



“This isn’t a high-risk body”:
Reframing Risk and Reducing
Weight Stigma in Midwifery Practice

***« Ce n’est pas un corps à risque élevé »
: recadrage du risque et réduction de la
stigmatisation liée au poids dans la pratique
sage-femme***

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ABSTRACT

This article investigates the standards of care for fat recipients of midwifery care through a lens that questions common risk-focused narratives related to fat pregnant bodies. Throughout this article, we use the term "fat" rather than "obese" or "overweight". We avoid the language of obese/overweight because these medicalized terms are used to stigmatize fat people. Working from a fat liberation standpoint involves reclaiming the word "fat" as a morally-neutral descriptive term for larger bodies. Drawing on data from a research project exploring weight stigma during pregnancy care, we present findings from eleven interviews with fat parents including those who identify as women or transmen who accessed midwifery care during their pregnancy and/or childbirth experiences. Participants had both positive and negative experiences with midwives, often within the same care relationship. Related to weight specifically, many participants reported that midwives focused on the risk factors often associated with being fat while pregnant, even when their clients did not display signs of these risks. We discuss how practitioners—particularly midwives—might shift away from an anti-obesity, risk-based narrative. Instead, practitioners might acknowledge the potential risks of fatness during pregnancy while simultaneously honouring fat individuals' embodied realities and treating fat clients with respect to facilitate positive pregnancy and birthing experiences.

KEYWORDS

midwifery, pregnancy, standards of care, weight stigma

This article has been peer reviewed.

RÉSUMÉ

L'article se penche sur les normes relatives aux soins prodigués par les sages-femmes à leurs bénéficiaires corpulentes sous un éclairage qui met en question les thèses axées sur le risque qui sont couramment énoncées au sujet du corps des femmes enceintes grosses. À l'aide des données d'un projet de recherche examinant la stigmatisation liée au poids durant les soins de grossesse, nous présentons les constatations découlant de 11 entrevues avec des parents gros, y compris ceux qui s'identifient comme hommes trans ou femmes et qui ont eu accès aux soins de sages-femmes durant leur grossesse et/ou leur expérience d'accouchement. Les participants et participantes ont connu des expériences tant positives que négatives avec des sages-femmes, souvent dans le contexte de la même relation de soins. Pour ce qui est du poids en particulier, de nombreuses personnes interrogées ont indiqué que les sages-femmes se concentraient sur les facteurs de risque qui sont souvent associés au fait d'être gros durant la grossesse, même lorsque leurs clients et clientes ne présentaient pas de signes de ces risques. Nous traitons de la façon dont les praticiens et praticiennes – en particulier les sages-femmes – pourraient délaissier un discours anti-obésité axé sur les risques. Les praticiens et praticiennes pourraient plutôt signaler les risques potentiels de la grosseur durant la grossesse, tout en honorant les réalités incarnées par les personnes grosses et en traitant leurs clientes et clients gros avec respect, afin de favoriser des expériences de grossesse et d'accouchement positives.

**Tout au long de l'article, nous utilisons, dans la mesure du possible, le mot « gros » et ses dérivés plutôt qu'« obèse » ou « en surpoids ». Nous évitons la terminologie « obèse/en surpoids » parce que ces termes médicalisés stigmatisent les grosses personnes. L'adoption d'un point de vue axé sur la libération de la grosseur implique la récupération du mot « gros » comme terme descriptif des corps plus larges.*

MOTS-CLÉS

Pratique de sage-femme, grossesse, normes de soins, stigmatisation liée au poids

Cet article a été évalué par un comité de lecture.

Fat patients experience weight stigmatization in various health care settings, and this has negative impacts on physical and mental health.

Literature about obesity and pregnancy assumes that obesity is an independent risk factor related to negative fertility, pregnancy, and birth outcomes. Midwifery, with its focus on client-centred care and informed choice, is well positioned to create safe, respectful environments for larger-bodied patients. This article reports on eleven interviews with obese individuals who identified themselves as women or transmen and who experienced midwifery care during their pregnancies. We report these findings alongside the Association of Ontario Midwives' Clinical Practice Guideline 12: The Management of Women with High or Low Body Mass Index and literature related to both risk and weight stigma in health care settings. We aim to widen a traditionally risk-focused lens by listening to the lived realities of pregnant obese people accessing midwifery care. We do not aim to “disprove” evidence related to weight and pregnancy but rather to suggest a shift in the frameworks used to engage with such clients by prioritizing competent, caring, safe, and respectful engagement, in line with midwifery’s general care approach.

From here on in this article, we use the term “fat” rather than “obese” or “overweight,” because these medicalized terms stigmatize fat people. Working from a standpoint of “fat liberation” involves reclaiming the word “fat” as a morally neutral descriptive term for larger bodies.¹

PREGNANCY AND BIRTH OUTCOMES

Risks associated with fatness and pregnancy are often presented as evidence that weight is the most

pressing consideration when a fat person becomes pregnant. However, there is limited research investigating how care frameworks and resources for fat patients are at least partly responsible for some of the risks traditionally associated with weight and pregnancy.² The broader medical literature indicates that weight stigma may contribute to risks traditionally ascribed to body size.³ There is room and justification to consider whether stigma also plays a role in the negative consequences correlated with higher weight during pregnancy, among them increased risk of gestational diabetes, a higher likelihood of the necessity for cesarean section, and macrosomia.⁴ We do not dismiss the seriousness of these possible complications; rather, we advocate investigating the lived experience of fat pregnant women to understand how these complications interact with the ways fat people are treated during pregnancy. We seek to understand the context of risk in light of contradictory evidence around what weight means for parent and child health.

We offer an example of the contradictory evidence surrounding risk to clarify the conflicting information that midwives and parents alike encounter. In the case of macrosomia, some studies report that fat pregnant people are more likely to have large babies.⁵ Other studies show that this may be true partially because obtaining an accurate fetal measurement can be more difficult when the client is fat, due to a lack of appropriate ultrasound equipment or skill in manual palpation.⁶ Rarely do investigators ask whether fat people are more likely to have larger babies because they are fat or

because imaging technologies and techniques are not adequately tested on or created for fat bodies, leading to delays in labour-inducing interventions.⁷ In addition, studies show that physical inactivity prior to pregnancy is a predictor of macrosomia, regardless of weight.⁸ Despite this, health care providers and research continue to focus mostly on higher weight as an independent risk factor for difficult pregnancy and birth outcomes such as macrosomia.

WEIGHT STIGMA AND PREGNANCY

Fat patients experience weight stigmatization in various health care settings, and this has negative impacts on physical and mental health.⁹⁻¹¹ In fertility and in antenatal and postpartum care, weight stigma may be linked to poor outcomes, including preterm births and higher rates of cesarean section.⁷ Additional outcomes include depression and increased stress, which can have negative impacts on the overall health of the parent and the fetus.⁷ Pregnant women report a wide array of negative experiences related to weight stigma, from dismissive care providers to misinformation and even to the refusal of care.¹²⁻¹⁶

Conversely, fat pregnant women who experience positive interactions with midwives' report feeling seen and heard, respected, and relaxed.¹⁷ Creating a positive pregnancy and childbirth environment requires that care providers examine their weight biases and take the whole person into account, beyond weight.

MIDWIFERY AND SIZE DIVERSITY

It is vital for care providers to feel competent and well equipped to work alongside patients of all sizes. However, midwives describe a lack of equipment to accommodate fat bodies, such as accurate ultrasound technologies, appropriately-sized wheelchairs and blood pressure cuffs, and hospital wards with toilet facilities that are accessible to fat patients.¹⁸ Midwives have also reported feeling uncertain about how to communicate respectfully with fat patients about their weight.¹⁹ This uncertainty results from a lack of skill in dealing with the anxieties that fat clients may have—*anxiety that is often the result of previous experiences with weight stigma in medical settings.*¹²

The field of midwifery maintains a number of core values, including informed choice and individualized care. In Ontario, the main practice guideline related to weight, developed by the Association of Ontario Midwives [AOM], is Clinical Practice Guideline 12: The Management of Women with High or Low Body Mass Index. This document outlines key research on various health outcomes for pregnant fat clients and makes recommendations for practicing midwives. Important, the practice guideline is not meant as a step-by-step guide but rather is to be used “in the context of clinical judgment and midwifery values” (p. 5).⁸ The guideline suggests supporting women in the context of their lives and using clinical judgment, which supports the notion that midwives could be key in advocating for competent and effective care for their fat clients and in helping to reduce weight bias in otherwise “fatphobic” medical contexts, such as hospital births or interactions with ancillary care providers. The research literature indicates that fat pregnant people experience weight stigmatization in health care settings. Whereas midwives, informed by clinical practice guidelines, are well positioned to provide respectful and stigma-free care to people of all sizes, they may be limited by a lack of appropriate skills and effective equipment for managing the care of fat patients.

METHOD

We sought to understand the lived experience of fat recipients of midwifery care, guided by the following research questions:

- What experiences do fat people have when they are working with midwives?
- What recommendations can be made for midwifery care to become more respectful and inclusive of fat bodies?

Participants

This study was part of an exploration of weight stigma in fertility and pregnancy care in three provinces. Participants were recruited by snowball sampling, along with outreach to pregnant and parenting individuals, community groups, and Internet mailing lists. There were 17 participants in the study's Ontario site: 15 women and 2 transgender men. The average age was 35 years. The majority of

participants identified as white, and one participant identified as Indigenous. Interviews were conducted by a member of the research team (A. L.) from 2015 to 2017 and were 20 to 60 minutes long. We analyzed interview data for all 11 participants from the Ontario site who had direct experiences with midwifery care. Research ethics approval for this study was obtained from the University of Manitoba, the University of Guelph, and Concordia University.

Data Analysis

Latent thematic analysis, guided by a feminist lens, was used to analyze the transcripts.²⁰ [Latent thematic analysis involves identifying patterns in the data and relating these to broader social discourses.] This approach allowed a deep analysis so as to provide a better understanding of the societal- and individual-level meanings of participants' experiences.

RESULTS

Good, Bad, and Confusing Interactions with Midwives

The study's participants—all of whom are referred to here by pseudonyms—reported both positive and negative experiences in midwifery care. Participants commented on the continuity of care that midwives provide, the longer length of appointments [compared to appointments with obstetricians], and greater control over health decisions. Megan commented, “there's a continuity of care, you actually get to know your midwives as people. So there's a familiarity. Your appointments are longer, so you do have that rapport built up; you know they're a phone call away.” Participants also noted that their midwives acted as advocates, even when the participants' care had been transferred to an obstetrician. As Scott commented, “[The midwife is] someone you consistently see through pregnancy and then birth and then until six weeks post partum, and they're able to form a relationship.” Similarly, Luke—whose pregnancy was deemed “high risk” because of a lifelong chronic illness—had a midwife on his care team as an advocate.

Out of my own luck in finding somebody who I think volunteered her time to do advocacy for me and just see

me. Because it felt grounding and community-based and important, even though she's not mandated to work with “high-risk” clients.

Specifically with regard to weight, some participants reported experiencing relief and positivity when they found a midwife who worked with a weight-neutral approach. Amber described her experience as follows:

I said, “Do you think that my weight in and of itself is a risk factor or issue for pregnancy?” And she said, “No, it's not. I'll test you the same way I would test anyone else.” So she was much more matter of fact about it. And I was confident with that.

On the other hand, participants also described negative experiences with midwifery care, particularly in relation to their weight. They described instances of midwives' not believing them about eating, exercise, and other behaviours, and of making assumptions about their health status based on body size. For example, Luke recalled his midwife's assumptions, based solely on his size, that he had or would develop gestational diabetes and preeclampsia.

The first midwife, the one I dumped, would say things like, “Well you know, you really should do the gestational diabetes test, because larger people are much more likely...” And I did test for gestational diabetes and was at the bottom end of the scale. She was, like, “That's surprising.”

Similarly, Cheryl described assumptions her midwife and other maternity care providers made about her.

It would really help if they stopped putting people in a box. I mean, I walk through the door, they assume I'm going to have a big baby, they assume I'm going to have gestational diabetes. They probably assume I'm going to have a c-section.

Rachel described feeling that her midwife and other maternity care providers were disgusted by her fat body. “I felt like that throughout my whole care no matter who I dealt with, whether it was a midwife or a physician...I felt like I was constantly being judged by my shape and my weight.”

Many participants felt they were subjected to ineffective equipment (e.g., for fetal monitoring) because of their size, as well as ineffective palpation to determine the approximate size of the baby. Cheryl, reflecting on her experience, said, “They wanted to make sure I didn’t have a 10- or 11-pound baby in there. Which again, if they were trained properly on how to palpate, they would be able to kind of determine that.”

Other participants reported a lack of information about post-cesarean section wound care that was specific to fat bodies. As Rachel reflected,

Keeping that area clean was also hard because my stomach always folded over the incision...and trying to keep that up and being educated as well from my midwives about how to keep it clean. It was very, it was really embarrassing, ‘cause it’s almost like you equate being fat with being unclean.

Other participants reported feeling unsupported in navigating breastfeeding. Cheryl commented that her midwife gave her inadequate breastfeeding advice that was not tailored to her body or her experience.

Women who are larger or women who have had a c-section, which I’m both, should be using the football hold to feed their baby, except nobody told me that.... [The midwife] was pushing the cross-cradle on me so much and it wasn’t working. And I was getting so defeated and so frustrated.

Generally, participants described a desire for a weight-neutral approach to midwifery care that was individualized and that did not rely on assumptions about their health. Cheryl summarized this desire as follows, referring to speculative health assumptions that are steeped in weight-based stigma as “these things”:

...I think projecting these things onto us just makes things so much worse. If you look at us with an open mind and say, “we’ll see what happens and we’ll just take it as it goes, and I’ll tell them the same things I tell somebody who would be 90 pounds,” that’s it, like, there should not be a difference.

Finally, Hanna summed up her longing for this kind of care by saying, “I think the biggest thing to take into consideration [is] a woman’s individual circumstances and her individual health...rather than making it black and white.”

Conflicting Care, Medicalization, and Deferral of Care

Because of their weight or health conditions, many participants under midwifery care were sent to other health care practitioners—mainly obstetricians and anaesthesiologists—for consultations. These consultations were often distressing and confusing for participants, in that the participants did not fully understand the reasons for the consult and did not know what to expect. Participants described many negative interactions with these other providers and reported feeling that the midwife had not adequately prepared them for the experience. For example, Hanna remembered that her consulting obstetrician “just kind of assumed that I would have high blood pressure or that I would have diabetes or all these funny conditions that I didn’t have.”

Many participants reported that their pregnancy and birth experiences were highly medicalized because of their weight. In addition, some participants experienced a refusal or deferral of care. For example, Lindsey wanted to have a midwife for her childbirth, but she was denied midwifery care because of her body mass index (BMI) despite not having any pre-existing or pregnancy-specific medical conditions. Lindsey recalled this experience as follows:

I went to [the midwife], and she checked my weight, and she calculated my BMI, and we talked about everything, like the type of care that we would get. And then, about a week later, I got a phone call from her saying, “sorry, I can’t take

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Midwives may require intentional education and hands-on training to provide a comfortable and inclusive care environment for patients of all sizes.

you on at this time. Because of your weight, you're high risk." I was really healthy through my entire pregnancy. So I could have gone under the care of a midwife. But they wouldn't take me.

Overall, participants described both positive and negative experiences with midwifery care. These experiences provide insight into how midwives may reduce weight stigma and create a more collaborative, inclusive approach for and with fat patients.

DISCUSSION

As our findings show, midwifery care could benefit from fully supporting the informed choice and overall care of fat patients. While midwifery care gave some participants positive outcomes (including advocacy, continuity of care, and in some cases, a judgment-free environment), participants also reported negative experiences. These findings, supported by previous research, indicate that midwives may require intentional education and hands-on training to provide a comfortable and inclusive care environment for patients of all sizes. AOM Clinical Guideline 12 lays out a care framework that supports a weight-neutral approach to health promotion in prenatal and pregnancy care. Our findings uphold previous research findings on the stigma, assumptions, and hyperfocus on risk factors fat people experience in pregnancy care and on the need for frameworks that emphasize compassion.^{12,14} Based on these findings, we offer three core recommendations for adopting an inclusive, weight-

neutral approach to midwifery care: [1] support of informed choice, [2] better collaboration with ancillary health care providers, and [3] education and advocacy regarding weight stigma.

Support of Informed Choice

A client or potential client's current health status should not be assessed by using BMI alone. Instead, in the interest of providing evidence-based and individualized care, midwives might discuss with the client the general risks of pregnancy and childbirth in a judgment-free environment. Fat pregnant individuals can be informed about the possible risks associated with weight and pregnancy; our participants' experiences highlight a desire for midwifery care that treats these risks as possibilities, not results that are taken for granted.

Better Collaboration with Ancillary Health Care Providers

Fat pregnant people are often sent for consultations with other health care providers to ensure that they are eligible for epidurals, intubations, and other procedures should the need arise. Participants often experienced a great deal of distress and stigma related to these appointments, a finding that is supported by previous research on weight stigma in health care settings.⁹ Midwives may consider collaborating with clients to prepare them for these additional appointments, sharing information about what to expect, fully explaining why the consultations may be necessary, and reserving such consultations for situations in which

they are medically indicated and not indicated by BMI alone. Midwives might also work with ancillary providers to advocate for their clients' needs and rights.

Education and Advocacy Regarding Weight Stigma

Midwives may consider training related to the lived experience of weight stigma (particularly in medical settings), as well as alternative, weight-neutral approaches to health promotion (e.g., Health at Every Size®). Further education may create more comfort for midwives in addressing issues related to weight and in reducing their own potential weight bias.¹⁹

One crucial component of education and advocacy is ensuring that midwifery clinics and collaborating hospitals have appropriate equipment (such as blood pressure cuffs and fetal monitors) for people of all sizes, as well as waiting room chairs, washroom facilities, hospital gowns, etc. that accommodate people of all sizes. Both our study and previous research indicate that fat patients commonly experience medical settings—including midwifery clinics—that do not accommodate people of their size.¹⁸ This lack of appropriate spaces and equipment is not only disrespectful but also potentially dangerous.

LIMITATIONS

This study had a number of limitations. Particularly in regard to those participants who received midwifery care and were therefore included in the analysis for this report, the study lacked racial diversity. It is important for future research to consider extending this study's findings by interviewing a larger population (including racialized and Indigenous people, in particular) that represents a broader diversity of lived experiences.

CONCLUSION

This study provides a unique opportunity for midwives to engage critically with the concept of weight stigma and to work to create more inclusive care environments for people of all sizes. This work requires education, collaboration with patients and with other care providers, and an ongoing

openness to questioning practices that may be perpetuating weight stigma.

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