women prior experience increased fears about labour and birth coupled with additional concerns that their advancing age might compound prior difficulties.

Developing a birth plan that is shared, flexible and a trigger for discussions can facilitate learning for those involved (Kitzinger, 2005), and can thus be enabling for some women.

For these women, expressing their wishes for the birth was an informal and sometimes private matter. Preferring to avoid unrealistic expectations and disappointment may deter older women from documenting their hopes, regardless of parity. Health professionals may believe that they are legitimately limiting women's options, because of their age-associated risks. However, being unable to fulfil their choices can lead to "clear emotional consequences" (Jomeen, 2012, p61) for women. Listening to and exploring women's birthing hopes and expectations may enable midwives to prepare and support older women more effectively for and during labour and birth.

Fluctuating perspectives

Making decisions is complex, involving specific contextual and temporal considerations and requiring acceptance of responsibility for the consequences. The women each encountered challenges in weighing the risks and benefits of options from their current perspective and in many cases the 'right' decision was inconstant. This reflects their evolving priorities and difficulties experienced by other women whose expectations fluctuated (MacDonald & Jonas-Simpson, 2009).

After being told she should not have a home birth and hoping to avoid a repetition of previous labour problems, Liz requested a caesarean birth. This was initially refused. However when her baby was found to be breech and the caesarean became a reality her fears about coping with this at 40 increased:

Postnatal interview with Liz (1) (sections393-397)

Liz: I just started then panicking, panicking about everything and then I thought: 'oh, God I'm 40, what if my body can't take the operation' [...] it were just silly, panicky really

JS: mmm, did that happen as you got closer to the operation?

Liz: closer to the operation, yeh, yeh...yeh, when they first said: 'he's breech and you can have a section', I was thinking: 'oh, thank God for that' (laughs) and then nearer to the time I thought: 'what if something goes wrong and I've risked everything for nothing?'

In hindsight Liz's experience was more positive than she had anticipated. Her concerns shifted according to the threat that was perceived to be greatest or more immediate at various points in her pregnancy. These temporal shifts continued after her baby's birth, with risk retrospection enabling her to understand her birth in terms of actual events rather than uncertainties. Older women's experience may result in higher expectations of their ability to deal with concerns. In feeling anxious about the caesarean, Liz's words suggest a sense of having broken a "feeling rule" (Hochschild, 2001, p147); rather than control she experienced panic and vulnerability.

Similarly Wendy had hoped to have 'the perfect natural birth' until her baby was also found to be breech and she was offered an elective caesarean birth. Initially disappointed, she considered the potential disadvantages of having an external cephalic version (ECV) (which she perceived were: lack of success; pain and discomfort during the procedure; risks to the baby) and possibility of subsequent induction of labour at term followed by an emergency caesarean birth. This led her to view a planned caesarean as advantageous:

Postnatal interview with Wendy (11) (sections 209-222)

Wendy: I thought: 'well, it's really looking like I'm not gonna have this wonderful natural birth anyway, so...might as well not put myself through the trauma of having him turned or attempting to have him turned' and plus he might have got distressed [...] I had started to watch that 'one born every minute' [...] there were a woman on there that had gone through all the labour, hours and hours of painful labour and then ended up having an emergency caesarean anyway and I thought: 'bloody hell that could be me!' How bad's that? She'd gone through all that and then she's having to have a caesarean and her caesarean went wrong as well and she lost loads of blood [...] so I thought: 'I'd rather go in knowing that that's what I'm having and planning for it'

Balancing the risks and benefits of options can be difficult where women have little to guide what this might mean for them and women can seek clarification through other sources. Although Wendy lacked personal experience of labour and birth, researching information, reflecting on the experiences of other women confirmed her fears and led her to amending her original viewpoint. This new perspective enabled her to identify previously unconsidered benefits, such as knowing the birth date, and retrospectively enjoying her birth experience. The stories of Liz and Wendy above illustrate how older womens' understandings about risk and uncertainty are temporal, subjective, unique (Lupton, 1997; Alaszewski, 2005; Zinn, 2005) and liable to change based on perceived increases or decreases in threat (Jordan & Murphy, 2009).

Minimising the risks

'Other people' were believed to judge older women as irresponsible for becoming pregnant outside the normative timeframe and therefore blameworthy for associated adversities. However Cholbi (2014) suggests that it is people's attitudes that render them blameworthy rather than the outcome of their actions. Taking responsibility for personal health enabled some of these older women to address and minimise the potential for adversity and blame in certain situations, although where women perceived significant danger, they were more inclined to be guided by the experts or to 'go with the

flow'. Several women's accounts suggested that since they were unable to alter their age, knowing that their age increased their risks was unhelpful since it did not make them feel any safer; others used this insight to do whatever they could to manage the risks.

'Going with the flow'

Involvement in decision making was important to women's overall birth experiences, but this was not at the expense of personal or the baby's safety. As already discussed risk-perception is individual and contextual and where women sensed danger this increased perceptions of uncertainty and reliance on health professional expertise. Overhearing a conversation between hospital staff during her labour Jenny sensed that her baby was at risk and sought expert guidance:

Postnatal interview with Jenny (7) (sections 182-184)

Jenny: 'meconium', yeh, I heard them words and I thought: 'ooh, I'm getting into a bit of danger here', and I were in and out of pain, so when I weren't having a contraction I had a chat to the doctor... and I said: 'what do you think's best?'

Having experienced a difficult time in becoming pregnant, Claire said that she would have followed any advice to minimise risks, although she wanted to avoid unnecessary interventions. When she developed hypertension and hospital admission was advised, 'doing the right thing' was perceived as accepting guidance and agreeing to additional surveillance:

Postnatal interview with Clare (10) (section 74)

Clare: ... you just do what you need to do at the end of the day and there is kind of an expectation that with twins you might have a few more problems and things like that [...] yeh, there's an increased risk of this, this, this and you just kind of think, you have to go with the flow, there's nothing you can do really is there? If somebody says you're stopping in; that's the choice you have – you stop in hospital or you come home and you take a risk and it's not worth it

Clare and her partner had invested significant emotion, time and money into becoming parents; her resultant vulnerability led her to viewing the acceptance of expert guidance and extra caution being taken as her responsibility.

Reflecting the findings of Levy (2006), there were numerous situations within the data where women preferred guidance or 'handed over' decisions when their situation was deemed hazardous. Where there are multiple potential outcomes, uncertainty further complicates decision-making (Heyman, 2010c). Reliance on doctors and midwives, with

appropriate knowledge, who can advocate in making appropriate decisions, is one way that people manage uncertainty (Alaszewski, 2010) and simultaneously reduce the emotional costs associated with fears about making the 'wrong' choice. This may be particularly pertinent for older women who believe that their opportunities for childbearing are limited and therefore cannot 'afford' to make the wrong choice.

Taking control

In association with their advancing age some women understood that they also had risk factors that might be reduced, such as general health and weight. Addressing these other issues, some women took responsibility for attempting to reduce their overall risks. Heather had worried about becoming pregnant at 40 and visited her General Practitioner for health screening prior to becoming pregnant. Based on her results she had been reassured that her general health was good and thus she felt that she was at no greater risk than younger women:

Antenatal interview with Heather (9) (section 193)

Heather: ... there's lots of women nowadays that are older, but it's just in general society thinks: 'oh you're an older mum and, you know, you're gonna be at risk'...a couple of people at work have said: 'oh you're brave having a baby at 40', erm and I said: 'well, you know, like I say, I don't think of it like... I'm fit and healthy enough, erm, and it works for me...

Developing new conditions during pregnancy, such as gestational diabetes, came as a shock for some women, although this simultaneously acted as a catalyst for several women adopting healthier lifestyles both during and after pregnancy:

Postnatal interview with Louise (4) (sections 247-249)

Louise: ... so that's kind of a positive thing that come out from this diabetes thing anyway, so when I say I need to not put on weight anymore and I need to do more physical activity...

JS: so do you feel that it's had an impact on you perhaps to be healthier?

Louise: yeh, yeh more exercise and more healthy which I hadn't been doing, so it's forced me to do that and I'm definitely gonna keep up with it and I've tried since birth

When conditions such as gestational diabetes are diagnosed, this can initially have an adverse impact on women's perceptions of health (Rumbold & Crowther, 2002), with some women feeling shocked or out of control (Evans & O'Brien, 2005). Managing this can be perceived as likely to improve longer term health for the women themselves and

their families, although it may have other restrictive implications, such as annual blood sugar monitoring, which some older women perceived would label them as risky in the long term.

Risk discourses implicate lifestyle choice in determining risk underpinned with a need to exercise self-control by acting appropriately to minimise risks in accordance with health warnings (Gabe, 1995). By addressing personal health and following expert recommendations, these older women demonstrated agency and self-responsibility: important attributes of the good citizen within a neoliberalistic framework (McGregor, 2001; Crawford 2004). When good citizens have worked hard to secure their personal security, they may be more likely to take responsibility for their personal health (Brown & Baker, 2012). A sense of personal security afforded by their age and experience may have contributed to the women in this study being more receptive than other women to surveillance and guidance. They expressed a desire to make the 'right choices', although their motivations may also have been shaped by perceptions about themselves and their ability to mother as more vulnerable than other women regardless of their 'actual' risk status.

Summary

This chapter has explored older women's experiences of understanding pregnancy-related risks and their associated decision-making. Older pregnant women may perceive themselves to be at greater risk in relation to pregnancy, childbearing and giving birth to a child with Down's syndrome although they may lack understanding about what the risks are or how these risks may affect *them* and their families. Prior life experiences, current understandings and hopes for the future combine with social and cultural aspects of women's lives to shape perspectives about their pregnancy, its risks and uncertainties. As a result of this complexity older women's decision-making may appear emotional rather than rational. An acceptable risk for one woman might be frightening or undesirable to others (Beck, 2009). Making the 'right' choices can be challenging and for some women in this study the right choice was to accept that 'whatever will be, will be', to 'go with the flow' of their pregnancy and the recommended maternity care. Whilst understanding aids decision-making, information must be timely and pertinent to avoid causing undue anxiety through availability bias or being disregarded as irrelevant. Regardless of their stated intentions or perceived understandings, having the opportunity to discuss important issues such as screening for Down's syndrome can help older women to contextualise the implications for the present and future. Priorities can change as new insight leads to greater clarity. Perception of risk therefore has a temporal

element with women re-evaluating their position to ensure that they are doing the right thing based on their understandings at any given time. Having numerous opportunities to explore important issues with their community midwife acknowledges this fluidity.

The older pregnant women in this study managed risk-related concerns in different ways including seeking further information, or, particularly when women felt vulnerable, being guided by experts. However, older age may be associated with increased autonomy and these women seemed keen to take responsibility for their personal health and the health of their babies by attending for antenatal care and doing whatever they could to address their health needs. It is possible that since these women were older, were accustomed to being responsible for their personal and others' health and they perceived themselves and their babies to be at greater risk, they were likely to respond positively to health advice. The concept of responsibility regarding their actions and family's well-being is discussed in the following chapter.

Chapter Five – Responsibility

Introduction

This chapter relates to the way that the older pregnant women in this study were influenced by and responded to responsibilities within their daily life in relation to being pregnant and becoming a mother. This is the second of the three concepts constructed from the data and relates to data generated through the interviews with women and their community midwives (see Figure 5.1).

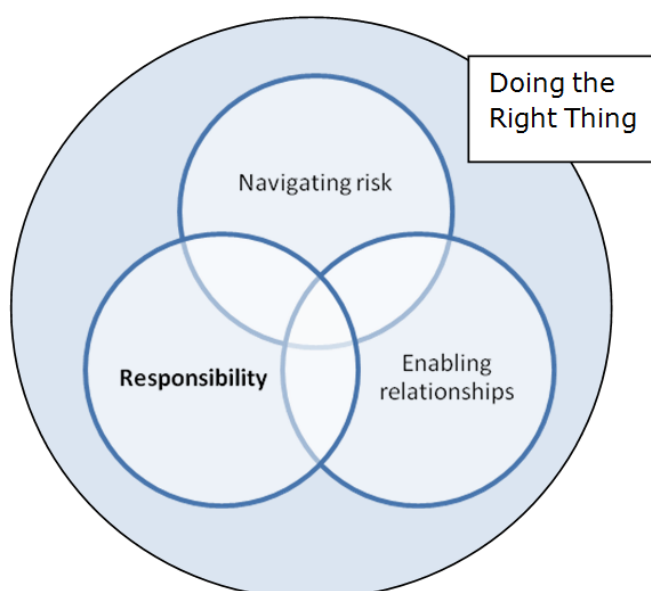


Figure 5.1. Relationship between the concept 'responsibility', the other concepts and the core concept: 'doing the right thing'

Responsibility and becoming an older mother involves three categories: being like other women, chance and uncertainty and, protecting others. Although data emerged relating to decision-making around the timing of pregnancy, this has been discussed extensively elsewhere (for example, Berryman, Thorpe & Windridge, 1998; Purewal & van den Akker, 2007; Budds et al., 2013; Cooke et al., 2012) and is not addressed within these findings. The first category explores how older pregnant women compare themselves to other pregnant women from bio-physical and social perspectives. As will be seen in section two, feelings of luck or chance in relation to becoming and staying pregnant and having a healthy baby were expressed frequently and seemed to be significant for many

women. It addresses the uncertainty some older women experienced during their pregnancy, despite attempting to do the 'right things' and includes discussion around the fluctuating nature of this predicament. In the final category findings relating to older women's sense of responsibility towards, and emotion work to protect family from any harm as a consequence of their pregnancy will be explored. The relationships between the concepts, categories and focused codes are demonstrated in Figure 5.2.

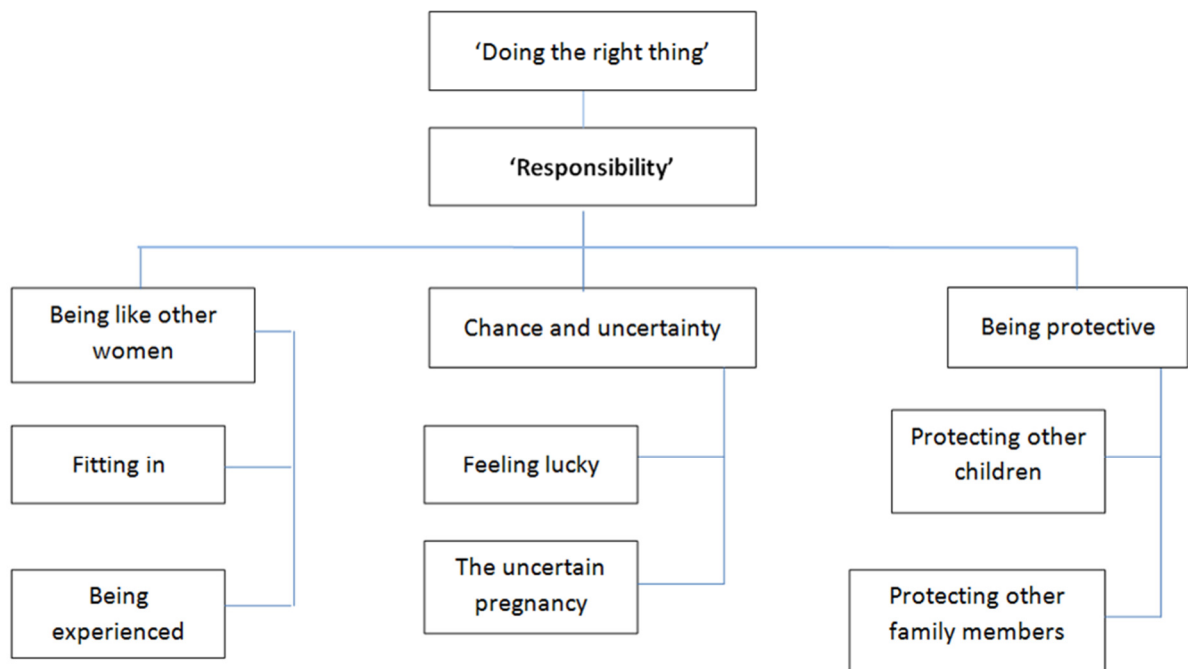


Figure 5.2. Diagram to illustrate the relationship between the core concept (doing the right thing), 'responsibility', and its categories and focused codes

Being like other women

"We are inhabitants of our own bodies and other people view us and may make judgements on those bodies" (Stewart, 2004, p26).

Budds et al.'s (2013) analysis of British press representations of older mothers revealed a lack of attention to the social factors influencing women's ability to make reproductive choice, reflecting the words of some older pregnant women in this study. Similarly some community midwives agreed that the media and some people perceived older mothering

as breaching social norms and questioned older women's 'right' to have babies 'at their age'. In contrast several midwives viewed 'most' older mothers as responsible when planning their pregnancies. Unanticipated events complicate people's lives (Petchesky, 1980) and this appears to have resulted in these women becoming pregnant at a time that may not have been their choice. The narratives of these women revealed a sense of them attempting to counter any moralisation about older women being irresponsible for deviating from societal norms and potentially placing themselves and their babies in a high-risk category. Understanding this context may explain why these older pregnant women made comparisons between themselves and other women, justifying their position as responsible rather than reckless and selfish.

Fitting in

Several women expressed surprise at how many older mothers they had met since becoming pregnant, realising that their situation was more common than they had previously appreciated. They valued older mothers sharing their stories and experiences even though these women might have been complete strangers, met purely by chance. Some women's narratives revealed that they differentiated themselves from younger women, suggesting that other people might also perceive them differently or make negative comments on account of their age:

Postnatal interview with Liz (1) (section 437)

Liz: once at work somebody said to me when I were pregnant, she says: 'oooh, you're gonna feel a right old granny stood in the playground picking your son up', and I thought: 'God is my son gonna think that when I'm picking him up from school - 'this could be my grandma?'" and she quite put me off a bit actually

Physical appearance and perceptions of being considered 'too old' to be pregnant or become a mother were issues raised by over half of the women, who were conscious that their appearance might make them conspicuous. Jenny expressed discomfort regarding clinic appointments, despite also acknowledging that there were other women there who appeared to be a similar age to her:

Antenatal interview with Jenny (7) (section 347, 420)

Jenny: I look like granny nanny when I go to the hospital [...] people sort of looking you up a bit, up and down and thinking: 'is she granny or is she mum?... you do feel a little bit... but you can't explain to somebody that's young: 'well, yes I'm nearly 45, but I feel healthy and I feel...you know, so...why not?'

Whilst other women discussed initial concerns about their appearance, they were pleasantly surprised at not feeling different when they attended clinics:

Antenatal interview with Karen (8) (section 77)

Karen: [age] hasn't been an issue at all, I think I've made it more of an issue than anybody else really, erm and as soon as you mention anything about your age...when I first found, even before we conceived this child, I had this daunting image of me sat in waiting rooms with 17, 18, 19 year old girls and I thought: 'I'm just gonna look like nanna-noo', you know, 'I'm just gonna stand out', and it's not been the case whatsoever

Nonetheless, some women seemed keen to prevent other people bringing up their age or uncertainty about their relationship with their baby by raising this first and explaining their relationship with their baby. This may have been a strategy to avoid personal and others' embarrassment. Other studies also report older women believing that their appearance could wrongly identify them as grandparents (Chen & Landau, 2015; Dobrzykowski & Stern, 2003) or set them apart from other pregnant women, resulting in women amending their appearance to make themselves fit in (Yang et al., 2007; Jarvie et al., 2015). Kelhä (2009) suggested that being older symbolises discordance with the ideal time for mothering and therefore older women may focus on their health and appearance to moderate their deviance.

Whilst no women in this study discussed changing their appearance, several seemed conscious of this and adopted other strategies to normalise their position such as comparing their age-related high-risk status to other women's risks. They compared themselves with younger women who were less healthy or who might have additional medical or social complications placing them also at increased risk in pregnancy or labour:

Antenatal interview with Louise (4) (section 48)

Louise: ...complications happen, anything can happen in any pregnancy and that's what I thought, cos even if you are young, you can have complicated... things

Postnatal interview with Cath (2) (sections 130-132)

Cath: there was a really large lady and so she was making no effort to change her diet whatsoever and she'd been put on medication and she refused to take the medication because she said somebody told her it wasn't good for your unborn child... and you know, I sat looking, and I thought: 'I'm here and I have changed my diet, I have really made changes and it's been a wakeup call that in many years to come, if I don't make changes I could end up with diabetes' [...] but when I sat there listening to her, I thought: 'gosh, this is why the NHS is in

the state it's in, because there are people there who just are like so ignorant to what was being [advised]...'

As illustrated in Cath's account, several women discussed 'other' women's lack of responsibility for their health. By making favourable comparisons, they attempted to justify their position and located themselves within a group that was no more blameworthy than women in other 'risky' categories. According to Mead (1934) people understand themselves from the perspectives of other members of a particular group to which they belong, adopting behaviours and attitudes which reflect that group. It seemed important that the pregnant women in my study felt accepted and justified their status by identifying commonalities such as other women having complications, wanting to become a mother and by attending antenatal appointments. 'Fitting in' or feeling normal may be used to gauge personal situations, although according to Murphy-Lawless (1998, p196) even though 'normal' can depict 'what ought to be', wide variations of normal exist so the boundaries are never clearly defined; as new understandings and technologies emerge pre-existing parameters become blurred and new parameters for normality are set. Through highlighting other women's positions, these older pregnant women seemed keen to position themselves within socially acceptable boundaries and for other people to adopt a balanced view of older mothering. For instance, Heather believed that older women could be as healthy and enjoy their pregnancy as much as younger women and should be treated individually rather than being stereotyped to fit a particular category:

Postnatal interview with Heather (9) (section 143)

Heather:... there's no reason why you can't have an enjoyable pregnancy as much as someone that's a lot younger [...] I think, looking at it you need to look at each person as an individual and I...there's probably no reason why... there can be people that are younger that can have more complications than what I've had

Risk categorisation groups women together who have a common attribute such as being over 40. However within that category individual women have different attributes, although differentiation may be selectively disregarded (Heyman, 2010b). Whilst it is evident that the women in this study wanted to 'fit in' with other pregnant women, it was important that their individual situations were acknowledged.

Being experienced

Despite women's narratives normalising their position amongst their counterparts, women often cited their maturity and experience as advantageous in enabling them to

better cope with complications associated with pregnancy and mothering. 'Being experienced' incorporated three aspects that were deemed significant in facilitating coping: life; pregnancy and mothering; and being a 'patient'.

Being older was considered advantageous over youth since life experience and maturity provided older women with greater financial and emotional security and a range of strategies to prioritise and deal with things more calmly. These women each expressed experiencing uncertainty or concern at some time during the course of their pregnancy, birth or postnatal period. Being older appeared to facilitate greater self-confidence, a more balanced perspective and a positive or calm disposition:

Antenatal interview with Cath (2) (section 97)

Cath: you're more laid back when you're a little bit older, I think, I think you've just got that maturity, a maturity that you just think, well, what will be will be and you don't get ruffled by it...

Antenatal interview 2 with Miriam (5) (sections 346, 162)

Miriam: your self-esteem – you don't have that anyway when you're younger, that builds up as you get older, and I say to my niece: [...] 'you'll love being 40, cos you'll know who you are and other people's opinions won't matter' [...] I'm at that stage, you know, 40 plus, where you think you can handle things yourself [...] if I have a problem I just try to find a solution

Having life experience might also mean greater financial security for older mothers, which could enable them to provide a more stable and supportive family life for their children:

Antenatal interview with Karen (8) (section 91)

Karen: it's fabulous, cos you're in such a better place at this age, you know, you know where you are, you've got a lot of experience, you've got a nice little nest egg going on, so you can just provide so much more

Older first time mothers may be deemed more anxious than younger women for example regarding birth (Aasheim et al., 2013), and some of the community midwives also expressed this viewpoint (see pp90-92). However, this view was not supported by the accounts of the nulliparous older pregnant women in this study. Karen described her age and prior life experiences as enabling her to develop coping strategies to deal with whatever happened:

Antenatal interview with Karen (8) (section 58)

Karen: ...I'm laid back in some stuff and I do worry about some other stuff but I ...just think to myself: 'well...' it sounds a bit, but I think: 'whatever will be'll be,

I'll just have to go with the flow' and having a baby, the first thing you think: 'I can't do this', don't you? And then you think: 'I haven't got no choice, just get on with it'

Whilst each of the three nulliparous women experienced some problems, their words suggested that their age and maturity enabled them to deal with these better than if they had been younger. This finding supports the work of Nilsen, Waldenström, Helmstadt, Rasmussen and Schytt (2012) which showed that older nulliparous women's resourcefulness was advantageous in dealing with challenges. Regardless of parity, notions of 'going with the flow' or accepting 'whatever will be will be' were expressed frequently throughout the data and were associated with gaining perspective through being able to see the bigger picture as a result of maturity. Previous studies have also shown that, in comparison with younger women, older maternal age and the associated possession of greater life skills increase older women's perception of their ability to be a good mother and to be organised (Nelson, 2004; Friese et al., 2008; Dobrzykowski & Stern, 2003; Morgan et al., 2012; Budds, 2013).

Women who were mothers already prior to their current pregnancy reported feeling more confident and relaxed than during their first pregnancy, with some women recalling how they had previously lacked insight and been surprised at their limited knowledge about their body, pregnancy and parenting. Postnatally Heather had been upset because her (second) baby had been transferred to the neonatal unit with a suspected infection and she then found it difficult to care for her baby due to poor post-operative pain control. Nonetheless she found the whole experience less stressful than being pregnant and becoming a mother for the first time:

Postnatal interview with Heather (9) (sections 127-129)

Heather...anxiety wise and stress wise I felt a lot more relaxed and the chance to enjoy the pregnancy, really was a lot better [...] it's still tiring and things, you're more relaxed and you can enjoy it more, er, that was it, just felt a lot more at ease really with him (baby) whereas with [older son] we were on tenterhooks...

Nulliparous women's lack of understanding was confirmed by Wendy, who had been surprised by her own lack of knowledge about the menstrual cycle and fertility when she had been hoping to conceive:

Antenatal interview with Wendy (11) (section 126)

Wendy: ...I'm in my 40s and I don't even know my own body, I don't know how it works properly [...] but I'm an educated women - I've got a degree!

Despite Wendy's education and life experience her lack of knowledge appeared to categorise her as a 'novice' in childbearing and challenge her perception of 'self' as a confident and capable women.

Discourses relating to previous pregnancy problems indicate that these problems could facilitate greater insight into current concerns and subsequently greater confidence in asking questions in order to reduce the risk of 'history repeating itself'. According to Kitzinger (2006) women who have previously experienced traumatic pregnancies or births may resolve to gain a greater understanding and behave differently in order to feel more in control. This appeared to be the case for several women in this study. Liz was more able to ask questions about diagnostic testing and Jenny had been more aware of the implications of raised blood pressure based on their previous experiences. Knowing that they could give birth to a healthy baby despite having problems may have enabled some women to perceive that not all dangers equated to a negative outcome, thus moderating concerns in their current pregnancy to some degree. However, for some women previous problems appeared to increase concerns particularly when those problems resurfaced and women felt out of control. Discussing plans for her current pregnancy and birth with her consultant caused Carol to reflect on her previous negative birth experiences and lead her to worrying about what would happen this time around:

Antenatal interview with Carol (6) (section 37)

Carol: as somebody said the other day, erm, 'when you're pregnant you go through it and that's it, you're finished, but as soon as you get pregnant again everything comes back to you'...and it has done

Re-ignition of previous fears did not cause Carol or other women to regret becoming pregnant when older, although each of the women in this study encountered challenges of some kind. Their journeys to motherhood were never completely smooth and worry-free. Prior experiences of pregnancy and mothering seemed unable to allay all uncertainties and in some cases increased these, suggesting that, for the women in this study, parity did not equate to having a more positive or less anxious experience of pregnancy and birth, although being a mother already did enable women to feel more relaxed and confident in caring for their baby during the early weeks.

Most women in the study reported some experience of being a 'patient' previously, reflecting evidence that older pregnant women are more likely to have prior or pre-existing medical conditions (Reddy, Ko & Willinger, 2006; Jahromi & Husseini, 2008). However, most women did not discuss on-going health problems. Having received medical or surgical treatment previously appeared to have some impact on how women perceived risks and problems during their current pregnancy, with several women

valuing doctors' input. However, women did not always accept interventions readily, particularly where their narratives revealed that their opinions counted for little. Karen's previous experience of health care and numerous operations appeared to contribute to her accepting an increased risk of complications and interventions and taking an open and positive view about what would happen, including the possibility of a caesarean birth:

Antenatal interview with Karen (8) (sections 23, 163)

Karen: I understood completely, right at the very beginning, you know, there might be some sort of complications with all the surgery that I've had [...] I don't see pregnancy as an illness or anything you know, it's just a body change isn't it, it's a lifestyle change and it's, yeh you get...aches and pains and diddly diddly der, but that's to be expected you know, but yeh it's quite straight forward really you know, in the grand scheme of things

Similarly women who had required the treatment and guidance of doctors for other conditions such as assisted reproduction and medical conditions may have come to rely on that input at a time when they had been vulnerable and dependent on that advice. According to Thomas (2003, p278) "members of a society abide by the rules because of the effective socialisation that took place when they were developing as society members". From a functionalist perspective, 'good patients' who are sick demonstrate that they have learned to act responsibly through seeking medical advice. However, in doing so they must also trust in medical expertise and follow medical instructions (Lupton, 2003). In contrast, patients may adopt a consumerist role in challenging the authority and recommendations of doctors, although the notion of the passive patient may act to moderate these challenges, particularly where threats are perceived to be significant. Lupton (2003) suggests that where women are good patients this does not necessarily indicate passive compliance, but may reflect a deliberate choice to facilitate emotional and physical well-being according to their social and embodied position at that time. Having previously been reliant on doctors' expert opinion and learning to either trust or distrust that opinion may influence older women's perception of their dependence on the input of doctors during pregnancy and childbirth although the extent to which they adopt a functionalist or consumerist role is likely to depend on their individual context at any particular time. The relationships between older pregnant women and the health professionals responsible for their care will be discussed further in Chapter Six.

Chance and uncertainty

Luck and risk are closely related, with chance and uncertainty indicating a lack of control (Broncano-Berrocal, 2015). The notions of luck and uncertainty with regard to pregnancy for these older women are explored here.

Feeling lucky

These older women's stories revealed a strong sense of 'feeling lucky' or 'blessed'. This perception related to many aspects of women's journeys to becoming a mother and, for several women, appeared to begin with meeting their partner before it was 'too late' and then being able to conceive. Women described feeling fortunate to have better pregnancy health than other women, with frequent references to younger women who experienced pregnancy-related illnesses or to women whose babies were less healthy than their own. Miriam compared her own situation to her younger sister-in-law:

Antenatal interview with Miriam (2) (section 117)

Miriam: my sister-in-law's like 15, 15-20 years younger than me, and erm, in her first one she had high blood pressure, and she had this really bad headache and they got her to the hospital and they found out it was high blood pressure and they had to do an emergency caesarean, so...I compare my pregnancies to hers and they're, she's only had a couple and she had quite a few issues in each one [...] I'm blessed

Previous studies report women who have encountered infertility expressing a sense of relief (Friese et al., 2006) or feeling lucky (MacDougall et al., 2012) to be pregnant. Being lucky to be pregnant was voiced most frequently amongst, but not exclusively by, those women who had experienced fertility problems or had recently experienced pregnancy losses or threatened pregnancy loss. For instance, Wendy had not met her husband until her mid-thirties; she had later been shocked that conceiving was more difficult than she had anticipated prior to experiencing a miscarriage. Consequently she initially found it difficult to relax and enjoy her pregnancy. However, Wendy seemed determined not to let her previous problems have a negative impact, preferring to focus on her luck in being pregnant and becoming a mother. After her baby was born this sense of good luck seemed to be even stronger:

Postnatal interview with Wendy (11) (section 336)

Wendy: Oh God, yeh, I feel really lucky, very lucky, yeh...I still can't believe we've managed it, that we've got him, it's all as if someone's just plonked a baby on us, d'you know what I mean? It's really weird...

Women who had conceived using assisted reproductive technologies (ART) described feeling luckier than other women who were unsuccessful and in particular through being in a position whereby they had been able to finance repeated treatments. However, these women seemed to understand that even with available finances becoming pregnant using ARTs involved an element of luck or chance:

Antenatal interview with Cath (2) (sections 35-39)

Cath: ... I've been incredibly lucky because both occasions, I've fallen pregnant. It's costly; it's cost us probably thirty-odd thousand pounds, twenty for the first and ten for this little baby. I feel sad at that [...] I'm so lucky that I've had one baby and I'm having another one. I'm so lucky that after certain events I've got a life again, erm, I do feel guilty that people can't afford what we've had

Perceptions of luck may relate to previous experiences and expectations as seen in Cath's words above when she compares her current happy situation to previous difficulties leading to potential childlessness. Similarly Heather had taken time out from trying to become pregnant using ART since she and her husband had found this to be emotionally tough and had resigned themselves to the possibility of not having children. Heather subsequently became pregnant naturally twice despite believing that the 'odds' of this were very low:

Antenatal interview 2 with Heather (9) (section 384-394)

Heather: you've gone through, you know, thinking that you're not gonna have it, I know lots of people do and I think that's why you do feel lucky, blessed, you're just like 'wow!' and this is it, so that's where I'm coming from when I feel I'm lucky [...] there is the higher rate of older women having babies, but there's also risks and problems and so, whilst everybody knows this, I think when it happens and you kinda think 'wow - all that! The odds', you know society's saying this, you know: 'you're older and this shouldn't happen and that shouldn't happen or there's problems with this', and then it happens and things are okay...you do...you feel...and you want to tell people: 'I feel really lucky - everything's been great!'

Heather's experience of beating the odds resonates with the findings of MacDougall et al. (2012), whose study of women having their first child after using ART found that 72% of these women considered themselves lucky in becoming pregnant. Some women in the current study expressed this sentiment in terms of their faith and spoke of 'feeling blessed' or 'thankful to God' for enabling them to become a mother, for having a healthy pregnancy and a healthy baby. Louise described feeling blessed that despite her age, having fibroids and having two pregnancy terminations in her youth, she was able to conceive:

Antenatal interview with Louise (4) (sections 44, 192)

Louise: ...it's a blessing that I managed to get pregnant at this age as well [...] I felt lucky, I've got 2 pregnancies now 20 years later and that's a blessing, you know, I said praying to [God] I believe in saying 'thank you' because after all losing those two babies and now in that circumstance I might have become barren or whatever the term is. I didn't know what they⁵ were I just took them stupidly, and yeh now I'm having children so I felt lucky and blessed as well

Although Louise experienced nausea throughout her pregnancy and developed gestational diabetes, balancing these with the possibility of being childless enabled her to maintain a positive outlook.

According to Fredriksen (2005) luck results from natural processes such as death and chance meetings which are ultimately uncontrollable and cannot therefore be changed. Health-related risks or luck are influenced by hereditary, incidental and significant factors and taking responsibility for one's health can influence these to some extent (Fredriksen, 2005). Nevertheless, complete control over personal health is impossible, despite the inferences of some health messages suggesting otherwise. Whilst a sense of responsibility for doing what they could to facilitate a healthy pregnancy and baby was evident in women's stories, factors such as finding a suitable partner or avoiding complications may have been beyond their control. The demarcation between health-related luck and control may be regarded as 'fuzzy' and as a result "accepting luck is to accept that we do not deserve everything that comes in our way. Every misfortune could not have been foreseen and counteracted" (Fredriksen, 2005, p536). It appears that these older women recognised the chance element of their situation, acknowledging their relative good luck in comparison to their counterparts. Although outsiders may perceive older mothers as blameworthy for adverse outcomes because of their seemingly irresponsible non-adherence to societal norms and rules (Cholbi, 2014), this attitude fails to acknowledge factors beyond their control.

The uncertain pregnancy

Even where women aged 40 or over have worked hard to navigate their way through life's challenges to create a responsible self-identity by attending to their health needs and providing a stable family life, such attitudes and behaviours do not guarantee a straightforward pregnancy. Narratives around early pregnancy concerns suggested that this represented an uncertain time, particularly for those older women who had experienced fertility problems or recent pregnancy loss. These women expressed

⁵ Medications to induce abortion

sentiments suggesting insecurity, at least until a gestation at which the greatest threats were believed to have passed, such as the time of a previous miscarriage. Bleeding in early pregnancy appeared to compound these fears and overshadow any sense of happiness about becoming pregnant, with a small number of women describing fears that miscarrying was inevitable. Wendy's recent miscarriage occurred when she had thought that her pregnancy was progressing well. She explained that there had been no indications of that loss until a routine scan diagnosed a missed miscarriage and that she needed early reassurance this was not happening again:

Antenatal interview with Wendy (11) (sections 14, 24)

Wendy: ...prior to [13 weeks gestation], and it was quite, it was quite agonising for me because it was like: 'is it gonna happen or isn't it gonna happen? What's happening in there?' and you're really kind of like, you know you're pregnant, your body's telling you you're pregnant, the pregnancy test is telling you that you're pregnant, but you don't know if it's a viable pregnancy [...] I was like: 'I have to have a scan, I need to have a scan early'

Ultrasound scanning provided only transient relief with Wendy's fears resurfacing after a couple of weeks. Recalling her anxiety, she believed that younger women might have coped better with her situation since they would have more opportunities for pregnancy and mothering. Similarly Cath, who experienced heavy bleeding in early pregnancy, paid for a private scan to reduce the uncertainty of waiting, fearing that a miscarriage was inevitable:

Antenatal interview with Cath (2) (sections 217-219)

Cath: I said is there any other hospital that I can go to where we can just have peace of mind and be scanned and they said 'no' [...] we would have paid anything to be scanned, so it's that waiting game [...] miscarriage seems to be... just one of those things, that's how they look at it. To you it's everything, you know, you're like potentially losing a baby, but at the hospital it's just like 'well we can't do anything, there's nothing we could do anyway', and it's like 'no there's nothing you can do to stop it, but there's something you can do to make people feel better'

Progressing beyond 12 weeks gestation was identified by some women as a time when they might start to feel more confident, although some women acknowledged that their anxieties persisted throughout pregnancy and they avoided making plans until close to birth in case complications arose. Clare's words suggest that after five unsuccessful attempts at conceiving using IVF her familiarity with disappointment extended beyond 20 weeks gestation and she still found it difficult to relax:

Antenatal interview with Clare (10) (sections 42, 46)

Clare: you're kind of still waiting for something to go wrong [...] cos you're kind of looking to see 'should that be happening, shouldn't that be happening?' and yeh, you're waiting for something to happen

Clare discussed worrying about 'every ache and pain', with one worry replacing another throughout her pregnancy until after her babies were born. The absence of conception or early pregnancy threats did not eliminate the potential for uncertainty with other risks presenting throughout these women's pregnancies. For Liz, fearing loss as a consequence of diagnostic testing increased her anxiety in the short term, although she later valued being able to get answers and move on with her pregnancy. Her anxiety was heightened because she had experienced diagnostic testing (amniocentesis) with her previous pregnancy and was having a different test (chorionic villus sampling) this time, which she did not understand and having seen the baby on scan she had already started to build emotional connections:

Antenatal interview with Liz (1) (section 107)

Liz: once you've been for your 12 week scan and you've had your date for your baby and then you've seen the baby there and then you're getting your results back afterwards, if they're bad results it's hard to make a decision whether you want to keep your baby or not afterwards because you've already seen the baby there

Ultrasound is popular with women, giving them an opportunity to see that "everything is alright" (Symonds & Hunt, 1996, p87). It can facilitate early bonding between mother and baby (Condon & Corkindale, 1997), potentially making it more difficult for women to contemplate loss. Having planned her current pregnancy seemed to further complicate Liz's decision-making since she appeared to have begun bonding with her baby prior to conceiving. Advances in medical technologies have increased reliance on experts to assist in the management of risks (Gabe, 1995), although as seen above these technologies and experts are not always able to meet the needs of women within the current healthcare framework. Whilst older women might feel more anxious about threatened pregnancy loss than younger women, they may have better access to financial, social and emotional resources to enable them to cope with this. Nonetheless midwives may be able to limit women's need to draw on the coping strategies they have developed by finding out about women's lives, acknowledging the potential impact of women's older age on their emotions, facilitating a balanced understanding and providing individualised care.

In facing uncertainties associated with becoming and staying pregnant and having a healthy baby, women's pregnancies may become tentative and only after the perceived threat has subsided can women begin to reconnect with the pregnancy. These findings support the work of others (Heyman et al., 2006; Lawson & Turriff-Jonasson, 2006; Rothman, 1986; White, McCorry, Scott-Heyes, Dempster & Manderson, 2007). Rothman's (1988) study of women undergoing amniocentesis described women not recognising fetal movements or outwardly acknowledging their pregnancy until they were certain that their pregnancy would be on-going (rather than terminated as a consequence of diagnostic testing). Some women in the current study described this uncertainty as 'subdued excitement' or being 'in limbo', which Beck (2009) suggests is a manifestation of denial or non-knowing and may be a strategy for protection against having to confront difficult situations or decisions. Community midwives suggested that older women who had experienced fertility problems or previous pregnancy losses were more likely to have disproportionately high anxiety levels, compared with other pregnant women, about miscarriage or other complications and as such they might need greater support.

Stainton et al. (2005) described women with high-risk pregnancies 'bracketing' time to reach milestones and manage their pregnancy-related concerns. When the women in the current study perceived that their pregnancy was more secure and any initial fears had passed, these worries seemed to be replaced by concerns about the baby's health. Their stories revealed a preference for more frequent scans throughout the pregnancy to 'see' their baby and more appointments with their midwife to 'listen to their baby'. This was despite knowing that all problems could not be detected or prevented, gaining some reassurance from feeling their baby moving and growing well and the logistical challenges of attending extra appointments. This supports Petchesky's (1987) suggestion that older women or women who have experienced previous pregnancy-related complications are particularly likely to find scans reassuring and that this facilitates mother-infant bonding. Whilst pregnant women are urged to take responsibility for their own health through adopting approved behaviours, they are simultaneously expected to rely on expert guidance and frameworks which promote vulnerability and dependence (Lupton, 2003; Brown & Baker, 2012). Doing everything possible to prioritise the health of the baby seemed important for these older women because of the potential risks associated with their age. Strategies for prioritising their developing baby's needs included optimising their own health, making choices that protected their baby and attending for regular appointments:

Antenatal interview with Miriam (5) (section 41)

Miriam: I'm not a priority myself, so I don't think you see, but the child is, so I have to keep that in my mind, it's not about me really, I have to make sure that I do it for the baby of course [...] they are all important, even the one I can't see

This finding concurs with other studies which demonstrate women with at-risk pregnancies protecting their baby through addressing their own health needs in relation to gestational diabetes (Evans & O'Brien, 2005), excessive worries (Georgsson Öhman et al 2006; Heyman et al., 2006) and threatened preterm birth (MacKinnon, 2006; Mu, 2004).

Postnatally, Jenny developed a severe wound infection and was readmitted to hospital for several days. Despite being very ill Jenny's positive attitude helped her to prioritise the things that were important, accept what had happened and focus on the things that were going well, which revolved around the health of her baby:

Postnatal interview with Jenny (5) (section 146)

Jenny: he's well and hopefully I'll get better soon and so they're the positives aren't they Jayne? you can't, can't think, and you know, for all maybe it's a...to me it probably is a major hiccup in my life, there's a lot more things that could have gone wrong and that's way you've to think, I think I am optimistic and I think well, I think I were more worried when he started losing weight

When women or their pregnancies have been labelled high-risk, women do fear for and prioritise the health of their child even though this may provide a challenge in the context of other considerations (Hatmaker & Kemp, 1998; Geissbuehler & Eberard, 2002; Leichtentritt et al., 2005; Bayrampour et al., 2012; Lee, 2014). This may be more difficult for older women who anticipate fewer opportunities for childbearing if something goes wrong, supporting the notion of the 'precious pregnancy' as identified by the community midwives in Chapter Six.

Being protective

Whilst the women in this study were conscious of addressing their own health needs and the needs of their unborn baby, there was also a strong sense of responsibility for protecting other people, who were close to them, from any harm that might result from their pregnancy.

Protecting other children

Women with other children expressed a need to ensure that their choices around having another baby did not negatively impact on these other children. They seemed to work hard to ensure that they prioritised time shared with young children and that sound plans were in place for childcare around the time of birth.

Antenatal interview with Louise (4) (sections 108-116)

Louise: I'm worried about [daughter] if I need to come [to the hospital] straight away, so I'm wondering, what time of the day it will be? How long do I stay in hospital? obviously you just want to go and come back, because you've got a child [...] I can cope being on my own in labour, I think, it's only the child I worry about so I told [partner]: 'if worst comes to worst, I'd rather you be with [daughter] and I can be on my own'

For some women focussing on caring for their child may have acted as a distraction to avoid dwelling on things that they might worry about:

Antenatal interview with Heather (9) (section 76)

Heather: the emphasis is on [young son] and his needs and whilst, you put yourself second really, you know... so it's first time round you don't do this and you don't do that and now you just, I just think: 'I've gotta get on with it'

Women with children who were young adults expressed concerns about the impact of a new baby in the family on their emotional well-being and on their relationship with those children.

Antenatal interview with Jenny (7) (sections 399-401)

Jenny: when things started getting delivered for the baby, [older daughter] says: 'I feel a bit, erm, left out' [...] and I said: 'don't be ridiculous [name]', I said: 'you'll never have to be. You're our first born' I says: 'you'll be our little girl always'

Antenatal interview with Miriam (5) (section 58)

Miriam: I think it's an embarrassing thing for teenagers for some reason that their mum's this old and they've got 20 years between their brother and their sister [...] I have to think of them all, all of them together, so even if there's one I feel is being neglected that'd worry me

In accordance with the findings of Jarvie et al. (2015) these women seemed to carefully balance simultaneously mothering babies and older children by involving but not taking advantage of their older child for example through *expecting* them to help with childcare. Women's concerns regarding their age had relevance for the present and the future, with

fears about future personal health and longevity leading some women to express hope that a baby would not become a burden on their older siblings should they or the father be unable to care for the baby due to ill health or death.

Antenatal interview with Jenny (7) (section 141)

Jenny: you're thinking, I'll be so much older, you know, and perhaps things that you can't do when you're in your 20s, when you're getting to 50 and 60, that's where you think you know you won't get as much time together, it's life...you know, but things can happen when you're young

Personal mortality and morbidity appeared to be significant with women aged 40 or over also feeling that a child born to older parents would have less time to spend with those parents in good health than other children, although this awareness did not deter them from having children.

Protecting other family members

Some women described their previous negative birth experiences as having a significant effect on their partner and they were careful to make decisions that protected their partners from any unnecessary trauma, such as plans for the birth. Partners were generally supportive, although the ways in which that support was provided differed. Some partners attended all antenatal appointments, some attended appointments seen as potentially challenging or important, most attended the birth and others provided support through being the 'breadwinner' or sharing chores. Similarly most women's families were described as supportive although having elderly parents meant that they were unable to provide any practical support or could require care themselves.

Whilst relationships with family and friends were important, many of these older women discussed being self-reliant and possessing skills to deal with issues independently rather than relying on others. In several instances they attempted to conceal their concerns to shield loved ones from worrying also. Older mothers may demonstrate greater "hardiness", which may be protective in managing anxieties (McMahon et al., 2007, p1172). Stainton et al.'s (2006) study of women experiencing high-risk pregnancies found that this status affected their relationships with others: women were concerned about their family worrying about them and felt responsible for those anxieties. In the current study some women described not wanting other people 'fussing', preferring to resolve worries before sharing them. For instance, Wendy concealed her pregnancy from her family following her recent miscarriage, fearing that this might happen again, stating: "I want to protect them and I didn't want them worrying a second time around" (antenatal interview with Wendy (11), section 98). Having developed gestational

diabetes and on-going sickness, Louise distracted herself by concentrating on her work in an attempt to also prevent her family becoming aware of her health problems.

Antenatal interview with Louise (4) (sections 288-290)

Louise: the more people make a fuss of me, the more I feel I'm not in control and I don't want that to happen to me

Similarly, despite having concerns, Jenny attended antenatal appointments alone having declined support from her partner, mother and sister. Her father had died recently and protecting her mother from additional upset was prioritised above her own needs. However in contrast with Louise and Wendy, Jenny was open with her family, explaining that she needed to deal with issues privately at first:

Antenatal interview with Jenny (7) (sections 544-547)

Jenny: I needed to do it on my own and I thought if there were anything wrong, if she could see anything... my mum's just had all that upset with my dad... I didn't want to put my mum through that...mmm...I'm like that [...] sometimes I need to digest that information and think: 'how am I gonna cope?' instead of people coming at me

Liz attended appointments regarding Down's screening and diagnostic testing alone, concealing her inner turmoil about the potential outcomes for herself and her family. Even as she waited for the diagnostic testing, she tried hard to protect her husband from her concerns:

Antenatal interview with Liz (1) (sections 233-235)

Liz: I don't like to worry him...no...no I don't like to worry him so I try to...(tearful) I tend to just get on with things, just deal with things myself to be honest, I just find it easier that way...but...I'll be alright. So no I don't think he knows to be honest, I don't. I don't worry him; I just deal with things

Older pregnant women may perceive that other people's awareness of their vulnerability could lead to personal feelings of self-doubt and loss of control. Whilst women said that they would eventually share any worries, they engaged different strategies for buying time to protect themselves and their family. Distraction from or concealing concerns can offer self-preservation (Beck, 2009) as well as protecting others. Other studies also report women being conscious of the potential strain that their high-risk status can place on close family and similar strategies for dealing with this (Georgsson-Öhman et al., 2006; Mu, 2004). However, sharing good news was a different matter with women sharing good news early.

Some midwives recognised that women might have issues they preferred to keep from their family, whilst also valuing the partner's involvement in the pregnancy:

Interview with Anne (midwife 8) (sections 40-46)

Anne: [partners] feel involved as well and then they go to give, hopefully, give the woman more support during her pregnancy if they feel more involved and it also gives them a chance to discuss their anxieties and worries [...] it's also good to see the woman possibly separately because if she's any, erm, concerns that she might not want to discuss with her partner there, then she has an opportunity

In addition, some midwives perceived that older, strong professional women might have partners with similar characteristics who might assume that the woman did not need their support. Older women may have developed resilience through dealing with life's events, enabling them to cope better with pregnancy challenges, but making it difficult to accept vulnerability and help.

Where women are busy with work, other children or relationship concerns, this may result in little available emotional resource to deal with pregnancy-related uncertainties. For some women in this study, this appeared to mean not allowing themselves to worry or finding out about issues until they reached a significant personal threshold. Using Mead's (1934) social behaviourist standpoint it can be seen that whilst these women were keen to be perceived as independent, this strong public 'self' may be so ingrained that it could be difficult for some older women to become a different 'me': to acknowledge they need support or to seek and accept help when this is offered. The emotional labour carried out to maintain the family's equilibrium accords with Gatrell's (2005) view that ubiquitous representations of women as self-sacrificing and responsible for the physical and emotional well-being of others makes self-prioritisation difficult. Hochschild (2001, p140) suggested that adults normally have a "considerable capacity to control emotion" and respond in a socially and culturally appropriate way to particular situations, despite their inner feelings. Emotion 'work' involves the effort of attempting to adapt the intensity or characteristics of emotion, and the 'rules' to which a person attempts to make their feelings or emotions conform are likely to be driven by external (cultural expectations of the responsible citizen, patient and mother) as well as internal factors (familiar or comfortable self) (Hochschild, 2001). In the instances above these older women appear to attempt to suppress their own anxieties to maintain their shared 'self' and benefit others and in doing so attempt to present themselves as strong and responsible.

Summary

Jomeen's (2006) exploration of women's early pregnancy experiences identified women's relationship with their unborn infant as triggering a desire to present themselves as responsible. This responsibility encompassed women relinquishing ownership of their pregnancy to medical and midwifery professionals and amending their pregnancy-related preferences. In the current study, being accepted as a 'responsible' older pregnant woman involved fitting in and attempting to justify this position when media and other people might perceive or portray older mothering as irresponsible or selfish. Normalising their position involved these women comparing themselves favourably to younger, less healthy women who might also experience pregnancy related complications or who might, because of their limited life skills, be less organised or able to deal with problems that could arise during their higher-risk pregnancy. Despite ensuring that they have acted responsibly to minimise any risks, in accordance with neoliberalistic values (McGregor, 2001), chance and uncertainty can play a significant role in shaping older women's views of their journey to mothering, since most eventualities such as becoming pregnant, staying pregnant and having a healthy baby are ultimately uncontrollable. Consequently, 'feeling lucky' was common amongst these women, who each achieved these goals. In contrast, fertility and early pregnancy complications caused some women to experience uncertainty about their pregnancy and feel 'in limbo'. Even when potential threats have passed, older women's anxieties about limited opportunities for future pregnancies may lead to these being replaced by new concerns. Parity may be unhelpful in indicating which older women might have the greatest pregnancy related worries; these women all had individual concerns. Whilst previous pregnancies may facilitate greater confidence about bodily changes and mothering, experienced older mothers may be anxious about previous problems resurfacing and the demands of caring for a newborn may come as a shock for first-time older mothers. However life skills can enable older women to feel better equipped for dealing with the challenges they might face. In addition to taking responsibility for their personal and baby's health, older women may have concerns about the impact of their pregnancy on others and work hard to ensure that loved ones do not suffer as a result of their pregnancy. This may mean that older women pay less attention to their personal emotional needs. Women's perspectives of their pregnancy and of their ability to take responsibility for their pregnancy are changeable, according to current circumstances. This influences the extent to which they adopt a functionalist or consumerist role with regard to their pregnancy and their relationships with health professionals. Despite older women often appearing to be self-assured, being able to make the 'right' choices and take the 'right'

actions can require extra support from their midwives. This is explored further in the next chapter.

Chapter Six – Enabling Relationships

Introduction

In this chapter the third concept of 'enabling relationships': relationships between older pregnant women and their named community midwives and obstetricians, is explored (see Figure 6.1). I draw on individual narratives of women and midwives, as well as their antenatal appointment recordings, to explore midwives' views of risk and to examine the relationship factors which have enhanced or detracted from women's pregnancy experiences and their ability to 'do the right thing'.

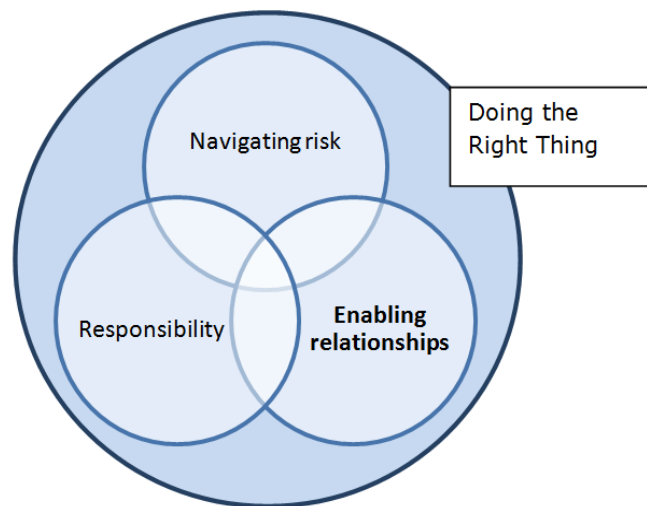


Figure 6.1. Relationship between the concept 'enabling relationships', the other concepts and the core concept: 'doing the right thing'

This concept includes three categories: 'communicating risk (midwives)', 'shared care' and 'being available'. 'Communicating risk' incorporates an analysis of how midwives attempted to facilitate balanced perspectives for the older women in their care; this is followed by an insight into how midwives sub-categorise women over 40. The midwives recognised the benefits of being informative rather than directing when communicating risk-related information and this is explored in the next section. The final focused code, within this category, addresses midwives' attempts to normalise older women's pregnancy experiences. 'Shared care' incorporates an examination of women's differing views of their consultant obstetricians and the impact of power differentials in their relationships. This category continues by addressing midwives' attempts to optimise women's experiences of shared care and concludes with insight

into the challenges midwives can face in managing women’s needs within a bureaucratic system. The final category analyses midwives’ availability for women and discusses the connections that can develop between older pregnant women and their community midwives. The difficulties of maintaining enabling relationships within the current maternity system and midwives being ‘stretched’ in order to achieve their responsibilities are also explored. The relationships between the core concept (doing the right thing), ‘enabling relationships’, its categories and focused codes are demonstrated in Figure 6.2.

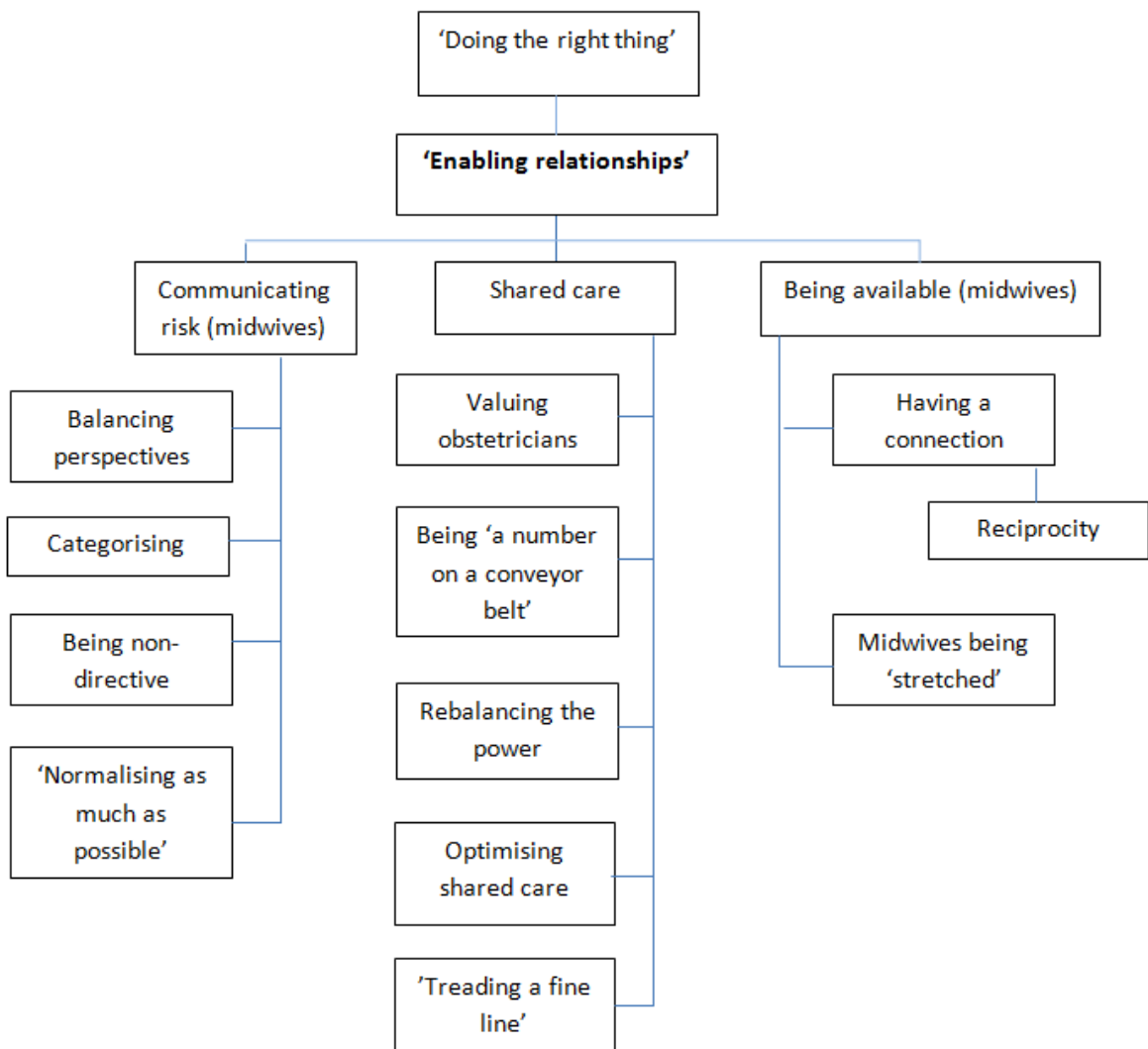


Figure 6.2. Diagram to illustrate the relationship between the core concept (doing the right thing), 'enabling relationships', its categories and focused codes

Communicating risk (midwives)

Health-related decision-making can be particularly complex where there is insufficient information or time to carefully consider each potential outcome (Zinn, 2008), where issues are risky (Alaszewski, 2003) or where expectations are unrealistic. Midwives are responsible for ensuring that women are equipped to understand and consider their options before making pregnancy-related choices (NMC, 2015). This section uses data from midwives' interviews and antenatal appointment recordings to discuss and illustrate the risk-communication strategies used by the midwives in this study with regard to older pregnant women.

Balancing perspectives

Informing older women that they were allocated to a 'high-risk' category on account of their age did not appear to pose difficulties for the midwives in this study. They explained that they would provide women with a simple reason for this. Referring to guidelines to justify this deviation from 'low-risk' care, midwives may have inadvertently implied that this was beyond their control, thus encouraging women to accept the organisational stance, which can restrict women's and midwives' choices. However midwives attempted to balance women's concerns through discussing differences between epidemiological data and individual women's risk status; they seemed keen to ensure that women understood that 'high-risk' did not equate to certainty:

Interview with Fiona (Midwife 4) (section 100)

Fiona: I'm not a person that makes a big deal of [risk] really, I just try and explain that this is how it is and this is what we've got to do. Sometimes I say: 'I don't make the policies and the protocols, it's just something that we have to follow'

Interview with Chris (Midwife 10) (sections 99-100)

Chris: you get some kind of feedback from their body language or their facial expression or whatever, and if she was shocked and looked frightened by it then I would diffuse it and say: 'you know, it's only a category, it doesn't mean you're not gonna have a straight forward normal healthy pregnancy and you're not gonna be safe'

High-risk labelling can predispose pregnant women to increased anxiety or stress (Hatmaker & Kemp, 1998) although this association may be small (Stahl & Hundley, 2003). Symon et al.'s (2015) examination of a nocebo effect in healthcare suggested

that women might be most susceptible to this and particularly those who might be predisposed to pessimism or depressive-type illnesses. They recommended practitioners remain mindful of this effect when advising about risk. In the current study, midwives' narratives demonstrated awareness of the potentially harmful effects of labelling older women and Chris's words above suggest that they may informally screen individual women's specific vulnerability and attempt to mitigate against this. Despite endeavours to present balanced risk-related information, some midwives expressed concerns around informing older women about their increased risk of complications through fear of subsequently predisposing them to a medicalised perspective:

Interview with Lynne (Midwife 11) (sections 129-133)

Lynne: oh, it's awful really, I hate it [...] risks are really low anyway, you know, they're really low. It's like sections, you know, previous section having a home birth, yeh, everybody assumes that the uterus is gonna rupture and everything else, so actually that risk is really low and it's same for older women in't it? [...] [it] medicalises everything

Whilst midwives were keen to minimise unnecessary concerns, being 'open and honest' was viewed as important in establishing and maintaining trusting relationships with women and for facilitating clarity about what was happening:

Interview with Ruth (Midwife 6) (section 18)

Ruth: ... if they've got a high-risk pregnancy and then they get a consultant appointment through and they have no idea why they have got the consultant appointment...they need to know why and why it is they've been referred ... I think most of them are fine as long as you...as it's out there right from the beginning, as long as you've told them right from the beginning why

Midwives must respond to deviations from normal and refer women's care to the most appropriate practitioner (NMC, 2015). However, despite several midwives stressing the importance of communicating the rationale for referral, some of the older women in this study remained unclear about this. Supporting the suggestions of van der Hulst et al. (2006), some midwives believed that older women were more knowledgeable and wrongly assumed that information did not need to be shared:

Interview with Sarah (Midwife 9)

Sarah: I think we think that [older] women know more than they do

Several midwives described experiencing most difficulty explaining high-risk status based on factors deemed to be under women's control, such as obesity, and for

which women could be considered blameworthy. Debbie described feeling comfortable telling women about age-related pregnancy risks since nothing could be done to alter someone's age and this, she perceived, did not involve value judgements. However, Heyman (2010d, p20) argues that observers "cannot attribute adversity, or benefit, to outcomes without making implicit or explicit value judgements". Making and communicating value judgements about potential outcomes associated with advancing age is inherent within midwives' risk assessment and risk management responsibilities, although being able to share such information in a non-directive way is challenging.

Direct reference to 'risk' within antenatal appointment recordings was sparse, although greater risk focus might have occurred earlier in pregnancy at the booking appointment, as found by McCourt (2006), or later in anticipation of potential complications around labour and birth. Direct questioning by women or their partners triggered the most detailed explanations. However, responding to questions about risk involved midwives shaping their answers to facilitate understanding whilst simultaneously playing down information that might prompt 'unnecessary' concern:

Interview with Lynne (Midwife 11) (sections 7-12)

Lynne: ...every little concern they have is blown into something major [...] we picked up a trace of protein or something and I can't remember if her blood pressure was a little bit higher, so then you're talking about things that you don't want to talk about because you don't want to put it into her head, because we were talking about pre-eclampsia [...] then she tends to go home and...panics about things

Additionally some midwives recalled unpicking preconceived and potentially inaccurate perceptions developed through media, friends and family. Prioritising "shock value" (Shaw, 2010, p139) or drama (Kirkham, 2013) over authenticity may disproportionately increase pregnant women's fears and some midwives' accounts suggested that addressing these fears might be more challenging for older women whose understandings might be more embedded:

Interview with Sarah (Midwife 9) (sections 144-148)

Sarah: [I say] 'please don't read [entertainment magazines] because all you do is frighten yourselves to death'...and a lot of ladies come and they say: 'oh my friend said this and the neighbours said that' and dedadedade and they ask you, don't they, to make sure it's right or wrong and I just say: 'oh, no, don't take any notice...if you've got anything to ask, ask me'

JS: do you ever feel like...

Sarah: like you're unpicking, yeh, ideas that are preconceived, yeh, definitely, and of course the older they are, the more they're sewn in aren't they?

Community midwives draw on their knowledge of women and factors potentially influencing their understandings to guide information-sharing strategies. Whilst several midwives described providing all women with the same information, it was apparent that although the essence of that information remained constant, nuances occurred in the content and delivery based on midwives' perceptions of the needs of individual women and groups of women. Occasionally midwives missed opportunities to clarify women's understandings; this may have been a strategy to avoid increasing women's concerns or through midwives missing potential cues due to being busy. For instance, Helen might have explored Jenny's understanding about the consultant's rationale for avoiding a post-dates birth:

Jenny's appointment with midwife Helen (7) (sections 66-70)

Jenny: [consultant] said: to be fair I'm just here as a consultant and I'm here for problems, and I can't find any, touch-wood, touch-wood'

Helen: which is good...

Jenny: yeh, which is good, but she said she wouldn't let me run over my date

Helen: and that, that's fine as well...I'll just do your MAT B1

Women may face important decisions in the absence of all the necessary information, despite midwives perceiving the need to facilitate balanced understandings. Time needed to discuss issues may be constrained by midwives' workload (Levy, 2006) and this appears to have affected some of the experiences of the older women and midwives in this study. Whilst midwives acknowledged being busy, their accounts revealed more about strategies for managing their work to meet women's needs rather than their inability to meet women's needs.

Categorising

Some midwives' accounts acknowledged stereotyping women to be wrong, yet several midwives allocated older mothers to one of two categories: firstly women who were well-educated, financially stable and health conscious who were likely to be having their first baby when older and would be most concerned about limited opportunities for future pregnancies; and secondly, older women who were more likely to be multiparous, possibly less well-educated, in a less fortunate social situation and less health conscious.

Interview with Chris (midwife 10) (sections 120-122)

Chris: the planned 40 year old primip who's planned it, who's in a financially stable position, who's got a stable relationship and ...I'd be less worried about her age related pregnancy than I would about a smoker, who's been a heavy smoker for 20-odd years, who's pregnant again and they've already had six [babies] and has poor housing and not very good support. I would be much more worried about that mum than the primip mum who might think she is a worry and that she's high risk

This finding resonates somewhat with a Norwegian mother and baby cohort study (Nilsen et al., 2012) which concluded that women giving birth at either advanced (33-37 years) or very advanced (38 years plus) age would be more likely to fall into a heterogeneous group of women who were either socioeconomically wealthy or vulnerable. However Nilsen et al.'s (2012) study did not include multiparous women therefore comparisons according to parity were not made. The women in the current study experiencing their first pregnancy during their late 30s or 40s appeared to be financially and socially secure and their community midwives did not associate older primiparous women with socioeconomic vulnerability.

In the current study, midwives' narratives suggested that the women most likely to understand pregnancy related risks and do whatever they could to address potential risks belonged to the first category (well-educated and financially stable). Ruth commented that in her experience women in their 40s understand and have acted on their health-related responsibilities, so that they are as healthy as possible. She and other midwives regarded these women as being less risky than women in the second category or indeed younger women who might have complex health or social needs:

Interview with Ruth (Midwife 6) (section 40)

Ruth: well there's research evidence that if you're over 40 you are more at risk of, of complications of pregnancy, but that doesn't mean that because you're over 40 you're definitely going to have those complications, nor does it mean that because you're under 40 that's it, you're going to sail through your pregnancy. I think there's ...you've got a lot of sort of like, your responsibility to look after yourself as well and erm, I think, just, from my personal experience, I think the ladies over 40, it's quite often been, its either a 'precious pregnancy' – one they've waited a long time for – or they've planned to have a pregnancy later in life because of a career, and so therefore, they're sort of like, er, they make sure that they're in as good a condition as possible before they even embark on pregnancy...erm, so it's probably a well thought out decision...why they're pregnant at that stage in life

Several midwives elevated older women's pregnancy status to 'precious' or 'special', suggesting that these women might be more careful and susceptible to greater

scrutiny and intervention by health professionals. This perception reflects the findings of others (Dulitzki et al., 1998; Carolan, 2003b; Treacy, Robson & O'Herlihy, 2006). Despite recognising that older women may have additional needs some midwives described the importance of not treating them with 'kid gloves' or 'delicate hands'. Midwives were thus attempting to normalise the experience of older mothers whilst balancing this with providing individualised care.

Being non-directive

Despite identifying 'typical' older women's responses to being labelled high-risk or investigations such as Down's screening, some midwives considered categorising women as potentially harmful. Some suggested that stereotyping might incline health professionals to disempower women aged 40 or more by making assumptions about their preferences and restricting information sharing. Midwives recognised the significance individual women's backgrounds played in shaping their perspectives and tried to balance this with offering women the same choices irrespective of their age. Clare had discussed her intentions to decline screening for Down's syndrome early in pregnancy with Chris her community midwife, and Chris had respected her wishes:

Interview with Chris (Midwife 10) (section 26)

Chris: ... to assume that cos they're older they automatically want to have Downs screening is *wrong* and I think that her words probably were: she works with children with special needs any way, there is no way she would consider other options, so it weren't a real issue to her

Similarly Fiona stressed the importance of providing the relevant information without emphasising a particular viewpoint:

Interview with Fiona (Midwife 4) (section 155)

Fiona: Yeh, she's 40, she is a slightly more increased risk but so is a 19, a young 16, 17 year old. They are also high-risk. So you are giving them, as a community midwife, I give everybody the same information and I don't think I put any emphasis on, other than that I might say: 'it is age related, and because you're that little bit older, it may put you into that higher risk category, but everybody's got their own risk'.

By explaining that other women were also 'at-risk', midwives believed that they were able to provide relevant information at the same time as maintaining some sense of normality. Nevertheless older women's location within a higher-risk category was perceived as potentially influential in decision-making and whilst some women

appeared to want guidance in making the 'right' choice, midwives recognised their role in providing balanced, understandable information rather than advice:

Interview with Helen (Midwife 7) (sections 112-114)

Helen: [women say]: 'well, what do you think?' 'It's not what I think it's your choice, there's the information', erm that's...

JS: do you think they're trying to...they're wanting you to help them...

Helen: yes, yes, I think, yeh they do, and I find that hard, I do find that challenging sometimes, because you *have* to resist, don't you? you have to resist, erm...that input and it's like: 'there's the information, it's not for me to say, it's your choice at the end of the day'

Refraining from advice-giving can be challenging; where women appear to lack an appreciation of potential consequences regarding their decisions this may be a source of concern for midwives. Sarah recalled one older pregnant woman who had conceived twins using IVF and who opted for Down's screening. Sarah was concerned that despite discussing potential outcomes such as the possibility of one baby being affected and subsequently facing difficult choices about what to do next, the woman had not appeared to understand the implications of this:

Interview with Sarah (Midwife 9) (sections 28-32)

Sarah: I had a lady once that had IVF twins and had Downs screening...and I were really sho...I couldn't get my head round it! [...] I were really shocked and I just thought: 'my God you've waited all this time and you've had IVF and you're... this is what's happened', I was really shocked [...] She didn't seem to have grasped it!

Midwives can develop strong bonds with women and this relationship may have greater significance for community-based midwives. On account of this closeness, community midwives may experience stress when there is a threat to women's or babies' well-being (Hunter, 2004; 2009) as demonstrated in Sarah's narrative above. Beck (2009, p13) suggests that "the reality of risk is shown by its controversial character" and that it "acquire[s] reality in the contradictory judgements of groups and populations". Women and health professionals are likely to interpret information differently based on their disposition, usual behaviour patterns and specific contexts (Royal Society Study Group, 1992; Lobel, Yali, Zhu, Vincent & Meyer, 2002; Zinn, 2005). Decision-making based on intuition or something feeling right may be perceived as inferior to decisions made by balancing risks and benefits, and midwives have to accept women's decisions regardless of their own feelings. Attempting to present risk information objectively can be challenging for midwives who must bypass their personal and professionally guided interpretations of risks and

perceptions of particular women. According to Beck (1992, p234) "self-criticism in all its forms is not some sort of danger, but probably the only way that the mistakes that would sooner or later destroy our world can be detected in advance" and learning through reflection is imperative for maintaining professional midwifery registration (NMC, 2015). Being aware of personal biases and recognising that their expertise can impact on the power dynamics of relationships with older women (Leap, 2010) may enable midwives to negotiate the challenge of effective risk communication and enable women to feel empowered (Hunter, 2001; Hall & Taylor, 2004). However the situation can be trickier when women wish to be guided rather than act autonomously or when they do not appear to have personalised the situation. Exploring issues with older women may help to avoid assumptions being made based on stereotypes.

'Normalising as much as possible'

Midwives' accounts and the recorded interactions between women and midwives suggested that these midwives were keen to normalise older women's situations whilst simultaneously enabling their understanding of age-related risks. Whilst the media may present unrealistic views of older mothering (Wood, 2008), several midwives attempted to contextualise the older women's risk label through comparisons with other women they had cared for or celebrities who had given birth after 40:

Interview with Chris (Midwife 10) (section 52)

Chris: I try and turn it round and say 'oh, look at Madonna, or look at...' and try and find some kind of icon type person that's done it and lived to tell the tale successfully

In addition midwives tried to ensure that attending for hospital care did not exclude older women from accessing 'normal' midwifery care, such as discussing birth-planning, feeding and caring for their new baby. Some midwives suggested that women's perceptions of normality might be enhanced by leaving risk-related discussions to obstetricians:

Interview with Helen (Midwife 7) (section 106)

Helen: ...I like to be there to give that...normality, and really do things that sometimes again, without being disrespectful, they're busy clinics (at hospital), they're not always good, [women] wait a long time, so I like to think that just sometimes they're coming into that environment on a one-to-one [...] and that that normality and that personal perspective still exists even though

they're happy to come up here (hospital) because of the risk factors and the ...yeh, the medical intervention that's required [...] sometimes, those, those normal things don't get discussed, I feel, like, the birth plan or, you know, the normality of things [...] so keeping the focus normal and erm, wherever we possibly can and let [obstetricians] deal with...the risk...

Some midwives also explained they tried to help older women focus on positive aspects of pregnancy, to 'go with the flow' and adopt a flexible approach to avoid disappointment.

Interview with Chris (Midwife 8) (section82)

Chris: I think if they're older [...] they're very knowledgeable by the time it gets to being pregnant [...] I usually try and ask, try and encourage them to stop looking for problems and let the problems find them

The International Confederation of Midwives (ICM, 2011) outlines the philosophy of midwifery as promoting normality during pregnancy and birth, detection and management of or referral for identified complications. Reflecting some women's perspectives, several midwives shared their opinions that local and national policies and guidelines restricted older women's pregnancy-, labour- and birth-related choices. These restrictions were deemed to apply because of older pregnant women's age defining them as high-risk regardless of their social, mental and physical health. According to Heyman (2010a, p83) risk selection is not only connected with evidence-based estimates of risk, but also with "deeper, ill-understood social forces" which may conflict with organisational priorities and thus risk thinking as a form of governmentality may be overcome by tensions between individual and organisational perspectives. Risk-identification can facilitate risk-reduction strategies, but cannot guarantee that the identified eventuality will be minimised or avoided (Lupton, 1993; 2013). The midwives in this study attempted to help women to develop a balanced view of risks by minimising the emphasis on risk and normalising their position, although at times this was challenging when women's views differed from their own.

Shared care

High-risk status resulted in these older pregnant women automatically being referred to a consultant obstetrician and limiting options about the place of their baby's birth; the option of birthing in a stand-alone midwife-led unit was unavailable and resistance to a home birth likely. During antenatal appointments midwives confirmed that women had received appointments with consultant obstetricians, yet the

purposes of these appointments were not explicit. Some women's narratives demonstrated a lack of clarity regarding the rationale for obstetric referrals and an expectation that clarification would occur during the appointment itself, although several women remained unclear even afterwards. Nonetheless, having an effective relationship with their obstetric consultant was highlighted as a significant factor for some women's pregnancy experiences. Several of these older women expressed either very positive or negative views of their relationship with and care provided by obstetricians.

Valuing obstetricians

A small number of women described their obstetricians as 'friendly' and 'approachable' and appreciated the consultant's honesty about their role in looking for problems:

Antenatal interview with Jenny (7) (section 513)

Jenny: [consultant] did say to me: 'because you're [older]...' she explained to me why I needed to do what, you know, these extra... she said: 'it's not that there's anything, we just want to make sure that [baby]'s growing properly' [...] she were straight as a die and said: 'I am here looking for problems', she says: 'touch wood I can't find any and let's hope there won't be any'...

Jenny was happy to follow expert guidance, perceived the obstetricians to be good listeners and believed that they had provided good care throughout her pregnancy, birth and postnatal difficulties. Vulnerability creates a tendency for people to defer decision-making to experts (Lupton, 2003) and in accordance with Kelh a's (2009) study, some older women considered delegating their safety to experts as acting responsibly; they were thus happy to assign decision-making.

Having care provided by several obstetricians did not appear to negatively impact on some women's perception of care. This finding supports Waldenstr om's (1998) and Green, Renfrew and Curtis's (2000) findings that effective interactions might be more significant for increasing women's satisfaction than knowing their care provider. However, for some older women, continuity of care from the same obstetrician was important in enabling them to feel respected and understood, which concurs with Howarth, Swain and Treharne's (2012) findings, although their study did not focus on older pregnant women.

Cath's narrative suggests that she particularly valued continuity of consultant care and the positive, enabling relationship that she perceived they had built during her current and previous pregnancy:

Postnatal interview with Cath (2) (sections 201-205)

Cath: there's not that personal touch when you see somebody different every time you go [...] we really did build a relationship with [consultant] both with [daughter] and...

JS: both yourself and [partner]?

Cath: yes both of us, [...] you do you just build relationships and I think that it goes back to what I said at the beginning, it's important that you can talk to, feel that we can talk to people and go in and know what they're like, just have that personal touch and they understand your pregnancy and he met [daughter] and said: 'ah, now this is the one!' and 'how are you, you foolish woman?'(laughing) and all that... and he was just... it was all lovely [...] he'd seen me at the beginning, he knew the story, you know, and yeh, it was lovely...

Cath appeared to view her relationship with her consultant as a partnership involving active participation in decision-making and taking responsibility for her health. She appeared to draw on her prior negotiation and management skills to treat investigations and management of her gestational diabetes as a project and participate equally in multi-professional appointments. In addition, this relationship incorporated light-hearted joking which may have been avoided or perceived negatively in a relationship lacking a sense of partnership. Indeed Cath perceived that women who lacked responsibility for personal health could have a different, less reciprocal relationship with their consultant. Brown and Baker (2012) suggest that citizens are expected to be simultaneously responsible and vulnerable - in need of expert guidance. By conforming to these principles of neoliberalism, presenting a positive attitude to expertise and making sensible choices, responsible women such as Cath can access maternity care whilst retaining a sense of control and autonomy. The hospital's formal environment, the language and professional manner of consultants may enable middle class women to establish relationships with their obstetricians more easily (Lupton, 2003); this appears to have been the situation for some of the professional women in this study. Furthermore, professionals may prefer to work with higher-status service-users since they may be deemed less culpable for problems and more receptive to advice (Hugman, 1991).

In contrast with several other women Cath described her consultant appointments as lacking time pressures, being more personal and affording greater opportunity for in-depth discussions than she experienced with her community midwife, whose appointments she perceived as rushed and task-orientated (see p150). Cath observed that whilst community midwives might rush women through appointments because other women were waiting, consultants kept women waiting until they

themselves were ready, facilitating longer appointments. She perceived this might reflect obstetricians' greater authority. Women appeared to tolerate lengthy waiting times if their consultant appointment then provided time to discuss concerns, perhaps reflecting the importance afforded to these interactions or to the differential in power. Earle and Letherby (2007) suggest that time is a symbol of power and waiting for doctors' appointments is an expectation, although if women are late they have to apologise or even forfeit their appointment.

Being a 'number on a conveyor belt'

In contrast with Cath's views and reflecting the findings of O'Connor et al., (2012) and some midwives, the busyness of hospital antenatal clinics negatively impacted on some older women's perception of consultant appointments. Some women described consultant appointments as impersonal and felt 'fobbed off' with insufficient explanations or time to discuss concerns in enough detail. When obstetricians did enable women to personalise information this was not always timely, although earlier understanding might have prevented some women worrying unnecessarily.

Several women's stories suggested relationships with consultants that were less balanced, effective or supportive than those experienced by Jenny and Cath as described above. Regardless of parity, these older pregnant women expressed a preference for a consultant who respected and treated them as an individual rather than being a 'number on a conveyor belt'. Impersonal, quick appointments with obstetricians appeared to reinforce the importance of having an effective relationship with their community midwife. Obstetricians were perceived, by some women, as having their own agenda rather than responding to women's needs; this resulted in some obstetric appointments being viewed as offering little benefit. According to Beck (1992, p205) medical progress "discharges people into illness [...] regardless of how they actually feel" and Heyman (2010a) argues that service providers can prioritise biophysical, legal and organisational issues above the consequences of health-related problems for the wider context of people's lives. These views were reflected in some women's stories. For example, Carol observed how being pregnant and giving birth to a baby are 'unique and special times' for women, whilst dealing with childbearing women is 'just a job' for obstetricians. Several other women's accounts revealed obstetricians' language lacking empathy and an ignorance of the fear their words could invoke. While Cath described a meaningful relationship with her consultant, her narratives suggested that she also believed obstetricians managed problems unemotionally on account of the frequency with which these were encountered:

Antenatal interview with Cath (2) (section 229)

Cath: they're seeing that all the time, but to you it's like everything though, but it's like [consultant] said, 'well you know it's not too late to terminate at week 20'. No... because he's seeing people all the time who... it just rolls off the tongue, but words like that... you think 'oh my God, oh no'

Other women similarly expressed negative views relating to their interactions with obstetricians and the apparent lack of empathy used to convey risk-related information. For example, Louise described feeling upset when told her unborn baby might die because of her gestational diabetes if she did not follow obstetric guidance.

Postnatal interview with Louise (4) (sections 200-202)

Louise: I think it's a big shock being told you are diabetic [...] but at the same time you adjust to it, cos at the same time I was distressed, upset and then afterwards I just think: 'okay, how do I deal with this?' and then you kind of move forward [...] but then I think [consultant] made it worse saying that the baby might die... but at least she was just telling me the worst case thing

In a study of primiparous women's relationships with their obstetricians, Howarth et al. (2012) identified women's difficulties in establishing relationships with their obstetricians; doctors' detached, impersonal approach made one woman feel awkward and another described feeling like a 'slab of meat on a table' (ibid, 2012, p492). Managing uncomfortable or distressing situations can mean doctors learn to respond neutrally and unemotionally (Lupton, 2003) and as a consequence this detachment may lead to routinised and impersonal practices (Deery & Kirkham, 2007) resulting in women experiencing 'a conveyor belt system'.

People choose whether to accept or refuse treatments or be involved in health-related decision-making, although they are also expected to "follow the course of treatment which [they] have agreed" (Department of Health, 2015b, no page). Pilnick and Dingwall (2011) argue that the powerful position of medicine within contemporary society facilitates a "remarkable persistence of asymmetry in doctor/patient interaction" (p1374). Some narratives suggested that where these older women's opinions differed from their consultant's, fear might be used to steer their choices through implicating their failure to acquiesce as irresponsible or irrational. However, supporting Kelh s (2009) findings, the narratives of some women in the current study demonstrated a strong desire to be actively involved in making decisions about their pregnancy and birth. Health professionals might reinforce their advice if women seem to be making illogical decisions (Lupton, 1993; Crawford, 2004; Alaszewski, 2005) rather than adopting a woman-centred approach whereby women's lifestyle factors and biophysical needs are kept in mind (Titterton,

2005). Emphasising a particular viewpoint can limit choice and disempower women. Since older pregnant women are susceptible to a number of risks, they may also experience increased susceptibility to informed compliance through fear of harm to themselves or their unborn baby (Stapleton, 1997, Jordan & Murphy, 2009). However, whilst some women were conscious of their older age, this was not always mentioned during appointments with midwives or obstetricians:

Antenatal interview 1 with Clare (10) (section 132)

They've not called me geriatric yet, so that's good!

Several women described consultants identifying their older age as a risk factor, although this was not always explicit or perceived to affect their care. Whilst Carol's consultant had drawn attention to her age by repeatedly circling this in her notes during their appointment and whilst she perceived an emphasis on being 'at-risk', she did not believe that her pregnancy care reflected this status. She believed that this emphasis reflected the obstetricians medicalised agenda rather than her own needs:

Antenatal interview with Carol (6) (sections 299-306)

Carol: it's just rubbish and that's something to keep you tethered...you know...a label...

JS: without...?

Carol: making you feel any safer – it doesn't does it [...] oh they listed the risks! They list the risks as they see 'em. But they're there regardless, so I don't see them doing anything about them

As discussed previously (pp112-113), the women in this study described their greater life experience as advantageous in dealing with challenges. Nonetheless and irrespective of any professional status, some women experienced interactions with their consultants which resulted in them expressing feelings of disempowerment, vulnerability and sometimes anger. These perceptions appeared to result from women believing that their viewpoint was not valued. For instance, Heather had hoped to have balanced discussions about her pregnancy and birth with her obstetrician, yet her retrospective narratives suggested perceptions of the consultant's attitude being driven by assumptions regarding age-related risk rather her personal potential for problems:

Postnatal interview with Heather (9) (section23)

Heather: literally the consultant cut me short and said: 'I'm going to send you for a growth scan and we'll bring you back at 34 weeks and we'll discuss there'. And that was that, so going from really good appointments all the way

through, all she'd done was look at my age, made the assumption that I was gonna have pre-eclampsia...

Making assumptions regarding individual women based on epidemiological data about women aged 40 or over may lead to inappropriate or unnecessary advice or communication (Mohanna & Chambers, 2001; Pilnick & Zayts, 2012), supporting some women's views of ineffective relationships with consultants prohibiting good care. These findings concur with Lerman et al.'s (2007) study of the relationship between women with high-risk pregnancies and care providers and the impact of this on their satisfaction. Effective risk-related communication is particularly important where women have risk-related worries, for example on account of their age.

Rebalancing the power

Power gaps between these women in their 40s and obstetricians were evident in some narratives and several women's words reflect the battles they experienced in attempting to have their opinions respected. As a consequence of feeling disrespected, Heather consequently declined to see the same obstetrician again. In addition she recalled 'too many people' being in the consulting room and that, although she believed this situation might have been disempowering for younger women, having greater life skills had enabled her to voice her opinions:

Postnatal interview with Heather (9) (section37)

Heather: ...there was four people in that room, and if I was somebody that was young, naive or somebody that wasn't prepared to stand their ground, I'd have been on medication that I didn't need to be on, I would have been, you know, nothing was really discussed with me [...] 'she's not looked at my individual notes, not accessed my notes' I said and yeh, so...really, really poor

Despite her age and life experience facilitating greater self-confidence, Heather had taken her partner to the following appointment for support and to rebalance the power; there she saw a different obstetrician. From Heather's perspective this experience had been more respectful and enabling; although she believed it had been necessary for her to assert her autonomy to achieve this. Louise recalled a similar situation, whereby 'too many people' in the consulting room caused her to describe feeling 'exposed' and 'vulnerable', despite her professional background and life experience. She viewed her appointment as a teaching opportunity for those people in the room and that this had detracted from her care. She too attempted to regain some control by drawing on her knowledge of national guidelines. However the obstetrician appears to have overruled these attempts:

Antenatal interview with Louise (4) (section 204)

Louise: [I said] last time about, erm, the NICE guidelines (chuckles) 'Oh! We know about the NICE guidelines!' she was quick to say: 'Oh yeh I know about the NICE guidelines'... and the next question is: 'what do you do?' (laughing) and I told her what I do and then she said: 'Oh, BMI is higher that's why we are doing this and that's what the NICE guidelines say', but I felt like being sarcastic, really, because she was saying: 'Oh, oh have you read the NICE guidelines about [gestational diabetes]...?' and I say: 'no I haven't', but she said: 'then shh!' you know, because I had mentioned the NICE guidelines

Middle class or professional women such as Heather and Louise may be better equipped to challenge doctors' authority (Lupton, 2003), although being a 'good patient' requires them to conform with expert opinion and the penalty for deviance may be a cutting remark (Lipsky, 2010) such as recalled in Louise's story. However Louise believed that her age had influenced decision-making and supported that by describing how doctors pointed to her age in her notes when discussing her care. She considered transferring her care to a different hospital based on her negative experiences. Similarly, Carol had been dissatisfied with the pregnancy care provided by her consultant since their opinions about the safest time for her baby's birth had differed. She perceived that women were vulnerable because of the powerful position held by the consultant as a consequence of their knowledge and their professional status and that this inequality in power had led to her succumbing to the experts and feeling undermined:

Antenatal interview with Carol (6) (section 83)

Carol: *you are the patient; you are extremely vulnerable in that room, because all the power is in that chair! They decide, they make all the decisions, they tell you what your options are, they tell you what they're prepared to do and what's open to you...erm, I mean I went in, and that's how I must have felt, I suppose, I felt like er...I suppose like an idiot really...by the time he'd finished with me I said: 'look, fine, you're the expert, leave it'*

In an attempt to regain some control Carol had found some research⁶ which suggested that older women might have longer pregnancies than their younger counterparts; she had tried to use this information to negotiate a later planned date for her baby's birth. Introducing this information did not appear to have had the desired effect, with Carol perceiving that the obstetricians had resented her having an opinion which differed to their own:

⁶ A study published around that time (Jukic, Baird, Weinberg, McConnaughey & Wilcox, 2013) suggested that women aged 32-40 could have a pregnancy lasting ten days longer than women aged 23-25 with each additional year adding approximately one day to the length of their pregnancy.

Postnatal interview with Carol (6) (sections 257-261)

Carol: ... I'd said, 'but there's a study there that...' it were only a small study, but I were able to criticise it – be critical of it, erm, a small study that I says 'older mothers are supposed to gestate for longer', and that's how she topped it off then: 'yes there's a recent research that says erm there's a higher risk of neonatal death to, erm, geriatric mothers...'

JS: did she say that?

Carol: yeh

JS: did she use those words?

Carol: ...er, yeh it was the , yeh it was, that was the study...and I just thought: 'well...fine, okay' (nervous laugh), so, no wonder I used to be fearful every time I went to the hospital, because you'd always be coshed down!' [...] they don't like to be answered back to do they? It's: 'I've got all the knowledge and I'm the expert you should listen to me,' yeh, I think: 'God help me'

Carol's professional career had led to her understanding and respecting power and this insight had emphasised to her the apparent lack of respect obstetricians could have for their privileged position. Reflecting back after her baby's birth, Carol described her obstetric appointments as being a 'real stressor' and despite being pleased with care at her baby's birth, antenatal encounters with obstetricians appear to have been a challenge:

Postnatal interview with Carol (6) (section 437-442)

JS: that first time when we met and you were in that clinic... and it was like...

Carol: a tug-of-war! (laughing) [...] I wasn't settled, you know, Jayne, I wasn't – all the way through, and it weren't... it were right at the end... that it came together

Carol perceived that her vulnerability had impacted on her interactions with the consultant and on reflection she believed that had she felt safe she might have reacted differently. She suggested that whilst consultants might have 'a bad day' this did not excuse disrespectful behaviour. Regardless of age and experience, feelings of vulnerability in consultant appointments may cause women to behave uncharacteristically, affecting their decision-making and their overall experiences. Informal bargaining may lead to fluctuating relative positions between pregnant women and obstetricians depending on specific circumstances (Lupton, 2013), although having balanced discussions whereby women's views are respected is imperative.

Several women believed that their relationships with obstetricians could be improved through greater respect for women's situations and views. Some women suggested

that knowing more about different consultants could enable them to request referral to a consultant who might be more empathetic. Having a professional background did not appear to influence older women's satisfaction with their obstetric consultant. However those women who described 'unacceptable' behaviours were women with professional backgrounds. Effective midwifery support may help older women to address difficulties in relationships with consultants, by enabling women to share their experiences or advocating on their behalf.

Optimising shared care

Midwives recognised that relationships between women and consultant obstetricians varied and that women's opinions of obstetric care also differed from woman-to-woman and obstetrician-to-obstetrician as discussed above. In some instances midwives appeared to pre-empt and address topics that older women might discuss with obstetricians so that they might feel better prepared. In other instances midwives demonstrated debriefing or mediation skills, enabling these older women to interpret what had been said or attempting to facilitate solutions to women's difficulties. Unable to facilitate immediate reconciliation between Carol and her consultant following an appointment which had resulted in Carol feeling upset, Ruth discussed alternative providers of obstetric care:

Carol's antenatal appointment with midwife Ruth (6) (sections 17-28; 34)

Ruth: ...you can either opt to see a different consultant at [current hospital]

Carol: there's always [female consultant] isn't there?

Ruth: or...

Carol: and feel like I'd end up seeing him, he didn't want to see me until [date]

Ruth: or we can just refer you to a different hospital altogether, it's up to you, or you could still deliver at [local hospital] but maybe go to [other hospital within the trust] and see [different consultant] at [different site]? It's up to you [...] think about it, let me know...

Doctors may have a greater focus on women's biophysical needs rather than other aspects of their lives (Heyman, 2010a) and several midwives' accounts demonstrated attempts to neutralise negative effects of this medicalised focus by facilitating better experiences for older women. Based on their prior perceptions of women's experiences some midwives identified and referred women over 40 to specific

obstetricians whom they perceived as being sympathetic towards older women's needs.

Interview with Ruth (Midwife 6) (sections 46-48)

Ruth: ... there's a particular consultant that we might choose to refer to in preference to other consultants cos he's got, like a lenient...view with these ladies, so if these ladies were *normal* other than their age and they were over 40, he'd be more than likely to sort of... erm, not give 'em *permission* for home birth, but if they were wanting a home birth he would probably suppo...be more supportive of that than other consultants. So I think if you...pick and choose your obstetrician as well, you know which one would, probably be more sympathetic with them as well...

JS: so, knowing, knowing what services are available and individual...

Ruth: and trying, trying to sort of steer them in the right direction

Ruth appeared to recognise that despite women being autonomous, the extent to which they can exert this autonomy is affected by the power hierarchy within maternity care and the dominant position of consultant obstetricians. Through selective referrals Ruth and some other midwives attempted to protect older women from potentially challenging situations and facilitate women's independence by guiding them towards a path of least resistance. An important role of midwives is that of advocate (NMC, 2015). However advocacy may conflict with organisational agendas and as a consequence workers may seek to use their discretion for assisting clients (Lipsky, 2010) and applying policies in practice (Hoyle, 2014). Some midwives did not selectively refer older women to particular obstetricians, believing this to be unnecessary where women are treated as individuals. Nonetheless whilst all women aged 40 and over were referred to consultant obstetricians, several midwives queried the need for this blanket intervention, expressing a preference for a more flexible, 'open-minded' approach based on women's individual requirements:

Interview with Fiona (Midwife 4) (sections 124-126)

Fiona: ... it's a little bit of a grey area: do they have to be a consultant booking? [...] do they *have to be a consultant booking* if they are straight forward, for healthy 40 year olds? They do if they've got underlying health problems, but why can't they be a 'wait and see'? so be a midwife booking, let's see how that pregnancy goes...nine times out of ten, they're uneventful, so they should remain as low risk and therefore if she's remained low risk, could she not come to the midwife led unit if she's been as straight forward as somebody who's been 39?

Referral to a consultant obstetrician was viewed by some midwives as medicalising older women's pregnancies, potentially resulting in women unnecessarily perceiving

pregnancy-related problems. Adopting a 'wait and see' approach such as suggested by Fiona may enable midwives to support older pregnant women in accepting uncertainties associated with their pregnancy rather than focusing on risk (Leap, 2010). Nevertheless, echoing the women's voices, midwives also recognised that for some older women referral to obstetricians could be reassuring because of women's particular circumstances, personality or societal influence. However, two consultant midwives had recently been appointed to the trust and some midwives suggested referral to a consultant midwife rather than an obstetrician for older women with no additional health risks:

Interview with Ruth (Midwife 6) (sections 56-58)

Ruth: I think that...low risk other than their age, these ladies might be more suitable to go on to say like a consultant midwife, rather than a consultant obstetrician, cos it's not medical interventions that they actually needing is it?

Consultant midwives were viewed, by several community midwives, as being greater promoters of normality, more 'in tune with women' than obstetricians and more likely to assess and manage risk according to individual woman's changing needs rather than on epidemiological bases, which could steer older women into expecting pregnancy complications. Nonetheless some midwives believed that referral to a consultant midwife could detract from their relationship with women and could also reinforce older pregnant women's status as different:

Interview with Chris (Midwife 10) (section 88)

Chris: they do have that lack of choice in the fact that they are automatically booked as high risk, I think they could have maybe a specialist midwife [...] but then you're still taking them away from the community to see somebody who... is... then again, that's not normalising it?

Interview with Lynne (Midwife 11) (section 186)

Lynne: ...if you do start treating them differently, then they're gonna feel as if...they're different, when, you know, I think it is becoming part of the norm now for older women, and by doing things differently, by having clinics for older women, we're making it seem as if they are...you know, doing something wrong by having their baby later

Ensuring that older women understand potential risks and receive appropriate care to promote safety without focusing on these unnecessarily can be a challenge for midwives. Disparity between meeting organisational expectations (providing risk-related information and making referrals to other professionals) and midwives' real feelings (older women may be negatively affected by risk communication or by their

relationship with other health professionals) may lead community midwives to experience emotional dissonance. Significant effort may be needed to disguise their true feelings (Morris & Feldman, 1996; Deery & Fisher, 2010). However when midwives are able to employ autonomy the negative effects of emotional dissonance may be moderated.

'Treading a fine line'

Whilst midwives acknowledged women's independence in decision-making, some considered that supporting older women's choices that deviated from institutional norms could locate them (midwives) in a tough position between balancing their professional duties and working within the remit of their employer. These difficulties reflect Lipsky's (2010) view that advocacy is incompatible with bureaucratic priorities. Anne recalled attending the home birth of a 40 year old woman who had previously experienced a shoulder dystocia. As a result of her age and history, the woman had been advised against a home birth by the consultant obstetricians:

Interview with Anne (Midwife 8) (sections 102-106)

Anne: I felt a bit, erm, a little bit anxious, and the good bit obviously I was aware of, erm, the details, er, beforehand [...] the most important thing obviously is talking to the woman, er, and finding out her choices and erm, trying to facilitate them as much as you possibly could within the safe environment... then she went ahead to have a nice, normal delivery, so it didn't cause too much, erm, you know, controversy

Being aware of potential complications in advance enabled Anne to prepare for dealing with these by creating an environment and relationship with the woman that were conducive to minimising and managing risks. Midwives' concerns about uncertainty and risk appeared to be context specific. Risk retrospection enabled 'having a nice, normal delivery' to be perceived as justifying working outside normal parameters, although having to do this can create anxieties and involve midwives having to perform emotional labour, concealing negative emotions in order to present "an acceptable face" (Deery & Fisher, 2015, p87). Some midwives' words conveyed relief when their situation had been tenuous but the outcomes had been 'good'. Being confident in their skills and knowledge and communicating effectively with women enabled midwives to safely facilitate women's choices, even where these differed from the norm, such as older women choosing a home birth:

Interview with Anne (Midwife 8) (sections 171-175)

Anne: [experience] gives you confidence to be able to push the boundaries as much as you possibly could within the guidelines [...] being able to support the woman, yes, whatever choice they make

Midwives must provide safe and compassionate care (NMC, 2012) and some narratives demonstrated that trying to facilitate both for older pregnant women required competence, confidence and courage, which these midwives seemed keen to demonstrate. Having volunteered to participate in this study, these midwives may have felt particularly confident about their practice or that this demonstrated the desired response. Indeed being confident and competent in supporting older women's choices was believed to have implications for women and colleagues. It was suggested that not *all* midwives would feel able to facilitate 'difficult choices'. However, because of the organisation of care, other midwives might become involved in a situation outside their comfort zone such as facilitating home births for women who might be categorised as high-risk, such as older women. Moreover, women who might have been supported to prepare for a particular type of birth could find themselves being cared for by another, less confident midwife:

Interview with Kirsty (Midwife 5) (sections 32-34)

Kirsty: I think you're up against it because I think we're not all singing from the same hymn sheet [...] if somebody high-risk wants [home birth], they completely know all the risks, and that's what they've decided they want then... fair enough, who are we to say no because they know that there is a risk associated with it, but I know that that wouldn't sit well with a lot of colleagues really. So you've got to have pretty broad shoulders...

Inconsistencies between individual midwives' confidence might, consequentially, result in midwives feeling guilty for giving women false hope and women experiencing increased interventions. For example, some midwives might feel ill-equipped to facilitate a home birth for older women and have a low threshold for transferring into hospital rather than supporting their birth at home. A strong sense of mutuality between women and midwives may result in midwives experiencing "(secondary) traumatic stress" if women in their care experience upsetting events (Leinweber & Rowe, 2010, p82). Furthermore, MacKenzie Bryers and van Teijlingen (2010) suggest the blame culture within healthcare, which demands practitioner infallibility, leads to negative attitudes. Consequently midwives may be swayed into providing institutionally driven rather than woman-centred care.

Interview with Kirsty (Midwife 5) (sections 28-30)

Kirsty: are we meeting the woman's needs or are we expecting her to meet the service needs? I think that's quite a big one for me as well, erm, making sure we're looking at what they're wanting, not what we want

Indeed some midwives identified how fears based on previous experiences and litigation risks posed a threat to women-centred care and their capacity to do the 'right thing'. McCourt (2006) similarly described midwives experiencing dissonance between wanting to meet women's needs and compliance with the organisation. Kirsty believed that her knowledge, confidence and personal accountability enabled her to effectively advocate for older women's choices, although she recognised the potential for negative or traumatic experiences to negatively affect midwives' ability to support women's choices. Responsibility for personal knowledge, skills and actions was viewed as important and is in accordance with professional accountability (NMC, 2012; 2015). However, supporting the work of Deery and Fisher (2010), some midwives recognised that 'other' midwives might adopt routinised practice, 'sticking with what they know' rather than deviating and having to justify their actions. Experience and confidence were perceived as enabling community midwives to support older women's choices more effectively and enable these women to feel empowered even when they had been labelled as 'high-risk'.

Being available (midwife)

Establishing connections influenced whether midwives were sufficiently present to meet women's psychosocial as well as biophysical needs. In addition, 'being stretched' by having insufficient time to manage their workload restricted midwives' opportunities to connect with women. This section draws on the data to illustrate the importance and challenge of midwives being available to older pregnant women.

Having a connection

Getting to know women who are older was believed to enable community midwives to detect social and communication cues and behaviour changes that might elude other health professionals. This relationship was highlighted as helping these women to feel safe and confident in the midwife's care and judgements. Some midwives believed this could facilitate older women's understanding when deviations from their

expectations occurred and their willingness to accept guidance. Whilst these beliefs may have paternalistic undertones, Chris's narratives suggest that trusting relationships between women and their midwives can empower women as well as being rewarding for midwives:

Interview with Chris (Midwife 10) (sections 103, 110, 132)

Chris: that's just why I like being a community midwife [...] you build up a kind of friendship and you get that feedback, and that's when you get protective about them because you're their advocate; you're with woman aren't you? And that's your job as a midwife, so whatever they want, if they wanted something that were unrealistic I would feel that I could approach 'em and they'd accept what I was saying because they knew I was on their side [...] it's that holistic approach really

Similarly, a study of the factors influencing midwives ability to develop therapeutic relationships with women found midwives "feeling satisfied" when they helped women, and getting positive feedback reassured them that they were "doing the right thing" (McCrea & Crute, 1991, p187).

Most women's narratives positioned community midwives as integral to their pregnancy experiences and becoming a new mother, with some of these older women expressing strong emotions regarding their midwife:

Postnatal interview with Carol (6) (sections 123-9, 245)

Carol: I wish to God they were all like her, [Ruth] is up there with a halo round her – she's fantastic!

JS: you get on well with [Ruth]?

Carol: yeh, I do, she's lovely...I, well as you can see (laughing) I were pouring out all my troubles to her and she always makes time... but that's what you expect from a professional [...] I have had a very good relationship and I have been extremely lucky to have got [Ruth]

Ruth had been Carol's community midwife with her earlier pregnancies and the relationship they had developed previously enabled Carol to trust Ruth. Establishing a good relationship or 'connecting' with their named community midwife was important for most women, with empathy, trustworthiness and approachability emerging as central to the development and maintenance of this relationship:

Antenatal interview 2 with Heather (9) (section 225)

Heather: I had one stand in [midwife] when, er, in my last pregnancy and she was in for one of my appointments, er, and I just, I couldn't connect with her, I felt, I felt that she wasn't approachable, erm, and I remember coming home and thinking: 'if she was my midwife I would hate that'

Where women had previously failed to establish connections with their community midwives or where they were aware of other women having negative relationships with midwives, this appeared to increase wariness about midwife-women relationships. Liz described being 'lumbered on' and unable to relate to the community midwife during her previous pregnancy; she believed that the midwife had disregarded her life and mothering experience and as such Liz had felt 'patronised'.

Postnatal interview with Liz (1) (sections 72-76)

Liz: yeh, yeh, [Margaret] were *really* nice, she were nice, so I was a bit worried. When I were pregnant with the last little boy I didn't really connect with my midwife with him and... I don't know, she were really young though and I just [...] I didn't just have that connection with her at all

The older women in this study valued community midwives being approachable, knowledgeable and good listeners, someone who was interested in *them* and not judgemental. This relationship appeared to differ from relationships with other health professionals; some narratives suggested that feeling valued was important. Despite many encounters with health professionals, because of her complex medical history, Karen appeared to be specifically impressed by her community midwife's care and compassion:

Antenatal interview with Karen (8) (sections 309-11)

Karen: it's all treated with a loveliness, you know, it's all very special [...] it's not like: 'well next please...' you know it's not like going to see a doctor, and 'take a few tablets and go away' or whatever, it's nice, you know, she's happy to see me

Some women's stories demonstrated how this relationship enabled their pregnancy-related confidence to grow. In contrast, whilst Cath 'loved' her community midwife, their interactions within antenatal appointments were brief, superficial and impersonal, so this continuity was not deemed important for her. O'Connor et al. (2012) observed similar disparities in care with some older women reporting excellent, supportive midwifery care, whilst others experienced dissatisfaction with poor continuity, inadequate information-sharing and apparent disregard for their concerns.

Reciprocity

Gaining insight into women's background, physical, social and emotional needs so as to build facilitative relationships was described by some midwives as affording potential benefits to women and a sense of emotional and professional fulfilment for

themselves. One midwife described 'feeding off' supporting women to feel empowered. Recognising and dealing with personal issues through being supported themselves, may enable midwives to enhance their relationships with women (Deery, 2005; McCourt & Stevens, 2009; Bewley, 2010).

Personal disclosures by midwives can convey empathy in balanced relationships with women, and achieving balanced exchanges or reciprocity between midwives and women is more achievable in community settings where there is greater continuity (Hunter, 2005). Insight into older women's lives developed through reciprocity can enable midwives to shift from task-completion to individualised care. Reciprocity was evident during my interactions with these women and their midwives and during antenatal appointments. Women were greeted warmly at antenatal clinics with midwives building on previous conversations about women's lives. Some midwives also shared personal experiences to empathise with women's situations and reduce perceptions of being judged or different. For instance, Chris used personal experience of 'renewed' mothering (Jarvie et al., 2015) to address some older women's needs, whereas Lynne drew on personal experiences of teenage mothering to empathise with 'out of sync' mothers (Dobrzykowski & Stern, 2003):

Interview with Lynne (Midwife 11) (sections 194-6210)

Lynne: I think sometimes we do [judge] don't we...but I, for me, cos I had a daughter when I was 15, so age for me is irrelevant [...] I think we focus too much on age, I really do, cos I, you know, stayed with her dad, and I just think there is that focus on age isn't there

Personal experiences appeared to influence how these midwives interacted with the women in their care. Some midwives' viewed this 'personal' care as helping older women to feel more 'normal'; it enabled discussions about non-obstetric issues, such as feeding and baby cares or how their baby's arrival might affect other family members. Midwives often arranged appointments around and extra to hospital appointments to facilitate this relationship:

Clare's antenatal appointment with Chris (10) (sections 122-123)

Chris: I would still say come and see me cos you might get a little bit more out of your midwife appointment than just at the hospital

Clare: no, that's fair enough, yeh [...] I might be missing you (both laugh)

The midwives recognised that being able to provide sensitive care requires understanding about what matters to individual women and accounting for varying perceptions of risk dependant on women's age, cultural, social and physical

perspectives. This finding resonates with the findings of others (Cooke et al., 2011; Laminpää & Vehviläinen, 2012). Being able to establish a connection between older pregnant women and their midwives through active listening and reciprocity appears to be mutually beneficial, supporting McCourt and Stevens' (2009) findings regarding caseload midwifery.

Hunter (2004) found that a 'with woman' philosophy could be very rewarding for community midwives, although in reality they were frequently disillusioned or compelled to compromise because of the "dominance of institutional needs over community work" (p269). Some midwives in the current study described adapting their care, manipulating and extending guidelines to prioritise older pregnant women's needs and simultaneously meet institutional demands. Some provided longer or additional appointments for extra support; they saw older women outside the normal schedule of work and rearranged clinics depending on women's perceived needs:

Interview with Chris (Midwife 10) (sections 34-36)

Chris: I tend...not to follow the NICE guidelines...I do my own guidelines (laughs) so I think as long as she's getting seen by the obstetrician, having the required amount of care as per the protocols, I would see her as and when she wanted to [...] I always offer my antenatal clinic appointments as well as an *extra* erm, because I think it's a totally different setting and I think the environment's different, so I think things, things that you talk about are different, I think the support's so much *nicer*

According to Fleming (1998, p141) effective relationships between midwives and women lead to midwives working 'with', rather than doing things 'for' women. Wanting to work 'with' older women was evident throughout the midwives narratives. Despite being 'stretched', trying to provide high-quality care and a positive experience for these women was a priority.

Midwives being stretched

Women's and midwives' narratives suggested that older pregnant women could benefit from additional pregnancy support, although time to facilitate optimal care was rare. Being busy distracted some midwives during antenatal appointments, reflecting O'Connor et al.'s (2012) findings that older women viewed health professionals as overworked and too busy to provide adequate care. However, their findings appear to concentrate on hospital rather than community care. Antenatal appointment recordings revealed midwives in the current study multi-tasking in order

to communicate with women whilst completing the appointment's practical and organisational requirements; midwives were frequently heard computing data during conversations. Occasionally this meant that midwives might miss important cues by failing to 'hear' what women said. In the conversation below, Liz describes her feelings about having an amniocentesis; whilst Margaret was listening to some extent, her focus was divided by simultaneously completing documentation:

Liz's appointment with midwife Margaret (1) (sections 50-55)

Liz: I've had [amniocentesis] before and I knew I were fine after with that...I just obviously I thought the sooner I know the less worrying you are

Margaret: yeh

Liz: ...but like I say with having spoken to her yesterday I felt a lot better for having spoken to her though...

Margaret: date of birth [date] of...?

Liz: [month and year of birth] ... you just feel a bit...that last time at 1 in 70 and this time 1 in 33 it... you just panic more don't you when it... your risk goes higher

Margaret: you do... and it's a normal thing to feel like that

As consequence of their age, older pregnant women may have additional concerns that they wish to discuss with their community midwife. However, midwives' workload pressures can limit their ability to be 'with woman'. Instead, some midwives were 'stretched', trying to balance their responsibilities. Routinised care, completing tasks and failing to hear women's voices involves a degree of distancing from women and prioritising organisational needs over women's (Kirkham et al., 2002; Kirkham, 2013). Some women's narratives depicted community midwives lacking the capacity to really listen or address their needs; these sentiments echoed several recorded antenatal interactions. For instance, Cath's antenatal appointment with Debby was short (5 minutes 40 seconds); their interaction seemed functional rather than supportive, with minimal opportunities for Cath to express or discuss her feelings. Whilst Debby recognised that older pregnant women might benefit from extra support, completing other tasks seemed to prevent her from really listening:

Cath's appointment with midwife Debby (2) (sections 22-23, 41-43, 51-53)

Debby: so has [baby] been moving? (22-23)

Cath: yeh...thank you

Debby: is your baby moving about well? (41-43)

Cath: ohh, she is, she's really kicking...

Debby: Awwh

Debby: did you say you'd felt movements? (51-53)

Cath: yeh, she's moving a lot, she's moving quite a bit

Debby: that's great

Cath's later account of that appointment suggests that she perceived her antenatal appointments with her midwife as task-driven rather than supportive:

Antenatal interview with Cath (1) (sections 203-205)

Cath: [Debby]'s a lovely person and I like talking to her socially [...] it's not [important to see the same midwife], because it's a fleeting visit, they're very quick visits, so you really...you, they're stretched the midwives. I feel...I probably should not have said that, but I feel that they're stretched, so time's a premium, so when I went to see her when you were there last week, she was...late, she was running late and that was important to her and she was 'oh, I'm late, now I'm late, see you [Cath]' and she's typing to get the next one in. [...] it's just such quick checks, you know, it's like 'let me measure your bump, let me measure your blood pressure, check your urine, see ya' that's it, here's your next appointment'.

Being self-confident and having a good relationship with her consultant obstetrician (as discussed on p131) seemed to mean that functional rather than personal interactions during midwifery appointments were not detrimental overall for Cath, although other women's interactions with their community midwife seemed highly important. Even so, supporting the findings of Boyle, Thomas and Brooks (2016) several women recognised that other pressures could restrict midwives' abilities to provide good care. Perceptions of midwives being 'stretched' seemed to result in some women manipulating their needs so as to protect midwives from additional work. Instead they arranged appointments with general practitioners or attempted to resolve problems for themselves. Where midwives appear to be "checking not listening" (Kirkham, 2013, p5) older women may be reluctant to seek support, instead conforming to routine. Whilst Liz believed that she could discuss anything with her community midwife she appeared reluctant to do so because she perceived that her midwife was busy:

Antenatal interview 1 with Liz (1) (sections 268-271)

Liz: (thoughtful) [midwife] has said if I'm worrying about my results I can phone and talk about it anytime, but you just don't like to bother people, you just think she's busy she doesn't need me pestering her. But that's just me it's not that...you know? [...] she's got enough on dealing with all her other pregnant ladies, she doesn't want me pestering her

Perceptions of harried midwives meant that sometimes midwives had limited physical and psychosocial availability and accessibility. In addition some midwives' perceptions that 'experienced' older pregnant women are unlikely to need 'extra care', resulted in them remaining oblivious to women's concerns and needs and thus unable to address these. Nonetheless, some midwives successfully created an atmosphere where women perceived them as being available:

Antenatal interview with Heather (9) (section231)

Heather: even though she may be running over, she'll say, you know: 'look is there anything else?', and she'll just take her time, so I think from my side of things it's, that's important cos if, you want someone that you can connect with, you need to have that confidence that should you need to ring her, or you know, should you need to say to her: 'look I want to discuss this with you...', you've got to have that type of relationship with her, you know and I certainly feel I can do with her...feel quite lucky

Organisations such as the NHS may allocate insufficient resources to enable workers (midwives) to provide the best care and clients (women) are expected to understand this (Lipsky, 2010). Midwives recognised the pressures of being busy and attempted to work within the local or national guidelines. Several midwives adapted guidelines to meet older women's and their own needs and in this way they acted as street level bureaucrats, using their discretion in implementing organisational directives (Lipsky, 2010). Nonetheless midwives' workload can negatively affect older women's experiences (Kirkham & Stapleton, 2004), resulting in some women being reluctant to seek support and leaving them feeling or being vulnerable. Extra responsibilities associated with increasing age and a propensity to manage problems independently may make it more difficult for older pregnant women to prioritise their own needs or seek support, even though they may have additional concerns that may or may not be associated with their age. Their role as a responsible citizen, who has "adopted an approved mind-set" (Brown & Baker, 2012, p16) requires older pregnant women also to assume some obligation for personal well-being in order to avoid burdening others. In addition, Lipsky (2010) suggests that clients may manipulate their behaviours to enhance future interactions through strategies such as acquiescence or expressing empathy with carers' problems and these behaviours were evident in the interviews with women and antenatal recordings. Community midwives making time to facilitate active listening through extra or longer appointments and demonstrating an empathetic approach may enable women to share their concerns so that these might be addressed or simply acknowledged. Indeed reliance on technological antenatal care might not improve women's health, rather what is likely to be beneficial is "the simple often-neglected art of human communication" (Oakley, 1983, p106).

Establishing and having meaningful relationships with their community midwife appears to have been a significant aspect of pregnancy for the majority of the older women in this study. Resonating with the work of others (for example, Fleming, 1998; Deery, 2005; Mander & Melender, 2009; Berg, 2010; Deery & Hunter, 2010; Leap, 2010), factors contributing to effective midwife-woman relationships include respect for women's individual circumstances, including their age, prior experience and knowledge, having a connection and time for meaningful discussions about women's concerns. Where women and their midwives had developed good relationships, caring appears to have been reciprocal with both attempting to do what was within their gift to protect the other. As discussed previously, several women associated their older age with greater life skills and being responsible for the welfare of themselves and other people. It is likely that such attributes influence midwife-women relationships, and whilst most older women valued the informative, empathetic nature of this relationship a degree of autonomy and reciprocity were simultaneously evident and may have moderated midwives perceptions of their needs.

Summary

This chapter has addressed the importance of older pregnant women establishing enabling relationships with their maternity care providers and focused on relationships with community midwives and consultant obstetricians. The concept of 'enabling relationships' comprised three categories: 'risk communication', 'shared care' and 'being available'.

Communicating risk involves community midwives attempting to facilitate balanced perspectives of pregnancy for older pregnant women, thus enabling them to optimise decision-making for themselves and their families. Whilst women over 40 are automatically allocated to a high-risk group, midwives attempted to enable them to understand that their age did not also automatically mean complications. Older pregnant women are viewed by their midwives as being likely to overestimate their risk status whilst simultaneously being more autonomous. Midwives may attempt to mitigate against 'unnecessary' worries and interventions by getting to know women socially as well as physically, and informally screening women's reactions to risk-related information. However, older pregnant women may also be informally categorised into sub-groups according to midwives' perception of their risks or potential responses to health-related information.

Making value judgements and assumptions about older pregnant women and their possible preferences may be viewed negatively, although judgements are inherent within risk management. Conscious that sharing risk-related information and allocating a high-risk label can increase older women's perceptions of risk, community midwives may defer responsibility for limiting women's choices back to the organisation, particularly where guidelines differ from their own views. Balancing non-directiveness with information-sharing can be challenging for community midwives within the context of current midwifery practice whereby guidelines and policies determine the focus of care. This may be complicated further when older women, who feel vulnerable, wish to be guided rather than supported with decision-making.

Older women's experiences of shared care vary; some women establish effective relationships with obstetricians, enabling them to feel safe and confident in their choices, whilst other women can experience significant power differentials. Being able to employ prior life skills in negotiating an active role and shared decision-making can be empowering for some older pregnant women. However other women struggle to feel respected despite employing previous life and professional skill-sets. Community midwives recognise relationships between older women and obstetricians sometimes neglect women's individual needs in favour of risk-related agendas. Midwives thus attempt to maximise the benefits of shared care through discussions with women and employing discretion by referring to consultants deemed sympathetic to older women's needs. Referring older pregnant women with no additional risk factors to a consultant midwife rather than an obstetrician may contribute to normalising older women's pregnancy experiences.

The third category concentrates on community midwives' availability for older pregnant women. Having a connection or reciprocal relationship can be mutually beneficial where midwives are physically and emotionally available to women and enables community midwives to develop insights that other health professionals might miss. Midwives may need to negotiate institutional requirements, using discretion based upon their understanding of a woman's needs to tailor and provide woman-centred rather than institution-centred care. However, this can 'stretch' midwives, potentially concealing important cues from older women and creating an impression of midwives' unavailability. Drawing on their life skills, some older women may seek to be independent, thus failing to share concerns, in order to protect midwives from additional pressures. This may consequently reinforce some midwives' view of older women as self-sufficient, potentially masking their needs, leading to missed opportunities for support and leaving these older women more vulnerable.

The following chapter consolidates the key findings of this study, draws conclusions and makes recommendations for further research, education and practice.

Chapter 7 – Concluding thoughts

Introduction

This final chapter provides a study overview prior to a critical review of the findings, which are discussed in detail and in relation to extant theory in the previous three chapters. It will summarise how older women's understandings of themselves and their world influence their pregnancy experiences and their ability to 'do the right thing'. The importance of effective risk-related communication and effective relationships with community midwives and obstetricians during pregnancy is highlighted. This is followed by acknowledgement of the study's limitations and challenges. The penultimate section identifies recommendations for midwifery practice, education and future research. Finally, I use Heather's words to close this thesis.

Overview of the study

The study aim was to explore women's experiences of higher risk status, conferred wholly or partially as a consequence of advancing maternal age. Specifically my objectives were to explore women's perception of pregnancy relating to their age, with particular reference to perceived risk status; to gain insight into midwives' views regarding maternal age, risk status and risk communication; to examine how risk is communicated in consultations between midwives and women and to obtain feedback about any proposals for improving practice, based on the study findings. A literature review relating to older maternal age in pregnancy and women's experiences of high-risk pregnancies, revealed that the experiences of women aged 40 years and over living in the United Kingdom have not previously been explored in an in-depth qualitative study, nor have the views of community midwives relating to older pregnant women been examined. The current study has explored these issues and its findings may thus contribute to the body of understanding about older women's experiences of pregnancy.

Overall 44 sources of data were collected and analysed, involving 10 pregnant women and their 10 community midwives from the host NHS trust. Data collection consisted of audio-recording one antenatal appointment between the women-midwife pairs followed by individual interviews with each. Interviews were repeated with women following the birth of their babies. This longitudinal approach facilitated an iterative, constructivist grounded theory method of generating and analysing data. Recommendations for further research, practice and education have been drawn and participants were invited to comment on these.

Summary of the findings: 'doing the right thing'

Findings reveal that the pregnancy experiences of woman aged 40 or over may be largely driven by their preference for 'doing the right thing'. Responsible behaviour in relation to older women's childbearing journeys may begin long before their pregnancies: influencing their perspectives, choices and actions. Three concepts were identified relating to 'doing the right thing': navigating risks, responsibility and enabling relationships. Whilst these concepts are addressed in discreet chapters, they are inherently interdependent. Older women's ability to understand their pregnancy-related risks and make the right decisions to minimise these are influenced by their sense of responsibility to safeguard the well-being of other family members including their unborn baby and by the support afforded to them by healthcare professionals.

This study has focussed on older women's experience during pregnancy and the care provided by community midwives and obstetricians. Whilst exploring obstetricians' influences was not a specific objective, their behaviour was frequently identified as influencing women's and midwives' perspectives, thus informing the development of focused codes and categories. Codes and categories relating to midwives' practice demonstrated their motivation to 'do the right things' for women, whilst balancing this with responsibilities towards their employers and their profession. 'Doing the right thing' is therefore important for all participants. Constructivist grounded theory and symbolic interactionism require researchers to acknowledge pre-existing assumptions and remain sensitive to research participants. They also acknowledge researcher influence throughout the research process. My interest in this subject has been explained earlier; I accept that my viewpoint cannot be objective and I have attempted to present the perspectives of these women and their midwives as faithfully as possible. Therefore 'doing the right thing' has been used as a guiding principle throughout this study.

The model introduced in the findings preface is reproduced below (Figure 7.1) to illustrate the factors influencing the pregnancy experiences of women aged 40 or over.

Individual people "experience themselves as such, not directly, but only indirectly, from the particular standpoints of other individual members of the same social group, or from the generalized standpoint of the social group as a whole to which he belongs" (Mead, 1934, p138). Furthermore people adjust their behaviour according to context and thus trigger changes in their world. This section discusses the study's key concepts and categories considering the impact of perceptions of the self, social interactions and the world on older women's and midwives' understandings, experiences and behaviours.

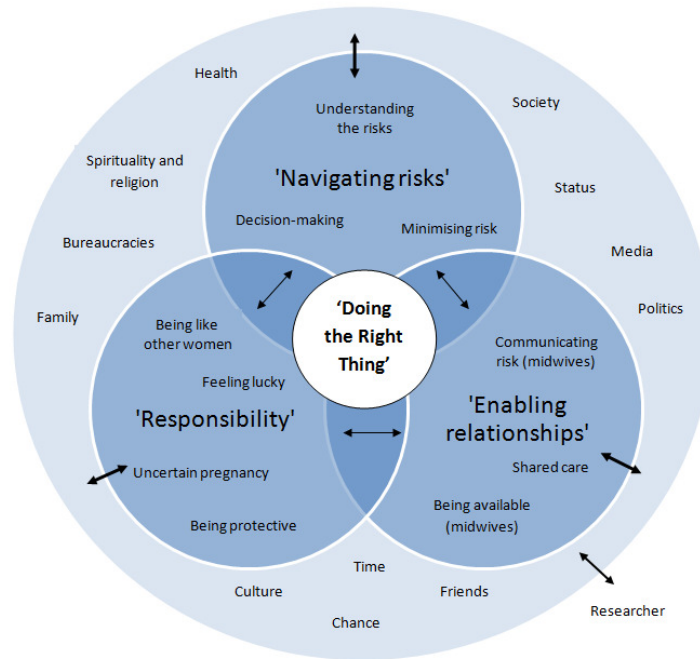


Figure 7.1. Factors influencing the pregnancy experiences of women aged 40 years and over

Older pregnant women’s self-perception and perceptions about childbearing appear to be determined by multiple factors including pre-existing understandings, former life experiences and current circumstances. However becoming pregnant introduces a new, changeable and sometimes surprising lens through which their priorities, roles and responsibilities are viewed. Since women over 40 are more likely than their younger counterparts to have broad life experience, they may have acquired numerous responsibilities and have a strong self-concept of behaving correctly. Thus older women may have high expectations of being autonomous regarding pregnancy and mothering. Acting responsibly or ‘doing the right thing’ may therefore be particularly important in influencing older pregnant women’s decision-making about themselves and others, but may not always be easy (Braedley & Luxton, 2010). Indeed some older women will have taken steps to optimise their health and finances prior to becoming pregnant and may therefore view themselves as ideally positioned socially, financially and physically for mothering. Having an ‘at-risk’ label on account of their age can be surprising, leading some older pregnant women to re-evaluate their personal health and capacity to be self-determined. These women may consequently become more conscious of their personal mortality and morbidity, fearing that they might not live to see their baby grow to adulthood and that this could leave older children or a younger partner responsible for raising their child. For others, discovering new and potentially unexpected age-related health concerns such as gestational diabetes can increase a sense of vulnerability, yet

simultaneously promote lifestyle changes which they intend to continue beyond pregnancy, potentially affording long-term health improvements.

Fears relating to personal health, longevity and limited opportunities for future childbearing may be particularly key in older women's decision-making regarding issues such as screening and diagnostic testing for Down's syndrome. However, women's actions in response to such fears vary according to a unique amalgam of factors. Women's views of their past, present and future worlds and the people within these, impact on their pregnancy-related choices. Previous negative childbearing experiences may lead some women to perceive little control over their reproductive health or that making plans is pointless. Thus luck and chance are viewed as influencing childbearing and subsequently women's control thereof, despite their best attempts to make responsible choices. Similarly women's viewpoint may be temporal: fluctuating throughout their journey according to immediate and anticipated circumstances and understandings. The older women in the current study considered themselves lucky, but were conscious that their age or other circumstances might easily place luck against them.

The behaviours of other people towards older pregnant women can have a significant bearing on how they perceive themselves and their subsequent actions (Ridgeway & Walker, 2001). The current study's findings demonstrate that pregnant women aged 40 or over may perceive themselves as 'different' and fear that other people's views of their age or health will attract judgemental behaviour, despite them wanting to be accepted as responsible and no more at risk than other women. Older pregnant women may therefore attempt to justify this status through drawing favourable comparisons with other, younger women who may be less healthy, financially or emotionally secure or by remarking that their physical appearance did not define them as different. However, these positive analogies may belie some older women's concerns and result in these going unrecognised or unaddressed. Where women and their community midwives have the time to develop trusting relationships older women may be more inclined to share their concerns and midwives may have sufficient availability to hear and respond to these.

Nonetheless pregnant women aged 40 or over may be perceived as voluntarily risk-inducing and thus contravening moral or social responsibilities. However, such viewpoints ignore uncontrollable circumstances, such as infertility or finding the right partner (Heyman, 2010b). Furthermore such perceptions demonstrate "status attribution" whereby people generalise understandings from what they already 'know', assuming "that a person's unknown status-relevant characteristics are consistent with the known ones" (Della Fave, 2001, p127). Whilst community midwives might recognise

such categorisation as potentially detrimental to women's care through limiting information-sharing and choices, assumptions *are* made about older pregnant women's preferences and needs based on factors such as parity and socio-economic status. Community midwives can perceive that older experienced mothers might 'just get on with it' and need little midwifery support. Whilst other studies suggest that older primiparous women can need additional support, the findings of this study demonstrate that *regardless* of former childbearing experience, older pregnant women can and do experience pregnancy-related vulnerabilities. Providing additional community midwifery appointments at times when women might feel most vulnerable, for instance around decision-making for screening or diagnostic testing, may enable midwives to provide the valuable support that these older women may be reluctant to ask for.

Community midwives' perceptions of older pregnant women and their possible childbearing experiences are determined by research, reading and their experiential learning. Midwives' understandings have been described in relation to other older women they have cared for, their personal experiences of pregnancy and becoming a mother. Their roles and practices are also determined through professional and employment responsibilities, although guidelines may conflict with midwives' beliefs about what individual women and their families need. Community midwives may thus attempt to facilitate helpful, supportive interactions for older women: using their discretion to make selective referrals according to their knowledge of other women's experiences and specific obstetricians' practices. Thus they act as street level bureaucrats (Lipsky, 2010). Community midwives understand that some older women value extra appointments and investigations on account of their perceived vulnerability. More testing may be seen as providing more reassurance (Gabe, 1995), a perception validated through some of these older women's voices; although additional surveillance can increase anxiety when associated with uncertainty. Conversely when investigations involve clarity and effective support they can be reassuring and enabling (Stapleton, 1997). Ongoing additional care and investigations may be particularly valuable for older women who have encountered earlier problems, for example relating to conception or pregnancy loss, or who perceive themselves or their baby to be vulnerable. As older pregnant women are more likely than their younger counterparts to have pre-existing, or develop new, health-related issues during their childbearing journey, additional care may benefit a large proportion of these women.

Most women need little childbearing intervention. For others deviations can be identified and managed accordingly (Oakley, 1980). Conversely, societal norms indicating a preference for hospital-based childbirth reinforce views of pregnancy as medical events. Hospitals can fortify power hierarchies through links with illness (Kingdon, 2009) and

interventions (Murphy-Lawless, 1998). In this study, impersonal, busy hospital-based appointments often negatively affected women's pregnancy experiences; sitting waiting for appointments emphasised the relative unimportance of women's time and differences in power. Developing policies whereby older women's needs for referral to a consultant obstetrician are assessed individually may avoid unnecessary hospital appointments and improve the potential for meaningful appointments to address women's specific needs.

Understandings of risks are generally perceived as culturally determined and relate to groups rather than individuals (Heyman, 2010b). However the implications of risk-related choices are deeply personal and the experts who determine and manage these should consider the psychosocial as well as biophysical impact of their actions (Beck, 1992). Despite recommendations and guidelines promoting women's choices for childbearing (for example, DH, 2007; NHS England, 2016b), older pregnant women may believe that they have, and experience, restricted choices simply because of their age. Furthermore, health professionals may overestimate older women's knowledge or desire for knowledge. Thus, older women may be uncertain when midwives and obstetricians fail to explain their allocated at-risk status, believing that they already understand or that providing information will increase concerns. Whilst older women may be accustomed to autonomy, pregnancy-related choices may have little to do with personal control and a lack of understanding may compound this. Community midwives sharing care with a consultant midwife could facilitate an approach focusing on normality and women's specific needs rather than population-based risk. Furthermore encouraging practices whereby women document important events or concerns in their own records may help to ensure that these are acknowledged and addressed and may contribute to older women experiencing a greater sense of control.

Risk relating to pregnancy and childbearing is complex. Moreover individual women's susceptibility to specific events is uncertain despite scientific authenticity steering them to a 'responsible' option (Nettleton, 1997b; Stahl & Hundley, 2003). Whilst statistical data, for example relating to conditions associated with advancing maternal age, are useful for developing guidelines, caution should be exercised in using such data to predict outcomes or guide decision-making for individuals (Heyman, 1998; Edwards & Elwyn, 2001; Kringeland & Möller, 2006). This evidence may predispose older women to medicalised experiences (MacKenzie Bryers & van Teijlingen, 2010) and to choices which conflict with their social and emotional needs although, regardless of interventions, "outcomes in childbirth can never be guaranteed" (Murphy-Lawless, 1998, p21). However, rather than having the opportunity to discuss the risks and benefits of a full range of alternatives with their health professional, some women aged 40 or over may receive limited options, for instance regarding birthplace, based on evidence suggesting

that they may be more at risk of labour and birth complications (Hsieh et al, 2010; Koo et al., 2012).

Enabling older women to personalise population-based data requires midwives and obstetricians to engage with women whilst using their knowledge of epidemiological, historical and psychosocial evidence to interpret and communicate this information in a way that supports women to make the right choices for themselves and their families (Shapiro, 2009). Risk communication should encompass the risks and benefits of all the options including the option to do nothing (Lupton, 2013). Being listened to, given the time and support to develop a balanced understanding of the underlying reasons for their specific context and act on this understanding is empowering for women (Gibson, 1991). Failure to achieve this may be particularly disempowering for older women since this may conflict with their sense of autonomy.

Humans develop strong bonds with the people who meet their needs (Della Fave, 2001). Therefore when health professionals meet women's needs, strong relationships may develop, as demonstrated through the relationships between the older pregnant women in this study, their community midwives and some obstetricians, although not necessarily both. Where effective relationships develop, these can be mutually beneficial and a significant aspect of pregnancy care for older pregnant women and the community midwives providing their care. However, providing genuine, supportive and facilitative care requires intense emotional and physical labour for midwives (Hochschild, 2001; Deery & Fisher, 2010; Deery & Hunter, 2010). Whilst they are responsible for limiting risk and increasing safety (Angelini & Krebs, 2005), they are also responsible for being with women and supporting their autonomy (NMC, 2012). This may place them in a vulnerable position, particularly when women fall outside the 'normal' category: 'treading a fine line' between meeting professional, employer and women's needs. Thus, bureaucratic demands make advocacy challenging (Lipsky, 2010). Community midwives may attempt to improve older women's experiences of pregnancy by establishing effective relationships, finding out about their lives, discussing concerns and supporting these women around obstetric care. Whilst 'doing the right thing' was important for the older women in this study, and relationships with community midwives were often instrumental in facilitating this, some relationships with obstetricians did little to empower women.

Status structures are inherently relational in that one actor is only high or low status in comparison to another (Ridgeway & Walker, 2001, p298). This ranking develops from a person's valuation of themselves and others according to shared values. Perceptions of power are influenced by individual factors such as knowledge, organisational status, physical capacity and the social norms of the group to which that individual belongs

(Thompson, 2000). Beck (1992, p4) suggested that technical experts, such as obstetricians, define risk-related agendas and, by accentuating risk, their status is reinforced (Stapleton, 1997). Hierarchies of power within maternity care can constrain women's decision-making ability. Stapleton, Kirkham, Thomas & Curtis, (2002) suggest that obstetricians hold the greatest power, women are least powerful and midwives negotiate a tenuous intermediary position between the two. Nonetheless, postmodern thinking views power as fluid and possessed by different groups (Gabe, 1995; Thompson, 2000). Status is negotiated and may be "more given than taken" (Ridgeway & Walker, 2001, p303). Older pregnant women's ability to negotiate their position varies and in some cases, they are able to negotiate shared power with consultants. This may depend on women's knowledge and prior negotiation skills, although Carol, Louise and Heather's attempts to establish collaborative care and defend their own viewpoint triggered defensive and coercive behaviours from obstetricians. This position may be particularly disempowering for older pregnant women who may be more used to having a sense of control.

Challenges to doctors' expertise may result in women being perceived and labelled as difficult (Hugman, 1991). Whilst women may have greater power in relationships with obstetricians than their predecessors, this relationship is uneven and obstetricians may limit opportunities for women to improve their position (Simpson, 2004). In addition, adversity foregrounding whereby potentially adverse outcomes are prioritised (Heyman, 2010b) fails to recognise risk-taking through the eyes of people affected. However, only by understanding how each of the options might impact on their world, can women begin to contemplate the best action. Regardless of reservations, where deviations from normal indicate an increased risk to themselves or their baby, older women may be more inclined to 'go with the flow': deferring responsibility to the experts (Alaszewski, 2010). Nonetheless, risk-oriented medicalised approaches to childbirth disempower women and strengthen the notion that women are helpless (Oakley, 1980) rather than autonomous. In addition vulnerability, as experienced by some older pregnant women, increases expert power by steering women to behave as 'good patients', to act responsibly for their health through attending regular appointments (Evans & O'Brien, 2005; Stainton et al., 2005), answering questions and complying with advice (Hugman, 1991). Relative power imbalances may be moderated where shared values or empathy exist as demonstrated in many of the relationships between older pregnant women and their community midwives. However this depends on mutual respect and midwives being sufficiently available to hear women's voices. Where older women's voices are insufficiently loud to be heard, they appear to comply or 'go with the flow', midwives have a responsibility to look and listen more closely to ensure that their vulnerabilities are not being overlooked.

Community midwives may adapt their schedules to meet older women's specific needs, unless they are oblivious to these. Busy workloads may limit midwives' ability to detect women's cues or predispose women to withhold information to avoid exacerbating midwives' pressures. Goffman (2001) suggested that people act out the characters they wish to portray. Older pregnant women may wish to be seen as responsible and confident and may hide their true feelings; they may sympathise with midwives whom they perceive as being powerless or unable to cope with their workload (Kirkham & Stapleton, 2004). Similarly harried midwives may attempt to present themselves as compassionate and competent, yet in attempting to simultaneously meet their employer's needs may lack the capacity to question the 'realness' of women's behaviours (Goffman, 2001, p178). It is possible that as older women are accustomed to protecting other people around them, their community midwife becomes drawn into this protective fold too, thus reinforcing perceptions of the older pregnant woman as knowledgeable and capable.

Discretion afforded to street level bureaucrats enables them to adapt policy application in their work (Lipsky, 2010), although the degree to which obstetricians and community midwives manage this varies. Health professionals' reactions to older pregnant women are important in forming women's perceptions of their experiences and their subsequent actions. Their relationships can increase women's anxieties or facilitate balanced, contextualised perspectives relevant to their families' needs; this depends on the health professional's ability to communicate balanced risk-related information and the nature of their respective relationships.

Beliefs are important aspects of people's worlds. For some of the older women in this study beliefs influenced their responses to situations such as screening and diagnostic testing and enabled women to judge the right decisions for themselves and their families. Faith may be particularly influential when women feel vulnerable (Price et al., 2007). Whilst older women may have developed the skills and knowledge to negotiate and manage their daily life, pregnancy can provide new and unexpected uncertainties, which may be reinforced or contextualised by health professionals or family members. Reflecting on personal experiences or on the experiences of other women can enable women to gain a more meaningful understanding of pregnancy and birth. Previous negative experiences of pregnancy or birth may act as a catalyst for women to take and retain greater personal control (Kitzinger, 2006). For example women with previous negative birth experiences resolved to avoid these in their current pregnancy.

Concepts are rarely named in neutral terms (Charmaz, 2014) and the language these older women used in relation to perceptions of themselves and their pregnancy supports this. Feelings of being different were demonstrated through women describing fears of

looking like 'granny nanny'; fears about labour and birth were evident through women's descriptions of disappointment and resignation about their limited options. Whilst these terms suggest negativity, and aspects of these older women's experiences were challenging, many aspects were framed in positive language. For instance, women described being lucky to become a mother at their age. Retrospectively women sometimes assigned more positive names to experiences which had been viewed as problematic previously. Risk retrospection involves reviewing a situation after an event has or has not occurred and hindsight bias occurs when judgements about the outcome of an event are affected by this understanding. Thus perceptions may be temporal and transient (Heyman, 2010e). Older pregnant women may have lower pregnancy and birthing expectations on account of their higher risk status; therefore reality may be better than expected. Listening to women's views during and after pregnancy has enabled me to identify and explore these amended perspectives.

Whilst midwives are expected to justify their actions and reflect on their practice (NMC, 2015), most people do not normally justify or analyse their actions. Being interviewed may have stimulated participants to consider and discuss issues that under other circumstances they might not have shared. Supporting Drury et al.'s (2007) views, our conversations seemed helpful, particularly for those women who wanted to share their experiences with other older women, wanted someone to listen to their story or for whom talking enabled them to explore their feelings and experiences. Meanings are generally adapted through familiar interpretive processes. However, where experiences are unfamiliar or difficult, normal coping strategies may be inadequate (Mead, 1934; Alaszewski, 2010). This can increase awareness of the situation and of the need to employ alternative strategies. Having someone to listen to their experiences during and after pregnancy might enable older women to develop a more balanced view of their position and believe that they are doing or have done the right things. Experiencing significant pressure or prolonged stress as a result of difficult events may dissolve the perception of self and blur the boundaries of identity. Through sharing stories as part of a healing process, the reaffirmation of self is not just centred on the individual's perception but also on the recognition of that reaffirmation by those who are listening (McHugh, 2007). Establishing a local or on-line peer support mechanism for older pregnant women may afford such an opportunity.

The findings from this study illustrate the complexity of older women's pregnancy experiences, having an 'at-risk' pregnancy and the challenges these women face in balancing differing concerns to enable them to do the right things for themselves and their families. Despite life or childbearing experience older pregnant women are likely to have additional physical, emotional and psychosocial needs although they may be more

reluctant to express these needs than their younger counterparts. Sensitive risk-communication and non-directiveness are important for community midwives in normalising older pregnant women's pregnancy experiences and facilitating balanced perspectives. Community midwives are pivotal in optimising older women's experiences of shared, effective, individualised and compassionate care. Whilst reciprocal relationships between older pregnant women and their community midwives have the potential to be mutually beneficial, midwives' ability to do the right things through balancing the multiple demands of their workload and being with older pregnant can be challenging due to organisational and time constraints. Providing additional care attracts additional costs, although the National Maternity Review (NHS England, 2016b) has prioritised personalised care, improved continuity and inter-professional working in targeting excellent care for mothers' and babies' changing needs. Furthermore, Warwick (cited by Dabrowski, 2015) asserted that more midwife time is necessary to address the additional needs of increasing numbers of older pregnant women and my findings support this recommendation. Involving older pregnant women in designing a service to meet their particular needs could help to ensure that resources are used efficiently and these women have access to safe, individualised and compassionate care.

Limitations

Theoretical sampling is integral to grounded theory and whilst I identified and attempted to explore certain characteristics of women, such as parity, using this technique, doing so was dependent on midwives identifying and sharing information with women whom *they* deemed suitable. Midwives who felt less confident in supporting older pregnant women may have avoided participation lest this revealed gaps in their own knowledge. Furthermore busy workloads appeared to affect recruitment, although including midwives with different characteristics, for instance newly-qualified midwives, could have enabled insight into how experience influenced midwives' views. However, the characteristics of midwives recruited were fairly typical of the community midwifery workforce within the host trust at that time (personal observation). Furthermore community midwives were included who had varying experience with women aged 40 or more and whose caseloads included older women from various socioeconomic backgrounds. Whilst all participants were recruited from one NHS trust, limiting the potential for transferability, midwives and women from each of the three geographical areas were included in the study, enabling some variety of perspectives to be considered. Nonetheless whilst the findings of this in-depth exploration of older pregnant women's experiences may resonate with the experiences of other women aged 40 or

over generalisability is not possible due to the small sample size and single NHS trust recruitment.

Data collection such as interviewing and audio-recording appointments for research purposes influences participants' behaviours; people only disclose what they feel comfortable with and may tailor their responses to what they perceive is the right thing (Nunkoosing, 2005). Conversely it can be argued that shared responses represent participants' interpretations of events. Alternative strategies for data collection, such as participant observation, may have resulted in greater participant reactivity and are additionally vulnerable to observer biases (Polit & Beck, 2008). Furthermore time and context influence participants' actions and understandings and researchers' research-related choices. Collecting data at different times could have affected the findings, for example recording antenatal appointments earlier in pregnancy could have captured conversations with greater reference to information-sharing about risk, although this was not possible. Using a longitudinal approach to data collection facilitated understanding of women's perspectives over a broader timescale and using a grounded theory approach enabled developing concepts to be explored. Constructivist grounded theory does not attempt to present the truth about a research topic, rather a constructed account of potential truths and I fully acknowledge that a different midwife or non-midwife could have interpreted the data differently. I discussed strategies used to generate and analyse trustworthy and authentic data in Chapter Three.

Some identified aspects of women's experiences have not been included in this report due to the constraints of this doctorate route. For instance women's reasons for older mothering and birth experiences have been omitted. Whilst the original objectives of this study included the views of older pregnant women and their community midwives, other people have been recognised as playing important roles in determining these. Understanding partners', older children's and obstetricians' viewpoints could have added additional and potentially valuable dimensions to the context of older women's pregnancy experiences.

Whilst the overall aim of the study has been achieved, meeting objective four (to obtain feedback about any proposals for improving practice based on the findings of the study) could have been stronger. Verbal feedback was gained increasingly throughout the course of data collection, although just one woman and one midwife provided written feedback relating to a summary of the recommendations. Whilst comments from both respondents were supportive (see Appendix Thirteen) a higher response rate could have strengthened the reliability of this feedback. Participants may not have received the shared information as I only had contact details provided prior to data collection or, as over two years had elapsed since our last contact, this was no longer seen as important.

One midwife replied to say "I can feel a guideline coming on", other midwives said that they would send comments but did not and one woman replied to let me know about her family, but did not comment on the recommendations.

Challenges and opportunities

Undertaking research within a familiar practice setting posed challenges such as recruiting participants, interview techniques, transcribing and managing data. These aspects of the study have been discussed in Chapter Three. Conducting and writing up the study has been a slow, challenging process; combining studying with working full time as a midwifery lecturer has required me to develop enhanced organisational skills, negotiation and tenacity. I have grown to understand more about myself, midwifery practice and older women's pregnancy experiences. Despite my prior personal and professional experiences and learning, I was emotionally unprepared for my new role and how this would make me feel. Seeing midwifery practice and listening to women's experiences as an outsider enabled me to gain new perspectives about these and made me question my own past, present and future actions. Reflecting on my behaviour through a new and unfamiliar lens, I became more aware of responsibilities, such as protecting confidentiality, which I had practised almost subconsciously for over 20 years. I have used my knowledge of the practice field to gain access to participants, although my familiarity was simultaneously a hindrance since it was assumed that I knew what midwives meant and that I could answer women's queries. Reflexivity through private journaling, discussions with colleagues and adapting my behaviours enabled me to begin to view myself as a researcher and to present this new self to others. As a novice researcher I was initially anxious about doing things wrong, although I came to realise the importance of, and reassurance provided by, using recognised procedures and seeking regular support. Whilst I knew about my chosen methodology, processes and methods in theory, it is only through conducting this research that I have begun to understand these. For example, I had read that grounded theory involved fracturing data, but could not envisage what this meant until I felt like I was drowning in bits of data. I was unable to visualise how I would use these to create something meaningful. A colleague reminded me 'you can't eat a whole elephant in one go', so, I stopped trying and worked slowly and carefully on small sections which naturally and iteratively developed into the focussed codes, categories and concepts discussed in Chapters Four to Six.

Recommendations

Recommendations for practice

1. Getting to know women

Relationships between midwives and women can be rewarding emotionally and socially. It is important for community midwives to spend time 'getting to know' and adopting a holistic approach to supporting older pregnant women and their families, rather than making assumptions about their needs. In accordance with the National Maternity Review (NHS England, 2016b) service providers could recognise the importance of continuity of carer and ensure that the organisation of maternity care enables women to access care provided by midwives that they know and trust. Involving older pregnant women in the design of their care could enable this to be more relevant.

2. Enabling meaningful referrals

Whilst some older women value obstetric involvement in their pregnancy care, for other women this can increase concerns or confusion. Providing additional support in preparation for and following women's appointments with obstetricians by listening to their concerns, clarifying any misunderstandings, providing and signposting sources of information community midwives could help to optimise these appointments. Additionally clearly documenting discussions and topics to be addressed during subsequent appointments within women's handheld notes and electronic systems could aid effective communication between women, their midwives and obstetricians. Encouraging older women to document significant events and queries in their personal records may contribute to ensuring that these are acknowledged and addressed and may be empowering for women.

A sound understanding of local services, service providers and the flexibility to refer to the most appropriate practitioner can enable community midwives to provide information that will help women to choose additional maternity care providers who will best meet their needs. Where women over 40 have no additional risk factors, sharing care with a consultant midwife rather than a consultant obstetrician could promote a normality-rather than risk-focused experience for them.

3. Balancing perspectives

Some older pregnant women have disproportionately high perceptions of the risks facing themselves and their babies, based on prior experiences, perceptions of others and societal influences. Midwives and obstetricians can compound this by focusing on risk and risk-reduction and prioritising service needs above women's. Enabling women to develop a balanced view of risks by individualising information and sharing the benefits

of pregnancy and mothering at or beyond 40 could enable older pregnant women to have a more positive experience and to make the best choices for themselves and their families. Developing a local or on-line network whereby older pregnant women and mothers can share their experiences with one another, could enable these women to develop and maintain a more balanced perspective.

4. Time for supporting decisions

National guidelines (NICE, 2008) for women with uncomplicated pregnancies recommend a minimum number of appointments for pregnant women, although these guidelines acknowledge that women aged 40 or more may have increased needs. Midwives can offer additional support if women need this. However older pregnant women may not access this support if they believe that the midwife is too busy. Providing additional appointments when extra discussions might be most valuable, such as during early pregnancy around the time of screening, with the potential for women to opt-out, could give older women the opportunity to share and address their concerns without feeling like a burden.

Recommendations for education

Midwives' understanding of the small but increased risk of certain conditions for pregnant women aged 40 or over, appears to be formed mainly from experiential learning. Broadening their awareness of these conditions may enable midwives to support the increasing numbers of older pregnant women in their care with greater confidence. Disseminating the findings from this study and information about pregnancy for older women at conferences or seminar presentations, in journal publications or via on-line resources will contribute to increased understanding and awareness. The experiences of older pregnant women could be given greater prominence in the midwifery curriculum and master classes could be offered for midwives and obstetricians within clinical settings.

Recommendations for future research

1. Older pregnant women who are also parents to teenagers or adults can be anxious about the effect that their pregnancy and introducing a new baby into their family might have on these siblings. Exploring older siblings' views could provide information that might enable parents understand and support their needs.

2. Several women's partners made interesting contributions during data collection although these were excluded in accordance with ethical approval. Gaining insight into partners' views could enable midwives to provide more holistic and family centred care.
3. This study did not seek obstetricians' views of older women and pregnancy. However, their role was important in women's and midwives' understandings and experiences. Further research to explore obstetricians' views could enable women and midwives to understand their motivations and actions and contribute to further improvements in maternity care for older women.
4. Continuity of care and relationships between community midwives and older pregnant women are significant in shaping women's pregnancy experiences. However the nature of relationships between older women and hospital midwives may differ according to differing structures of care. Research to investigate hospital midwives' views, specifically labour ward and screening midwives, regarding older women's childbearing experiences could develop the findings of the current study.
5. Further research exploring the labour, birth and early postnatal experiences of older pregnant women from women's and midwives perspectives could build on the findings of this study and add to the growing body of knowledge around older women's experiences of becoming and being a mother.

Final words

Whilst literature, media and social interactions frequently highlight the risks associated with older childbearing, several women and midwives in this study felt that a more balanced perspective could be portrayed and that health professionals, particularly community midwives, are integral to facilitating this. Discussions around pregnancy-related risks must embrace individual's values and beliefs and the potential benefits of taking risks, whilst balancing these with intrinsic negativity associated with risk thinking (Titterton, 2005). This study would not have been possible without the generosity of the women and community midwives who shared their time, their experiences, hopes and fears with me. Reflecting on their words and developing a new lens through which to understand their experiences, has been an enlightening and emotional journey. It is my pleasure to end this thesis using Heather's words:

Second antenatal interview with Heather (9) (section 414)

... if people are wanting to have children later in life, it's not a case of, you know, that's it you've hit the brick wall and it's not going to happen, you know, I think they need to, to know that it's... whilst the other studies and the other research and work that's been looked into about the issues, is quite rightly viable and

needs to be out there as well, there needs to be that redress of a balance, cos I think that's where it lies. I know there's this imbalance of like, there's all the bad stuff out there but there's not so much good stuff [...] the first thing when you're probably that bit older and you're told about all the risks [...] I think they could balance it out... yes, I agree that they have to tell you, but they could say actually, we've done...we've spoke to older mums and these are all the older mums that have had a really good experience [...] of course you want to know and you need to know about risks and you need to know about, you know, erm, you know, certain factors that may affect you if you're older, erm, but at the same time, I think it needs to be a positive experience [...] I think we forget that because we become focused on 'we must tell people... it's a priority to tell them what the risks are...'

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Appendices

Appendix 1 - Challenges associated with advanced maternal age

Introduction: Advanced maternal age

Inconsistency of the age at which a woman is defined as 'older' makes it difficult to synthesize data from research relating to maternal age (Boivin et al., 2009). In 1958 the International Federation of Obstetricians and Gynaecologists referred to women aged 35 or over in their first pregnancy as 'elderly primigravidae' (Aref-Adib, Freeman-Wang & Atallah, 2007, p43). However Aref-Adib et al. (2007) suggest that improvements in women's health have resulted in 'advanced maternal age' being reserved for pregnancies relating to women aged 40 years and over. With appropriate care and management, older women are likely to have a successful pregnancy in the majority of cases (Boivin et al., 2009; Verma, 2009), nonetheless contemporary UK maternity care places women aged 40 and over in a category whereby they may need extra care on account of the complications associated with older maternal age (NICE, 2008). This section provides the reader with an overview of some of the conditions which may affect the journey to becoming an older mother.

Decision-making around timing of childbirth

Characteristics of the older mother have changed over time, with many older mothers previously being multiparous and experiencing complications associated with grand multiparity; whereas women in the past may have been giving birth to their last child in their 40s, in recent decades more women are becoming a mother for the first time in their 40s (Wildschut, 1999; ONS, 2014). Becoming a mother when older may be associated with personal choices and Boivin et al. (2009) suggest that older mothers are more likely to be more autonomous, better educated, satisfied with their job and financially stable. Such social changes may lead women to delay childbearing with the notion that assisted reproductive technology may help them to conceive if they experience difficulties at a later time (Liu & Case, 2011). The timing of mothering for older women is discussed further in Chapter Two.

Fertility

Despite a lack of overt physical symptoms, women's fertility begins to decline around the age of 30-35 years. This is due to the reducing quality and quantity of oocytes rather than the ability of the uterus to carry a pregnancy (Madankumar, Cohen & Brenner,

2003; Atallah & Freeman-Wang, 2005; Hansen et al., 2008). Older mothers may therefore take longer to conceive and, for some women with age-related infertility, egg donation may be the only effective treatment (Liu & Case, 2011). Tough et al.'s (2007) study found that the relationship between older maternal age and fertility problems appears to be recognised by the majority (70%) of men and women. Understanding the correlations between maternal age and fertility is important for older women so that they can make informed family planning choices (Madankumar et al., 2003).

Changing attitudes and medical advances have made it more feasible, usual and acceptable for older women to become pregnant, although the impact of pregnancy on older mothers and vice versa may be controversial (Eisenberg & Schenker, 1997). Women over 36 years seeking investigations for delayed conception may be investigated more promptly than younger women since advancing maternal age is associated with declining success of interventions such as in-vitro fertilisation (IVF) (NICE, 2015). In the UK women aged below 35 can expect a 32.2% chance of having a live birth using IVF, compared with a 13.6% chance for women aged 40-42 and 1.9% for women aged over 44 years (NHS Choices, 2015a). There is wide variability in women's fertility when women reach their 40s although, as Roberts and Noyes' (2009) systematic review revealed, clinical guidelines may not take account of the age-related socio-cultural factors influencing older women's choices.

Egg donation for older women who are unable to conceive naturally is controversial since this may result in complications for the mother and / or baby (Atallah & Freeman-Wang, 2005), although denying women this opportunity limits their freedom of choice (Eisenberg & Schenker, 1997). More recently Campbell's (2011) assessment of media representations suggested that the links between older mothers and assisted reproductive technologies (ARTs) are framed by socially, politically and culturally 'comfortable boundaries' (ibid, 2011, p270); older women becoming pregnant as a result of ART challenges the socially constructed and accepted boundaries regarding ARTs.

Previously infertile women may experience greater concerns about their pregnancy, resulting in a lack of attachment to their baby in the early stages of pregnancy (Berryman & Windridge, 1996) however this does not appear to have a negative impact on the wellbeing of the child during early and mid-childhood (Boivin et al., 2009).

Early pregnancy

Advanced maternal age is associated with early pregnancy complications including spontaneous miscarriage; women aged 40 or more have a 34-52% risk of miscarriage, compared with a 7-15% risk for women aged less than 30 (Liu & Case, 2011). Whereas

for younger women visualisation of fetal heart activity is a positive indicator of fetal viability, this may not offer the same reassurance for older women (Madankumar et al., 2003). The rate of ectopic pregnancy also increases with advancing maternal age, possibly due to the increased fallopian tubular lesions associated with older maternal age (Aref-Adib et al., 2007). Delayed fertilisation and suboptimal oocyte quality may also increase the risks (Ataullah & Freeman-Wang, 2005). Older maternal age is also associated with an increased risk of gestational trophoblastic disease (Palmer, Hancock & Tidy, 2007).

Liu and Case (2011) suggest that a significant number of early pregnancy losses are associated with chromosomal anomalies. Pregnancies affected by aneuploidy significantly increase with advancing maternal age. Women aged 20 to 34 years have a 5.4% chance of carrying an embryo with aneuploidy, whereas women aged over 40 have a 27.7% chance (Madankumar et al., 2003). Women aged 40 years have a one in 100 (1%) risk of carrying a baby with Down's syndrome. This is significantly higher than a one in 1500 (0.07%) risk for a woman aged 20 years (UK National Screening Committee, 2004). However, around 80% of babies with Down's syndrome are born to women under 35 years, so current guidelines recommend all pregnant women are offered screening regardless of age (ibid, 2004).

Maternal mortality and morbidity

Triennial confidential enquiry reports highlight a persistent association between maternal age and maternal deaths. Although the mortality rate for women aged 40 years or over has fallen significantly since the 1980s (48.2 per 100,000 maternities) and has fallen since the previous confidential enquiry report (CMACE, 2011) the highest maternal mortality rates are still recorded for these older women (19.9 per 100,000 maternities compared with 5.4 for women aged 20-24: the reference group) (Nair & Knight, 2015) (see table on next page).

Similar age-related trends have been observed in other developed nations such as Belgium (Temmerman, Verstraelen, Materns & Bekaert, 2004) and the Netherlands (Schutte et al., 2009); Restrepo-Méndez and Victora (2014) suggest that confounding factors associated with older mothers such as increased wealth could mask even stronger links. However, since maternal mortality is relatively rare within the developed world, these figures alone are inadequate determinants of maternal health and maternal and perinatal mortality may be more useful indicators (Carolan, 2007). Most women in this category have a safe and successful pregnancy and a healthy child – in absolute terms the risks remain very small (Ataullah & Freeman-Wang, 2005). The United

Kingdom Obstetric Surveillance System (UKOSS, 2014) is currently exploring the epidemiology of pregnancy for women of advanced maternal age with one of aims being to identify the risk of adverse outcomes for these women and their babies.

	<i>Total maternities 2011-13</i>	<i>Total deaths</i>	<i>Rate per 100,000 maternities</i>	<i>95% CI</i>	<i>Relative risk (RR)</i>	<i>95% CI</i>
Age						
<20	111805	8	7.2	3.1 to 14.1	1.33	0.51 to 3.08
20-24	427329	23	5.4	3.4 to 8.1	1 (Ref)	
25-29	662206	50	7.6	5.6 to 10.0	1.40	0.84 to 2.41
30-34	701163	63	9.0	6.9 to 11.5	1.67	1.02 to 2.82
35-39	374999	51	13.6	10.1 to 17.9	2.53	1.52 to 4.33
≥40	95607	19	19.9	12.0 to 31.0	3.69	1.90 to 7.09

Table to show maternal mortality rates amongst different age groups 2011-13

Note: this table was adapted from Nair and Knight (2015, p16) and is reproduced with permission from MBRRACE-UK

Older mothers may be more likely to experience less severe complications such as perineal pain in the immediate postnatal period (Francisco, Vasconcellos de Oliverra, da Silva, Bick & Gonzalez Riesco, 2011) and pregnancy-related lumbo-pelvic pain (Chang, Jensen, Yang, Lee & Lai, 2011). Longer term outcomes associated with advanced maternal age include reduced risk of cervical and endometrial cancers, but an increased risk of breast and brain cancers (Merrill et al., 2005).

Maternal medical disorders

Hypertension and diabetes are two of the commonest medical conditions affecting pregnancy and can result in a range of maternal and fetal complications (Reddy et al., 2006). Older women are more likely to develop hypertensive disorders in pregnancy and may also be more likely to have pre-existing essential hypertension (Sibai et al, 1998; Jahromi & Hussein, 2008). Women aged over 40 may be three times more likely than women aged 20-24 years to develop hypertensive disorders (Joseph, et al., 2005) with multiparous women aged 40 years having double the risk of developing pre-eclampsia (Duckitt & Harrington, 2005). Where these women do develop pre-eclampsia it is more likely to be severe than for younger women (OR 1.4) (Jacobsson, Ladfors & Milsom,

2004) and is likely to increase the risk of other complications such as venous thromboembolism (Lindqvist, Dahlbäck, & Maršäl, 1999).

Advancing maternal age is associated with an increased risk of gestational diabetes when compared with younger women (Luke & Brown, 2007; Koo et al, 2012) and the risk appears to increase with increasing maternal age (Dulitzki et al, 1998; Schoen & Rosen, 2009). Diabetes predisposes to other complications such as preterm birth (Jacobsson et al., 2004) or macrosomia. Women of very advanced maternal age (≥ 44 years) have been shown to have a significantly higher rate of medical complications (Chibber, 2005) such as hypertension and diabetes (OR 2.5) when compared with women aged 20-29 (Dulitzki et al., 1998).

Perinatal mortality and morbidity

Fretts (2001) suggested that the causes of fetal deaths had changed since the 1970s when women over 35 years were 1.5 times more likely to suffer a fetal death than younger women and that higher numbers of congenital anomalies was one of the main causative factors. Screening for such anomalies and options for terminating affected pregnancies appeared to have reduced the numbers of older mother experiencing fetal loss due to severe anomalies (Fretts & Usher, 1997). However, Fretts and Usher (1997) identified that women aged 35 or more had an increased risk of fetal death (OR 2.2) where there were no other identified risk factors. Other significant factors were first birth and obesity. Recent figures show that this association persists.

Maternal age has a U-shaped association with infant mortality and morbidity, with babies of the oldest and youngest mothers being most at risk for singleton pregnancies (Misra & Ananth, 2002; Delpisheh, Brabin, Attia & Brabin, 2008). For multiple pregnancies the risk associated with older age is less marked than for young mothers (Misra & Ananth, 2002; Office for National Statistics, 2012a, 2016). Recent infant mortality rates for England and Wales demonstrate a reduction in rates for women aged over 40 years from 5.8 per 1000 live births in 2012 to 4.6 in 2016 (Office for National Statistics, 2012b, 2016). The table below demonstrates these and other adverse perinatal outcomes associated with advancing maternal age.

Mother's Age	Number of Live births	Number of Stillbirths	Stillbirth rate⁷	Perinatal death rate⁸	Neonatal death rate⁹	Infant death rate¹⁰
All	698,512	3284	4.7	6.7	2.7	3.8
Under 20						
Singleton	28,785	163	5.6	8.4	3.5	5.5
Multiples	351	9	25.0u ¹¹	41.7u	25.6u	37.0u
20-24						
Singleton	117,600	544	4.6	6.4	2.5	3.7
Multiples	2,119	21	9.8	21.5	16.0	21.7
25-29						
Singleton	191,737	813	4.2	6.0	2.3	3.2
Multiples	4,956	46	9.2	17.6	10.7	14.1
30-34						
Singleton	205,042	842	4.1	5.9	2.4	3.3
Multiples	7,264	54	7.4	15.4	10.6	12.9
35-39						
Singleton	106,478	559	5.2	6.8	2.2	3.2
Multiples	5,022	54	10.6	18.3	12.3	15.5
≥ 40						
Singleton	27,317	157	5.7	8.4	3.7	4.6
Multiples	1,841	22	11.8	16.6	7.1u	8.1u

Live births, stillbirths and infant deaths by mother's age, 2013 (provisional data) (ONS, 2016). Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0. [<http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/>]

Stillbirth

Older maternal age appears to be a significant factor in stillbirths and the risk appears to rise with increased age (Salihu et al., 2008; ONS, 2016). Using multivariate analysis, a large study of birth outcomes in the USA found that when compared with 20-34 year olds, women aged 35-39 (odds ratio 1.28) and aged 40 years or over (odds ratio 1.72) were more likely to have a stillborn baby (Bateman & Simpson, 2006). The authors acknowledge that they did not have autopsy reports which may have influenced their findings. Similar results were found by Reddy et al (2006) who noted that co-morbidities such as diabetes and hypertension are more common in older women and that these are historically associated with stillbirth, although better management has reduced the

⁷ Stillbirths per 1000 live births and stillbirths

⁸ Stillbirths and early neonatal deaths per 1000 total births

⁹ Deaths of infants up to 28 days old per 1000 live births

¹⁰ Deaths of infants up to one year old per 1000 live births

¹¹ u denotes that reliability may be affected by small numbers affected

numbers of related stillbirths to a level that is closer to that for the general population. As with low birth weight, impaired adaptation of the uterine vasculature to pregnancy has been proposed as a contributory factor (Reddy et al, 2006). It is important to note that although women over 40 years may be almost twice as likely to have a stillborn baby as younger women, the actual risk of 2% for a woman aged 47 years (21.9/1000 births) (Bateman & Simpson, 2006) may be perceived as much lower. Differentiating between absolute and relative risk is important in facilitating understanding and decision making. A systematic review examining 96 studies relating to the causes of stillbirth in high-income countries found that maternal age over 35 contributed to more stillbirths than maternal smoking, although this was not the case for disadvantaged women who smoked (Flenady et al., 2011). The Royal College of Obstetricians and Gynaecologists (RCOG), (2013) suggest that there is an argument for induction of labour for women aged 40 or over in order to minimise the risk of stillbirth, although they acknowledged a lack of data relating to the impact of this on the numbers of caesarean births or perinatal deaths.

Chromosomal anomalies

In the United Kingdom, around one in 1000 (0.1%) babies will be born with Down's syndrome (Trisomy 21), a chromosomal condition resulting in varying degrees of learning difficulty and physical health problems (Down's Syndrome Association, 2015). Screening for Down's syndrome is currently offered in early pregnancy throughout the UK, apart from Northern Ireland, as part of a package of fetal anomaly screening. Although some variations exist, screening is offered between ten completed weeks and 13 weeks and 6 days of pregnancy incorporating ultrasound calculation of the gestation, measurement of the fetal nuchal fold and biochemical serum screening. Based on the results of this combined test women are placed in either a 'higher' (>1 in 150) or 'lower' risk (<1 in 150) category for having a baby with Down's syndrome (NHS Screening Programmes, 2015a). Women falling into the 'higher' risk group are offered invasive diagnostic testing, either amniocentesis or chorionic villus sampling (CVS), and information provided to women includes a one percent chance of miscarriage associated with the amniocentesis and a one to two percent risk of miscarrying with the CVS. Where an abnormal result is identified following diagnostic testing, women are given the opportunity to discuss the results with a specialist clinician including the options of continuing with or terminating their pregnancy (NHS Screening Programmes, 2015b). Women are also offered screening for other conditions during pregnancy. However, since these aim to identify maternal conditions which may be modified through interventions, they may be perceived as being routine rather than optional. Since the risk of Down's

syndrome increases with advancing maternal age and involves significant decision-making involving their baby, this process may be particularly challenging for older mothers. By far, advanced maternal age is the most significant risk factor (Sherman, Allen, Bean, & Freeman, 2007). NHS Choices (2015b) give the risk for Down's syndrome as one in 800 for women aged 30, one in 270 at 35 years, one in 100 at 40 years and one in 50 or more for women at 45 or older, based on the work of Cuckle, Wald and Thompson (1987). Other non-chromosomal abnormalities such as cardiac defects are also more common in the babies of older women (OR 3.95) when compared with women aged 20-24 years (Hollier, Leveno, Kelly, McIntire & Cunningham, 2000).

Preterm birth

Preterm birth is more likely for older mothers, with increasing maternal age correlating with increasing risk (McIntyre, Newburn-Cook, O'Brien & Demianczuk, 2009; Hsieh et al., 2010; Koo et al., 2012). Delpisheh et al., (2008) highlighted a stronger correlation between maternal age ≥ 40 years and low birth-weight or very preterm infants where women are primiparous compared with multiparous women of the same age (9.4% vs. 5.3% and 8.9% vs. 4.4%). They report that although the mechanisms for this are unclear older mothers are more likely to take medications or have medical disorders than younger women which may affect fetal growth and development. Following adjustment for confounding factors, older maternal age (≥ 35 years) still correlates with very preterm birth (OR 1.51) and very low birth-weight (OR 1.69) (Delbaere et al., 2007). This association is less significant for women aged 35-40 compared with women > 40 years (Jolly et al., 2000).

Low birth-weight

Older maternal age is also reported as being associated with having a low birthweight infant. Although less marked when women are healthy and have a higher socioeconomic and educational status, the association persists (Cnattingius, Forman, Berendes & Isotalo, 1992; Aldous & Edmonson, 1993; Raum, Arabin, Schaud, Walter & Schwartz, 2001; Odibo, Nelson, Stamilio, Sehdev & Macones 2006; Verma, 2009; Hsieh et al., 2010; Koo et al., 2012) and may be attributable to diminishing uterine circulation related to advancing maternal age. Jahromi and Hussein (2008) found that the associations between maternal age over 40 years and prematurity and low birthweight were more significant ($p < 0.002$ and $p < 0.04$ respectively) when women were primiparous. In contrast, older multiparous women may also be at risk of having macrosomic babies.

Macrosomia then predisposes women and their babies to increased risks such as shoulder dystocia and subsequent complications.

Intrapartum complications

Older pregnant women are more likely than younger women to birth their baby by caesarean section (Luke & Brown, 2007; Jahromi & Husseini, 2008; Roman, 2008; Verma, 2009; Hsieh et al., 2010; Koo et al., 2012). Koo et al. (2012) reported a four times relative risk for women over 40 compared with women aged 20-29. The risk is significantly increased as women's age increases beyond 44 (Schoen & Rosen, 2009). Similarly older women may be more likely to have their labours induced or augmented (Tan & Tan, 1994; Main, Main & Moore, 2000) or their birth assisted by forceps or vacuum (Hsieh et al., 2010; Carolan & Frankowska, 2011). Higher caesarean section rates have also been reported for women who have had infertility treatments (Dulitzki et al., 1998). Diminishing myometrial efficiency associated with advancing maternal age has been proposed as contributing to increased intervention rates (Main et al., 2000; Treacy et al., 2006; Roman, 2008). Greenberg et al. (2007) found that on average younger nulliparous women (age <20 years) had a shorter second stage of labour (up to 97 minutes) than nulliparous women aged over 39 years. Atallah and Freeman-Wang (2003) suggested that women undergo caesarean births for "real or perceived risks" (p50) and that older women may choose interventions; since they may be more assertive than younger women they may be better able to articulate their choices. Alternatively obstetricians may prefer caesarean birth for older women in response to their potentially limited opportunities for future pregnancies (Treacy et al., 2006) and the notion of the 'premium baby' (Cohen, 2014).

Psychosocial issues

Older women may be better educated, more financially stable and more ready emotionally for childbearing and rearing than their younger counterparts (Eisenberg & Schenker, 1997) as previously discussed in Chapter Two. In addition they may have better general health and a more positive outlook, which may enable these women to be more accepting of pregnancy symptoms and more likely to breastfeed (Atallah & Freeman-Wang, 2003). The absence of clinical problems and older maternal age were significant factors in infant feeding behaviours reported by Henderson and Redshaw (2010), for example 33% of women aged 35 years or more were still breastfeeding at three months compared with 3.6% of 16-19 year olds.

Stowe and Nemenoff (1995) suggested that postnatal depression may be more prevalent in older mothers particularly where they are primiparous and when they have been anxious during pregnancy. More recently, a UK study of low-risk pregnant women (Lynn, Alerdice, Crealey & McElroy, 2011) found that primiparous women were more likely to have a higher anxiety score than multiparous women, healthier women were less likely to report high stress levels and that younger women experienced higher distress scores than those women aged 36 or more.

Despite all of the above it is important to remember that "the great majority of pregnancies in older women are relatively uncomplicated and end quite satisfactorily. Our role is to identify those that will benefit from our help" (Cohen, 2013, p254).

Appendix 2- Example of literature review appraisal

Critical Appraisal Skills Programme	10 Questions to help you make sense of qualitative research (CASP, 2006)
Paper	Mandel (2010) The lived experience of pregnancy complications in single older women. American Journal of Maternal Child Nursing, 35(6), 336-340.
Screening questions	
1. Was there a clear statement of the aims of the research?	Yes – to ‘understand the physical, emotional, and developmental needs of single older women as they experience a complicated pregnancy’. Justifies importance in terms of increasing numbers of older mothers and the increased risk of complications for women in older age; single women may have less social support. Relevant to current study, which aims to explore the pregnancy experiences of older pregnant women and does not exclude single women or women who have identified complications.
2. Is a qualitative methodology appropriate?	Yes – the study aims to explore the lived experiences of these women and to gain an in-depth understanding.
Is it worth continuing?	Yes.
Detailed questions	
3. Was the research design appropriate to address the aims of the research?	Yes - justifies use of phenomenology following van Manen (1992) as enabling ‘thick, rich’ description of participants’ experiences. Might have provided greater detail about rationale for method, but may have been constrained by length of paper.
4. Was the recruitment strategy appropriate to the aims of the research?	Yes – participants (mean age 40.8) recruited through advertisement in ‘Single mother by choice’ newsletter and also on study specific website. Women contacted the researcher if interested in participating i.e. not under pressure to participate. 16 women contacted the researcher, 3 did not meet inclusion criteria. 11 women were included in the study (unclear why the other 2 women were not included – may not have experienced pregnancy complications).
5. Was the data collected in a way that addressed the research issue?	Yes – semi-structured interviews (lasting 65-120 minutes) were conducted either face to face or by telephone at time convenient to participants. Strategy for data collection not justified but commonly used for phenomenological studies. Interview guide was modified during the course of the study to ‘concentrate on areas where further information was required’.
6. Has the relationship between researcher and participants been adequately considered?	Can’t tell – more details could have been provided, although researcher did describe using bracketing to explore any preconceived ideas and put her personal perspectives aside in order to concentrate on participants’ perspectives.

7. Have ethical issues been taken into consideration?	Yes – could have been explained in more detail, but study had university ethical approval.
8. Was the data analysis sufficiently rigorous?	Can't tell – difficult to ascertain from the paper although has stated processes used. Analysis dealt with very briefly. As stated above: used bracketing to examine their own role.
9. Is there a clear statement of findings?	Yes – themes named and explained with examples from data to illustrate arguments. Acknowledges limitations of homogenous, small sample and recruitment strategy.
10. How valuable is the research?	<p>Discusses research findings in relation to clinical practice for nurses working with childbearing women. Discusses the importance of being aware of local and peer support services to improve support for these women. Implications clearly presented.</p> <p>Could have provided more detail in some areas, but appears to have been limited by length of paper. Deborah Mandel is a Professor of Nursing – appropriately qualified to produce a trustworthy account about this subject. Although generalizability is limited and study conducted in USA, findings do add to international understanding of older pregnant women's experiences and support the notion that older childbearing women have particular needs that can be addressed by nurses/midwives.</p>

Appendix 3 – Extract from reviewed literature tables

Example pages from 'Summary of reviewed studies relating to pregnancy and older maternal age'

Author, date and location	Aim of study	Sample and response rate (RR)	Data collection and analysis	Main findings	Limitations (as identified by the author)
Aasheim, Waldenström, Rasmussen & Schytt (2013) Norway	To examine the links between advanced maternal age in primiparous women and their postnatal assessments of childbirth	30,065 primiparous women aged ≥32 years. Reference group aged 25-31 years	Part of the National Norwegian Mother and Child Cohort Study (MoBa). Women completed three questionnaires (at 17 & 30 weeks pregnant & 6 months postnatally). Descriptive and multiple logistic regression analysis used	Older women can experience more negative experiences of childbirth than younger counterparts when birth is spontaneous. Women aged ≥ 38 years reported the most positive birth experiences when having an instrumental birth or caesarean section	Feelings about the impending birth were estimated based on single item questions; sample characteristics differed from the national cohort sample
Bayrampour, Heaman, Duncan & Tough (2012) Canada	To explore risk perception of women of advanced maternal age	15 pregnant nulliparous women aged ≥35 (35-44)	In-depth semi-structured interviews conducted; qualitative descriptive study Content analysis (Holsti, 1969)	Four main themes were found: definition of pregnancy risk factors affecting perception of risk risk alleviation risk communication with health professionals	Purposive sampling and sample size limit generalizability of findings
Bayrampour, Heaman, Duncan & Tough (2013) Canada	To compare risk perception in pregnant women of advanced maternal age with younger women; to explore relationships between risk perception and selected variables	Convenience sample: 159 primigravid women (105 aged 20-29; 54 aged 35+ years); women recruited through hospital and private obstetricians' offices	Comparative descriptive design to compare the groups by variable. A number of questionnaires were completed: Perception of pregnancy risk questionnaire (PPRQ, Heaman & Gupton, 2009); pregnancy related anxiety scale (Rini, Dunkel-Schetter, Wadwa & Sandman, 1999); knowledge of maternal age-related risks of childbearing questionnaire (Tough et al., 2009); SF-12v2 health status survey; multidimensional health locus of control (MHLC) questionnaire; prenatal scoring form; demographic and childbirth data collection form. Data analysis used: <i>t</i> tests, chi-square	Older women perceive a higher pregnancy- related risk than younger women. Results related to the following variables: pregnancy characteristics pregnancy risk-perception pregnancy-related anxiety knowledge of maternal age-related risk health specific perceived control medical risk	Authors acknowledge the use of convenience sampling in producing findings that may be non-representative of the general population; exclusion of multiparous women limits generalisation to this group

			analysis, Fisher's exact test, Predictive Analytics Software (PASW), Pearson <i>r</i> correlation matrices		
Benzies, Tough, Tofflemire, Frick, Faher & Newburn-Cook (2006) Western Canada	To examine the factors that influence women's decisions about the timing of motherhood from a lifespan perspective	Convenience sample of 45/78 (RR58%) European Canadian women; age range 20-48, but grouped according to age (oldest group ≥ 35 years); mainly well-educated.	Socio-demographic questionnaire; focus groups for 30 women; individual interviews for 15 women who could not attend focus groups; semi-structured interview guide. Nonnumeric unstructured data indexing searching and theory building (revision 4) software. Iterative thematic data analysis	Factors influencing timing of pregnancy: independency relationship stability /partner readiness declining fertility family influence Social factors are also significant: acceptability of delayed childbearing, divorce rates and policy	Sample characteristics limit generalisability to other settings
Budds (2013) UK	To explore constructions of older motherhood, how older mothers take up, negotiate or resist ways of being and how women negotiate older motherhood	26 newspaper articles 11 older mothers aged ≥ 35 (range 35-43)	Social constructivist thematic analysis Semi-structured interviews with women. Thematic analysis using a critical discursive psychological approach	The media represent older mothers as selfish, placing themselves and their babies at risk because of their choice to delay mothering; older mothers can work hard to challenge this representation and construct themselves as good mothers; society dictates the right time to become a mother and what constitutes a good mother	Homogeneity of the sample – does not represent diversity of older women's ethnic, cultural or sexual background
Campbell (2011) Canada	To examine 'how an apparently 'settled' sociotechnical network (ART ¹²) becomes reframed in terms of risk	Exploration of media coverage relating to Ranjit Hayer's ¹³ birth: 2 television transcripts, 20 articles, 17 editorials and 7 editors letters	Qualitative discourse analysis and categorical aggregation (Cresswell, 2007) with a focus on the effect of media framing on boundaries and risk	Five frames (boundaries) of risk were identified: ontological international / cultural gender epistemological responsibility	Not acknowledged
Carolan (2003a) Australia	To explore the experiences of childbirth and early parenting for first time mothers aged over 35 years	20 primiparous women aged >35, RR not stated	In depth interviews at 35-38 week gestation, 7-10 days and 6-8 months postpartum; focuses on data collected at 7-10 days postpartum. Thematic analysis affiliated with grounded theory (did not use theoretical sampling); inductive methodology	Contradictions in findings: women appeared to be in control - planning and intellectualising, but then seemed to feel inadequate with caring for the baby	Small sample size – limits transferability of findings

¹² Assisted reproductive technology, e.g. in-vitro fertilisation (IVF)

¹³ Ranjit Hayer (aged 60) gave birth to twins in 2009 following embryo implantation using donor eggs, becoming Canada's oldest mother in history

Appendix 4 - Application of Lincoln and Guba's (1985) characteristics of naturalistic research to the current study (Adapted from Samples, 2010)

Characteristic	Application within this study
Naturalistic setting	Data were collected during planned antenatal appointments in the clinic setting, at women's or midwives' homes or workplace. Location was determined according to participants' wishes
Human data collection method	I have been the primary research tool – interviewing participants and recording interactions
Utilisation of tacit knowledge	Using my insight into midwifery practice and the processes within maternity care has helped to develop my research; I have acknowledged the impact of my pre-existing understandings on each stage of my study by recording reflexive memos and keeping a reflective journal
Qualitative methodology	I have used a loosely structured interview technique, which became more focused as the study progressed. I have used transcribed recordings of antenatal appointments and interviews and field notes relating to recorded and interview data collection methods to build the data. I have used a grounded theory methodology
Purposive sampling	Pregnant women aged 40 years or older at the time of giving birth, who were booked to give birth within the host NHS Trust and their community midwives were recruited to the study. Theoretical sampling was used to refine and develop codes and categories
Inductive data analysis	Data were analysed to identify codes and categories which developed the study's focus and findings
Emergent design	I have analysed data from the commencement of gathering data. This enabled me to identify and focus on key and emergent concepts, categories and codes through refining interview questions and theoretical sampling
Negotiated outcomes	Involvement has been through informed consent. Participants were informed that they could decline to take part at any time without this affecting their care; emergent findings were checked with participants and recommendations circulated for participants' feedback
Individual interpretation	Data have been collected and analysed according to the woman's and midwife's perspective and context at that particular time of data collection
Tentative application	Theories have been developed from the data
Focus determined boundaries	This study and its findings relate to specific older women's and midwives' experiences at a particular time in their lives and the study's findings are not expected to be transferable to the wider population
Criteria for trustworthiness	Ethical approval for the study was granted at University, NHS Trust and National (IRAS) levels; I have adhered to NRES and professional standards and guidelines. I have included participant checking of data, codes and findings, a reflexive journal and memoing and I have worked with the support of academic and professional supervisors

Appendix 5 – Grounded theory studies

Examples of grounded theory (GT) studies relating to pregnancy and maternity care

Author/s and GT approach/es used	Title	Participants	Findings
Darvill, R., Skirton, H. & Farrand, P. (2010) (Strauss and Corbin, 1998)	Psychological factors that impact on women's experiences of first-time motherhood: a qualitative study of the transition	13 women aged 16+ who had given birth 6-15 weeks prior to semi-structured interviews	Changes in women's self-concept included 3 main themes: control, support & forming a family; early pregnancy included a change in self-image from themselves to the needs of the fetus
Dobrzykowski, T. & Stern, P.N. (2003) (Glaser, 1998, 2001)	Out of Sync: A generation of first-time mothers over 30	53 primiparous women aged 30 years or over	Core category was 'being out of sync' and incorporated 3 sub-categories: awareness of mortality; time-wise vitality – diminished energy due to age; recognising social structural situations
Koehn (2008) (Glaser, 1978, 1992; Glaser & Strauss, 1967)	Contemporary women's perceptions of childbirth education	9 pregnant women (aged 22-37) attending 'childbirth preparation classes'. Participants were interviewed three times	Core category - "Negotiating the Journey"; supporting categories 'Exploring the Unknown', 'Making It Real' & 'Sensing the Readiness'. Value of childbirth education may help women prepare for childbirth rather than influencing bio-physiological outcomes
Lalor, Begley & Galavan (2008) (Glaser, 1978)	A grounded theory study of information preference and coping styles following antenatal diagnosis of foetal abnormality	42 women, following diagnosis of fetal abnormalities; in-depth interviews at three time intervals	Recasting Hope, the process of adaptation following diagnosis is represented temporally as four phases: 'Assume Normal' - incredulity, 'Shock' – initial reactions, 'Gaining Meaning' – making sense of negative events and 'Rebuilding' – extent of recovery from loss
Levy (1999, 2006) (Strauss and Corbin)	Protective steering: a grounded theory study of the processes by which midwives facilitate informed choices during pregnancy	Observation of 12 midwife-women interaction and follow-up interview with women	Core category: protective steering - midwives wanted to protect the women and themselves regarding choices. Categories identified: orienting, protective gatekeeping and raising awareness

Examples of grounded theory studies employing a constructivist approach

Author/s and GT approach/es used	Title	Overview of participants and study
Barnett (2012) (Bryant, 2009; Bryant & Charmaz, 2007a, 2007b; Charmaz, 2000, 2003a, 2006, 2008a, 2008b, 2009)	Constructing new theory for identifying students with emotional disturbance: A constructivist approach to grounded theory	Participants: 27 practitioners & one parent involved with recognising students with emotional disturbance. Data collection involved semi-structured interviews, focus groups and documental reviews
Chen & Landau (2015) (Charmaz, 2009; Strauss 1987)	First childbirth and motherhood at post natural fertile age: a persistent and intergenerational experience of personal & social anomaly?	Semi-structured interviews with 20 single (n=11) and married (n=9) women. Age range 41-69 years; women had undergone ART
Larkin (2014) (Charmaz, 2006; Bryant & Charmaz, 2007)	An exploration of midwives' experiences and practice in relation to their assessment of maternal postnatal genital tract health	In-depth interviews with 14 midwives; observation of 15 postnatal assessments involving 5 midwives & 15 postnatal women
Tapley, Jack, Baxter, Eva & Martin (2015) (Charmaz, 2006)	The process of adopting and incorporating simulation into undergraduate nursing curricula: a grounded theory study	Two (maximum) in-depth semi-structured interviews with administrators, academic nursing staff & simulation leaders; follow up interviews after reviewing institutional documentation
Templeman, K., Robinson, A. & McKenna, L. (2015) (Charmaz, 2006; Strauss & Corbin, 1990; Birks & Mills, 2011)	Complementary medicines in medicine: conceptualising terminology among Australian medical students using a constructivist grounded theory approach	In-depth, semi-structured interviews with 30 medical students; 28 via telephone & two face to face
Williams & Keady (2012) (Charmaz, 2000)	Centre stage diagrams: a new method to develop constructivist grounded theory – late-stage Parkinson's disease (PD) as a case exemplar	Longitudinal study using interviews with couples (number not specified in current article) use & 'application of centre stage diagramming' through a couple-based exemplar taken from a 3-year constructivist grounded theory study on late-onset Parkinson's Disease

Appendix 6 - Extract from reflective journal (December 2013)

In this reflective account I explore my experiences of the insider-outsider situation which has become a significant consideration in ensuring that my research is conducted ethically. I am using Borton's (1970) three reflective questions to frame my account.

What...?

When beginning my professional doctorate I remember discussing, as part of a planned teaching session, the potential challenges of being a health professional and conducting research. At the time I read and thought about the potential for conflicts, acknowledging that there were potential challenges. I wrote about these in assignments and in research proposals. On reflection I realise that I was more reassured that as a registered midwife and mother I had an advantage in that I would have an understanding of the midwifery practices and women's experiences that I hoped to explore in my work.

After successfully gaining ethical approval to conduct my research, I began to contact midwives in the Trust where I intended to conduct my data collection. After discussions with my named contact within the Trust I was able to access the community midwifery managers and through them discuss my work with community midwives (target participants). At community midwifery meetings I was given the opportunity to discuss my work. I received a range of responses to asking these midwives to consider participating in and recruiting women to my study. Many of the midwives had known me prior to this in a number of different roles.

Collecting data from midwives appeared to make some of the midwives uneasy. It was almost as though some of them felt like they were being assessed by me, although I had tried to reassure them that this was not the case and that I was interested in their opinions and experiences rather than their knowledge. Although midwives were making appropriate referrals, at times I recognised that some of the midwives could have had a stronger understanding about the potential complications associated with older maternal age, but was not in a position to assist with developing their knowledge during the data collection stage since this might influence subsequent data collection.

Gaining informed consent to participate from women, many of the women asked me whether I was a midwife (information sheet stated this) – this seemed important to them. I reassured the women that I am a midwife and explained about my roles as midwifery lecturer and researcher. Several of the midwives appeared to have told the women that they knew me. It seemed that *I* had been an important factor in midwives' recruitment of women as well as the study itself. During interviews (or at the meetings

where I met with the women to hear their stories) there were a number of occasions where women told me about concerns or issues when I found it very difficult to maintain my role as a researcher rather than a midwife.

So What...?

Although I was addressing midwives with whom I was familiar and this without doubt enabled me to gain access to some situations, because this was in a role unfamiliar to me, at times I felt very nervous. On reflection I realise that I was experiencing difficulty in my own transition to this new role and in attempting to feel comfortable as a researcher, I reverted to the role in which I felt comfortable by trying to show these midwives that I was one of them, that they could trust me. My familiarity with these midwives meant that they listened to me and some of them even said that they had participated because it was me and that they already liked me based on their prior knowledge of me. I was able to use this familiarity to feel reasonably comfortable in contacting them at regular (monthly) intervals to remind them that I still wanted to recruit midwives and women to my research. At the same time I was mindful that I didn't want to abuse this relationship or make them feel that because of my other role as a midwifery lecturer / link tutor, they were obliged to respond or to be nice to me.

Recording antenatal appointments I have remained outside the rooms so as not to interfere with the antenatal appointment process. However, listening to the recordings and transcribing these I realise that the recorder itself does have an impact on the conversations within the appointments. Midwives have asked me afterwards whether they have said the right things. The midwives clearly do feel that they are being judged or vulnerable. Some midwives were hesitant about being recorded for their interview although I had discussed this at the outset and they had signed a consent form agreeing to this. Where this was the case I was able to empathise with their concerns – I would have felt vulnerable to have my experiences and opinions recorded and listened to. In this way I feel that being a midwife I was able to absolutely appreciate their feelings and reassure them that I would treat anything they said with respect, that this would be anonymised and that should they say anything that they wanted me to delete I would be happy to do so without question. Interviewing midwives, I have felt the need to conduct this more as a conversation rather than an interview in an attempt to make them feel comfortable. At times midwives have expressed sentiments and have said to me: 'you know what I mean'. As a midwife I believe that I have known what they meant and I have had to make a conscious effort to ask for further clarification in such cases so that I do not make assumptions based on my own experiences and assumptions that my perspective is the same as theirs. To avoid creating the impression of testing the

midwives or not understanding their viewpoint, I have had to develop careful ways to do this. I feel that asking for clarification of some issues may be easier for people without insider knowledge, since they could not be expected to understand the midwife's perspective.

Having developed a very good understanding of the risks associated with older maternal age as part of the literature review for my study, and having an educator role, sharing my knowledge and understanding about and debating this has become something that I do almost subconsciously. Being unable to share my knowledge to fill perceived gaps for some of the midwives was challenging and emphasised to me my position as outsider. Being a part of the team or facilitating learning was outside the sphere of my current position and felt uncomfortable since these are 2 of the skills that I feel proud to have developed. I have discussed this with a nursing researcher colleague who expressed the same feeling around not being part of the team. I have truly begun to understand the insider-outsider position.

Gaining consent from women for their participation, it was important to them that I was a midwife. However during the data collection I had a very different role – collecting data. It was very difficult at times to avoid making suggestions or exploring issues from a clinical perspective. When asked what I thought or more direct questions I have tried to balance being honest with reflecting the contents of the conversation that we had already had so as not to influence the content of the remainder of the conversation or their care. Where women were left with questions after our discussions I recommended that they ask their midwife or consultant for clarification, although at times this was very frustrating because as a midwife I would have been able to address these issues quickly and easily. In some ways I have felt uneasy using my midwifery qualification to gain the trust of women participants, yet not being able to fulfil my role as a midwife in discussions with them. This has felt uncomfortable, although as my recruitment to the study has progressed I feel that I have been able to make my role as a researcher rather than as a midwife more explicit and I have been able to ensure that women were aware of how they could gain the answers that they wanted.

Now What...?

I am developing and will continue to develop my ability to question and listen to answers in a way that reduces the potential for collusion or making assumptions about what people are saying. I need to continue to be conscious that the meaning of what midwives express to me may be different to my own understanding of that communication. I must clarify issues to accurately present their viewpoint, although I recognise that my own

experiences will impact on data collection, analysis and any conclusions, because my personal experiences have shaped my ways of understanding and knowing.

I am developing a greater confidence in my role as a researcher and no longer feel as strongly the need to be perceived as one of the midwives in the practice setting – this is not my role although being accepted and welcomed has had a positive impact on my experience. I am more confident in communicating my role as a researcher explicitly. Where it is clear to participants that my role is as a researcher rather than a midwife, there may be fewer expectations of me to provide information or advice. I continue to be aware of my differing roles and their respective responsibilities.

Appendix 7 - School Research and Ethics Panel (SREP) approval

Jayne Samples

From: Kirsty Thomson
Sent: 27 July 2012 16:04
To: Jayne Samples; Jayne Samples U9560521
Cc: Karen Ousey; Abigail Locke
Subject: Your Amended SREP Application - Jayne Samples (9560521) - APPROVED - 'The pregnancy experiences of women aged 40 years and over'.

Follow Up Flag: Follow Up
Flag Status: Completed

Dear Jayne,

Dr Karen Ousey, Deputy Chair of SREP, has asked me to contact you with regard to your amended SREP application as titled above.

Dr Ousey has confirmed that you have addressed the issues raised and your application has now received full ethical approval.

With best wishes for the success of you research project.

Regards,

Kirsty
(on behalf of Dr Karen Ousey, Deputy Chair of SREP)

Kirsty Thomson
School of Human and Health Sciences Research Office (HHRG/01)
University of Huddersfield
Queensgate
Huddersfield
HD1 3DH
Direct Tel: +44(0)1484 471156
Email: k.thomson@hud.ac.uk

Appendix 8 - IRAS ethical approval



Health Research Authority

NRES Committee East of England - Norfolk

Victoria House Capital Park Fulbourn Cambridge CB21 5XB

Telephone: 01223 597733

Facsimile: 01223 597645

05 November 2012

Miss Jayne Samples
Senior Lecturer in Midwifery
The University of Huddersfield
Queensgate
Huddersfield
HD1 3DH

Dear Miss Samples

Study title: The pregnancy experiences of women aged 40 years and over.
REC reference: 12/EE/0511
Protocol number: 1

The Proportionate Review Sub-committee of the NRES Committee East of England - Norfolk reviewed the above application on 05 November 2012.

Ethical opinion

The Committee wished to congratulate you on a well presented application.

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter from Jayne Samples		25 October 2012
Evidence of insurance or indemnity - Zurich Municipal		24 July 2012
Interview Schedules/Topic Guides - Topic guide for Women	1	13 June 2012
Interview Schedules/Topic Guides - Topic guide for Midwives	1	13 June 2012
Investigator CV - Miss Jayne Samples		21 October 2012
Investigator CV - Dr Abigail Locke		
Investigator CV - Bob Heyman		19 September 2012
Investigator CV - Professor Ruth Deery		30 October 2012
Letter from Sponsor - University of Huddersfield		17 October 2012
Participant Consent Form	1	13 June 2012
Participant Information Sheet (Women)	2	15 July 2012
Participant Information Sheet (Midwives)	2	15 July 2012
Protocol	1	23 October 2012
REC application	IRAS Parts A&B 82877/37776 9/1/973	
Referees or other scientific critique report - Email correspondence between Jayne Samples and Kirsty Thomson		27 July 2012
Referees or other scientific critique report - Supervisors' Report 14/06/2012 and Amendment to Proposal 11/07/2012		11 July 2012

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website. After Review

12/EE/0511

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



PP

Dr Elizabeth Lund Chair

Email: Anna.Bradnam@eoe.nhs.uk

PTO

Enclosures: List of names and professions of members who took part in the review
“After ethical review – guidance for researchers”

Email to: Miss Jayne Samples j.samples@hud.ac.uk

Copy to: Professor Nigel King (Sponsor) n.king@hud.ac.uk

NHS Trust (NHS R&D Contact)

NRES Committee East of England - Norfolk

Attendance at PRS Sub-Committee of the REC meeting on 05 November 2012

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
	Psychological Therapist/Occupational Therapist	Yes	
	Retired East Anglian Eye Bank Nurse Manager	Yes	
	Independent Consultant, Nutrition and Gastrointestinal Health	Yes	

Appendix 9 - Host Trust ethical approval

Research & Development Office

If you need this correspondence in a larger font size please contact:

JS

15th April 2013

Tel:

Fax:

Private & Confidential

Miss Jayne Samples
Senior Lecturer in Midwifery
The University of Huddersfield
Queensgate Huddersfield
HD1 3DH

Dear Miss Samples,

Letter of access for research • The Pregnancy Experience of Women aged 40 years and over, R&D

This letter confirms your right of access to conduct research through **NHS Trust** for the purpose and on the terms and conditions set out below. This right of access commences on 15th April 2013 and ends on 03rd December 2014 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at **NHS Trust** has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to **NHS Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organization, in particular that of an employee.

While undertaking research through **NHS Trust** you will remain accountable to your employer The University of Huddersfield but you are required to follow the reasonable instructions of **Consultant Midwife** in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organization in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **NHS Trust** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **NHS Trust** in discharging its duties under the Health and Safety at Work etc Act, 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on **NHS Trust** premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust **Research and Development office** on _____ prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

The **NHS Trust** will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

HEAD OF RESEARCH AND EFFECTIVENESS

Appendix 10 - Information sheets (Adapted from Samples, 2010)

1. Information Sheet for Midwives

The University of Huddersfield

The pregnancy experiences of women aged 40 years and over.

Jayne Samples. 01484 473522 (direct line and 24 hour voicemail)

E-mail: j.samples@hud.ac.uk

Information sheet (Midwives)

You are being invited to take part in my research study about the pregnancy experiences of women aged 40 years and over. Before you decide, I would like you to understand why the research is being done and what it would involve for you. Please take the time to read through this leaflet and ask me if there is anything that is not clear or if you would like additional information.

Who is organising the study and what is the purpose of the study?

My name is Jayne Samples. I am a registered midwife and midwifery lecturer at the University of Huddersfield. I am conducting this research as part of my Professional Doctorate (Midwifery) studies.

The aims of this study are:

- To develop an understanding about the pregnancy experiences of women who will be aged 40 or over at the time of their birth.
- To gain insight into the views of midwives regarding the needs and experiences of older pregnant women.
- To explore the communication that takes place during antenatal consultations between the midwife and the woman.
- To obtain feedback about proposals for improving practice based on the findings of the study.

Why have I been invited?

You have been invited to participate in my study because you are a community midwife who has identified one or more pregnant women in your caseload who will be aged 40 years or over when giving birth to their baby and who has agreed to participate in the study.

Do I have to take part?

It is up to you to decide whether or not to join the study. I will discuss the study and go through this information sheet with you. If you agree to take part, I will then ask you to sign a consent form. You are free to change your mind and withdraw at any time, without giving a reason. Should you decide to withdraw from the study, you will have the option to have any information already collected from you deleted. Your decisions will not affect any other relationships between you and your employing Trust or the University

What will my participation involve?

If you agree to take part in the study, I would like to meet you at an antenatal appointment where I will record (sound only) your antenatal appointment with a pregnant woman who will be aged 40 years or over at the time of her baby's birth who has also agreed to take part in the study. I will remain outside the room. I would like to conduct a short interview with you following this appointment to hear about

your views concerning care for older pregnant women and their babies. This will take place at a time and venue that is convenient for you and should last about 30 minutes. To help me to remember accurately what has been said I would like to audio-record this interview, and I may wish to make a few notes. I will ask you to sign a second consent form if you agree to take part in this interview. You will be invited to review and provide comments on any proposals for improving practice based on the study findings at a later date. I would also like to interview the pregnant woman following this consultation. I will ensure that anything that you and the woman say will be kept completely anonymous. I will not share what you have said with the pregnant woman or vice versa in a way which would allow your identity or hers to become known to anyone other than myself.

Are there any advantages or risks of taking part?

Although there are no direct benefits, you will be contributing to research which may provide information that could lead to service improvements. I hope that you enjoy taking part in this study and I do not anticipate any disadvantages. By being recorded and interviewed you may share some personal information or thoughts – the amount of information that you share is up to you and if you wish particular information or details to be excluded from the study your wishes will be respected. If the interview raises any issues which concern you, confidential support will be available via your named supervisor of midwives.

Will my taking part in the study be kept confidential?

Yes. No-one, apart from me, will have access to information that will identify the source of any information included in this study. Where any direct quotations are used these will be anonymised with the use of pseudonyms and any potentially identifying information will be removed. Some parts of the information collected for the study will be looked at by my supervisors from the University of Huddersfield, but only in anonymised form. Information collected for this study will be retained securely for use in further studies, unless you state otherwise. In the very unlikely event of serious risk to any of those involved being identified I will discuss this with you in the first instance. If the matter cannot be resolved, I would report my concerns to the most appropriate person in a timely and professional manner.

What happens next?

If you would like to ask me any questions about the study please do not hesitate to contact me. If you think that you may be interested in taking part in this study, could you please contact me by telephone or e-mail. I will then discuss your possible participation in the study, in telephone or in person. I will then invite you to complete the participant reply slip and enclosed consent form if you decide to take part in the study. I will contact you to arrange to meet with you before your next antenatal appointment with the woman. I can answer any questions that you might have, confirm that you are happy to take part in the study and I will ask you for the signed consent form.

What will happen to the results of the research study?

The results of this study will be submitted as part of the evidence required for my doctoral studies. If you would like to receive one, I will provide you with a brief report about the findings and recommendations from the study. You will be invited to comment on these should you wish. I intend to publish findings from my research in health professional journals to share my learning with others. As my studies progress I will write articles for professional journals and present papers at conferences that use learning gained through my research. I will inform you when my work will be published if you wish. No-one who has taken part in the research will be identified in any report or publication. All names will be changed to protect confidentiality.

Who is organising and funding the research?

The University of Huddersfield is organising and funding this research. The University will fund any travel costs which you might incur and will also offer a small payment to Trust in

appreciation of their support for the project. This funding can be used to support professional development activities for midwives working within your Trust.

Who has reviewed the study?

Ethical approval has been granted from the University of Huddersfield, School of Human and Health Sciences Research Ethics Panel and the NHS National Research Ethics Service.

Further information and contact details

1. General information about research.

INVOLVE – A national advisory group that promotes public involvement in the NHS and social care research.

<http://www.invo.org.uk/>

2. Specific information about this research project.

You may wish to speak to me (Jayne Samples) or my main supervisor (Dr Abigail Locke).

Researcher contact details

Jayne Samples, Senior Lecturer in Midwifery.

The University of Huddersfield, Queensgate Campus. Huddersfield. HD1 3DH

Telephone: 01484 473522

E-mail: j.samples@hud.ac.uk.

Whom you should approach if there is a problem or you are unhappy with any aspect of the study?

You may wish to speak to me, my main academic supervisor (Dr Abigail Locke, The University of Huddersfield, telephone: _____, email _____); or the Head of Midwifery (_____)

2. Information Sheet for Women

The University of Huddersfield

The pregnancy experiences of women aged 40 years and over.

Jayne Samples. 01484 473522 (direct line and 24 hour voicemail)

E-mail: j.samples@hud.ac.uk

Information sheet (Women)

You are being invited to take part in my research study about the pregnancy experiences of women who are aged 40 years or over. Before you decide I would like you to understand why the research is being done and what it would involve for you. Please take the time to read through this leaflet and ask me if there is anything that is not clear or if you would like additional information. You can also talk to others about the study if you wish.

Who is conducting this study and what is the purpose of the study?

My name is Jayne Samples. I am a registered midwife and midwifery lecturer at the University of Huddersfield. I am conducting this research as part of my studies (Professional Doctorate in Midwifery).

Why have I been invited?

You have been invited to take part in my study because your community midwife identified that you may be 40 years or over when your baby is born.

Do I have to take part?

It is up to you to decide whether or not you want to join the study. I will discuss the study and go through this information sheet with you. If you agree to take part, I will then ask you to sign a consent form. You can change your mind and withdraw from the study at any time, without giving a reason. Should you decide to withdraw, you will have the option to have any information already collected from you removed. This would not affect the standard of care you receive.

What will be involved if I take part?

If you agree to take part in the study, I would like to meet you at an antenatal appointment with your community midwife. I would like to audio record your appointment with the midwife who has also agreed to take part in the study. I will remain outside the room. After this appointment, I would like to do a short interview with you to hear about your experiences of your pregnancy so far. This will be at a place of your choice and may be in your own home or at the hospital. This interview should last approximately one hour. To help me to remember accurately what has been said I would like to audio record this interview and I may wish to make a few notes. I will discuss this with you and ask you to sign an additional consent form before this and any other interviews that you agree to take part in. I will also be interviewing your midwife following this appointment, but at a different time.

If you have an appointment with a hospital doctor, I may wish to re-interview you after this to find out about your experiences at this time. I would like to record this interview which should last about one hour. With your permission I will contact you after these appointments but before your baby is born. This might be by phone or e-mail and the number of times we are in contact will be agreed between us – this may be once or twice.

After your baby is born, I would like you to contact me to let me know and I may arrange to talk to you about your experiences. This will be at a time and place that is convenient to you and will be after your baby is one week old. I would like to audio record this interview, which should last about an hour. With your permission I may also wish to make a few notes. I will not need to interview all the women that I have interviewed earlier in their pregnancy. You will be invited to review and provide comments on any proposals for improving practice based on the study at a later date.

I will not have access to any of your records or additional information about you. I will ensure that anything that you and the midwife say will be kept completely anonymous. I will not share what you have said with the midwife or vice versa in a way that would allow your identity or your midwife's to become known to anyone other than myself.

Are there any advantages or risks from taking part?

Although there are no direct benefits, you will be taking part in research which may provide information that could lead to service improvements. I hope that you will enjoy taking part in this study and I do not anticipate any disadvantages. By being recorded and interviewed you may share some personal information or thoughts – the amount of information that you share is up to you and if you wish particular information or details to be excluded from the study your wishes will be respected. I am aware that some women may find it upsetting to discuss certain aspects of their pregnancy and birth experiences. If you do become upset and would like to talk things through, I can help to organise this for you through the NHS Trust. After the interviews have been completed, you will receive a £20 gift voucher as a token of appreciation for your contribution to the study.

Will my taking part in the study be kept confidential?

Yes. I will not have any information about you until you contact me. No-one, apart from me, will have access to information that will identify the source of any information included in this study. To ensure that all those taking part remain anonymous, all names will be changed and any information that might lead to you being identified will be removed. Some parts of the information collected for the study will be retained safely for use in further studies, unless you state otherwise. In the very unlikely event of a serious risk to you being identified I will discuss this with you in the first instance and if the matter cannot be resolved I would report my concerns to the most appropriate person in a timely and professional manner.

What happens next?

Please do not hesitate to contact me if you would like to ask me any questions about this study. If you think that you may be interested in taking part, please could you contact me as soon as possible by telephone or e-mail? We can discuss your possible participation in the study either by telephone or in person. I will then invite you to complete the enclosed participant reply slip and consent form if you decide to take part in the study. I will contact you to arrange to meet with you before your next antenatal appointment with the midwife. I can answer any questions that you might have, confirm that you are happy to take part in the study and I will ask you for the signed consent form.

What will happen to the results of the research study?

The results of this study will form part of the evidence required for my doctoral studies. You will be provided with a brief report about the findings and recommendations from the study. You will be invited to comment on these should you wish. As my work progresses I will write articles for professional journals and present papers at conferences to share my learning with others. I will provide you with a summary of my findings and inform you when my work will be published, if you wish. No-one who has taken part in the research will be identified in any report or publication; all names will be changed to protect confidentiality.

Who is organising and funding the research?

The University of Huddersfield is organising and funding this research. I am not being paid for including you in this study. The University is funding the cost of the gift vouchers in appreciation of your contribution for this project. There are no conflicts of interest.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. Ethical approval has been granted from the University of Huddersfield, School of Human and Health Sciences Research Ethics Panel and the National Research Ethics Service.

Further information and contact details

3. General information about research.

INVOLVE – A national advisory group that promotes public involvement in the NHS and social care research.

<http://www.invo.org.uk/>

4. Specific information about this research project.

You may wish to speak to me (Jayne Samples) or my main supervisor (Dr Abigail Locke, The University of Huddersfield: telephone _____).

Contact details

Jayne Samples,

Senior Lecturer in Midwifery.

The University of Huddersfield, Queensgate Campus. Huddersfield. HD1 3DH

Telephone: 01484 473522

E-mail: j.samples@hud.ac.uk

5. Who you should approach if you have any problems or you are unhappy with the study.

You may wish to speak to me, my academic supervisor (Dr Abigail Locke, The University of Huddersfield, telephone: _____, email _____); or the Head of Midwifery (_____)

Alternatively you may wish to speak to either your midwife or doctor.

If you wish to make a formal complaint you can do so through the _____ NHS Trust complaints procedure (By telephone on: _____ (Monday to Friday, 8.30am to 5pm) or e-mail: _____).

Appendix 11 - Consent form

The pregnancy experiences of women aged 40 years and over.

Jayne Samples

Participant Consent Form

I have been fully informed of the nature and aims of this research and consent to taking part in it.

I understand that I have the right to withdraw from the interview/s at any time without giving any reason.

I understand that I have a right to withdraw my information if I wish although it may not be possible to remove or destroy all information that has been provided by me.

I give my permission/do not give my permission for an antenatal appointment to be audio recorded.

I give my permission/do not give my permission for my interview/s to be audio recorded.

I understand that the tape/s will be kept in secure conditions at the University of Huddersfield.

I understand that no person other than the interviewer will have access to information that will link me to the recordings.

I give permission to be quoted (by use of pseudonym).

I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.

Name of participant

Signature

Date

Name of researcher

Signature

Date

Two copies of this consent form should be completed: One copy to be retained by the participant and one copy to be retained by the researcher.

Appendix 12 - Topic guides

Topic guide for women (following antenatal consultation with a midwife).

The pregnancy experiences of women aged 40 years and over.

Can you tell me about your pregnancy?

How do you see your pregnancy going?

What do you think have been the most positive things about your pregnancy so far?

Do you have any concerns about your pregnancy?

(If yes)

Can you tell me more about these?

What are your concerns?

Why does this worry you?

(If no)

What has helped you to feel confident about being pregnant?

There are a lot of decisions to make about your pregnancy and birth – can you tell me about these?

Tell me about your last appointment with your midwife. How do you think that went?

Can you tell me about any ways in which you think that the care that you have had so far could be improved?

What do you think are the main risks relating to pregnancy?

Do you think that your age has affected your experience of being pregnant? Can you tell me about this?

Can you tell me about any other people that have been affected, or will be affected, by your pregnancy?

Is there anything that you would like to add to what we have discussed?

How did you find the interview?

Thank you for participating.

Topic guide for women (following antenatal consultation with obstetrician).

The pregnancy experiences of women aged 40 years and over.

How have things been since we last met?

How is your pregnancy going?

I'm interested to hear about your appointment with the doctor. Can you tell me about this?

What kinds of things did you discuss with the doctor?

What do you think were the most positive things about your appointment with the doctor?

Did you have any worries either before or after your appointment with the doctor?

(If yes)

Can you tell me more about these?

(If no)

What has helped you to feel confident about your pregnancy?

Did anyone else attend this appointment with you?

(If yes)

Who came to the appointment with you?

How did it make you feel about attending the appointment knowing that (this person) was with you?

(If no)

How did you feel attending the appointment alone?

Do you think that your age has affected your pregnancy so far? Can you tell me about this?

Can you tell me about any ways that you think the care you have had so far could be improved?

Is there anything that you would like to add to what we have discussed?

How did you find the interview?

Thank you for participating.

Topic guide for women (following the birth of the baby).

The pregnancy experiences of women aged 40 years and over.

Congratulations on the birth of your baby.

How have things been since your baby was born?

What would you say has had the greatest effect on this?

It's a while since we met when you were pregnant. Looking back, can you tell me what your pregnancy was like after that?

What were the most positive aspects of your pregnancy?

Did you have any concerns whilst you were pregnant?

(If no)

What helped you to feel confident about being pregnant?

(If yes)

Can you tell me more about these?

What were you concerned about?

Why did this/these things worry you?

Was there anything or anyone in particular that helped? If so, what or who was this?

Thinking about your experience, what would you say are the main risks relating to pregnancy?

Do you think your age has affected your experience of being pregnant and giving birth? Can you tell me about this?

Can you tell me about any other people that have been affected by your pregnancy and the birth of your baby?

Can you tell me about any ways in which you think that the care that you have had could have been improved?

Is there anything that you would like to add to what we have discussed?

How did you find the interview?

Thank you for participating.

Topic guide for midwives (following antenatal consultation with a woman).

The pregnancy experiences of women aged 40 years and over.

It is [amount of time] since your antenatal appointment with [woman's name]. I am interested to hear how you felt that appointment went.

What are the main factors that influence a woman's experience of pregnancy?

In your opinion, what influence, if any, does a woman's age have on her experience of being pregnant? (If some influence) How does this affect her care or the management of her pregnancy?

Are there any additional risks for pregnant women who are aged 40 or over?

(If yes) Can you tell me about these?

(If no) Why do you think that the NICE guidelines for antenatal care recommend that these women 'usually require additional care'?

Can you tell me what you think about risk assessment in pregnancy? How do you feel about deciding whether a woman's pregnancy fits into a high- or low-risk category?

How would you explain to a woman that her pregnancy falls into a high-risk category? In your experience, how do women respond to this?

Do you think that there are any ways that the care for older women could be improved?

(If yes) What would you recommend?

(If no) Why not?

Is there anything else that you would like to add to what we have discussed?

How did you find the interview?

Thank you for participating.

Appendix 13 - Responses to recommendations

Return copy

The pregnancy experiences of women aged 40 years and over

Recommendations for practice

1. Getting to know women

Relationships between midwives and women have the potential to be rewarding emotionally and socially. It is important for community midwives to spend time 'getting to know' and adopting a holistic approach to supporting older pregnant women and their families, rather than making assumptions about their needs based on perceptions of their lives, their health and prior experiences of pregnancy. This type of approach could enable community midwives to prioritise women's needs and build a relationship that is individualised, supportive and meaningful.

Comments

Woman – Totally agree, I feel that the newer trained midwives do not do this, but the longer trained midwives do

Midwife – This is relevant, but perhaps applies to all women

2. Balancing perspectives

Some older pregnant women can have a disproportionately high perception of the risks facing themselves and their babies, based on their prior experiences, perceptions of others and societal influences. Midwives and obstetricians can compound this by focusing on risk and risk reduction and prioritising service needs above women's needs. Enabling women to develop a balanced view of their risks by individualising information and valuing the benefits of being pregnant and becoming a mother at or beyond 40 may enable older pregnant women to have a more positive overall experience and to make the best choices for themselves and their families.

Comments

Woman – I had shared care at [hospital names]. I felt let down and ignored at [hospital name] with my concerns but listened to at [tertiary unit]

Midwife – I agree – there is generally too much focus on risk leading to negative experiences and impacts on care delivered

3. Enabling meaningful referrals

Whilst some older women value the involvement of obstetricians in their pregnancy care, for other women obstetric appointments can cause increased concern or confusion. By providing additional support in preparation for and following women's appointments with

obstetricians, listening to their concerns and clarifying any misunderstandings community midwives could help to maximise the benefits of these appointments. In addition they could identify and address any problems.

A sound understanding of local services, service providers and the flexibility to refer to the most appropriate practitioner can enable community midwives to provide information that will help women to choose an additional maternity care provider who will best meet their needs. Where women over 40 have no additional risk factors, sharing care with a consultant midwife rather than a consultant obstetrician could help to promote a normality focused experience for women rather than one driven by a focus on risk.

Comments

Woman – One major thing I found confusing was when speaking to my obstetrician because she has a strong [foreign] accent and I could hardly understand what she was saying. Leaflets are recommended in different languages

Midwife – What a fantastic idea

4. Time for supporting decisions

National guidelines (NICE, 2008) for women with uncomplicated pregnancies recommend a minimum number of appointments for pregnant women, although these guidelines acknowledge that there are women who may have increased needs such as women aged 40 or more. Midwives may offer additional support if women need this. However older pregnant women may not avail themselves of this support if they believe that the midwife is too busy, especially when extra discussions might be most valuable, such as early pregnancy around the time of screening and later in pregnancy when planning for labour and birth. Providing additional appointments, with the potential for women to opt-out, could give women the opportunity to share and address their concerns without making them feel like a burden.

Comments

Woman – Totally agree. Some women need more appointments than others. We all deal with later pregnancies differently. This should be discussed between mother-to-be and midwife

Midwife – My experience is that these women will attend additional appointments at drop-in sessions

Recommendations for education

Disseminating the findings of this research with midwives and other maternity care providers could enable them to understand and empathise with older pregnant women's hopes, fears and experiences, to anticipate and address actual or potential needs. In addition, these findings could be useful in planning for future maternity services.

Midwives' understanding of the small but increased risk of certain conditions for pregnant women aged 40 or over, appears to be formed mainly from their experiential learning - based on the women they have cared for. Increasing their awareness of a broader range of these conditions may enable them to support the increasing numbers of older pregnant women in their care with greater confidence.

Disseminating the findings from this study and information about pregnancy for older women at conferences or seminar presentations, in journal publications or via on-line resources will also increase understanding and awareness.

Comments

Woman – I think older women should be given leaflets on different disabilities and the long term affect with these and decide whether they could cope or get help in the future if they go ahead with the pregnancy

Midwife – I have never received any education on this subject and my knowledge is either self-educated or experiential

Recommendations for future research

1. Older pregnant women who are also parents to teenagers or adults can be anxious about the effect that their pregnancy and introducing a new baby into their family might have on these siblings. Exploring older siblings' views could provide information that might help their parents understand and support their needs.

Comments

Woman – leaflets on how to cope with your parents having a baby in later life would be ideal for teenagers

Midwife – N/A

2. Several women's partners were present during data collection and made interesting contributions although these were excluded in accordance with ethical approval. Gaining insight into partners' views could enable midwives to provide more holistic and family centred care.

Comments

Woman – totally agree – after all it's the man's baby too and he has a right to have a say in things

Midwife – N/A

3. This study did not directly seek obstetricians' views of older women and pregnancy or their care. However, their role played an important part in women's and midwives' understandings and experiences. Further research to explore obstetricians' views could enable women and midwives to understand their motivations and actions and contribute to further improvements in maternity care for older women.

Comments

Woman – I felt the obstetricians at [hospital] brushed away my concerns like I was a teenager having a baby for the first time

Midwife – This would be extremely valuable as the majority of women are on a high-risk pathway

4. Continuity of care and relationships between community midwives and older pregnant women play an important part in women's experiences of their pregnancy. However the nature of relationships between older women and hospital midwives may differ due to factors such as the philosophy of care and duration of the

relationship. Research to investigate the views of hospital midwives, in particular labour ward and screening midwives, regarding older women's childbearing experiences could build on the findings of the current study.

Comments

Woman – I was happy with care I got in the actual maternity ward and with my midwives at the GPs. I was unhappy with my pregnancy check-ups at [hospital]

5. Further research exploring the labour, birth and early postnatal experiences of older pregnant women from women's and midwives perspectives could build on the findings of this study and add to the growing body of knowledge around older women's experiences of becoming and being a mother.

Comments

Woman – Totally agree, more and more women are having babies later on now due to either second marriage or wanting to concentrate on career first

Midwife – Absolutely essential to direct considerations as to models of care women need to receive

Please return in the enclosed pre-paid envelope

Thank you

Jayne Samples

e-mail: j.samples@hud.ac.uk