



Researching Obesity

Sara Wickham offers an overview of four recent studies

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- [A qualitative study of the experiences of women who are obese and pregnant in the UK](#)
- ['Not waving but drowning': a study of the experiences and concerns of midwives and other health professionals caring for obese childbearing women](#)
- [From the womb to the tomb: obesity and maternal responsibility](#)
- [Higher caesarean section rates in women with higher body mass index: are we managing labour differently?](#)

As the editor of Essentially MIDIRS, a monthly journal for midwives, it is my happy task to read everything that goes onto the MIDIRS database (www.midirs.org) each week and to decide which articles, papers and studies I want to include in the Update pages of the journal.

I have begun by mentioning this because this task inspired a conversation with Nadine Edwards which in turn inspired me to write this article. I mentioned to Nadine that, over the course of a fairly short space of time, I had read four papers relating to obesity, all of which we had featured in our journal, but which I also felt were really relevant to the readers of AIMS Journal. (Note to self: remember, in future, that AIMS Committee members have been well trained in conscripting volunteers and rarely respond to such comments by saying: 'Good idea, Sara; I'll write that myself'!) I feel it is important to point out that I haven't done a systematic search of the literature; these are articles which I came upon relatively serendipitously, but all of them have something important to say about the current situation in maternity care as far as the treatment of larger women is concerned.

The first study looked at the experiences of childbearing women who are obese and pregnant in the UK [1 \(figure 1\)](#)

These researchers interviewed 19 women and you will probably not be surprised to see from the abstract that the women's experiences were largely negative, with feelings of humiliation, stigma and distress appearing frequently through their words:

'When you're listening to the heart beat and she's [the midwife] saying, "Which way's she lying? I think this way, but I have to dig a bit deeper with you." She just makes me feel awful for being big. It makes you think that you don't want to be pregnant and that you don't want to go if it's going to save you being told that you're fat. I already know I'm fat. That I don't need to be told.' [Furber and McGowan 2011: 439](#)

One area that emerged was the impact that what was written in women's notes could have. This is discussed in the abstract but also illustrated by several of the quotes from the women:

'Mums and aunties love reading through your notes don't they? I remember being embarrassed all the time cos it was literally written everywhere. They take the measurements to work out roughly how big the baby is, don't they? But on every one it was saying increased body mass index, overweight blah blah blah...' [Furber and McGowan 2011](#): 441

It would be nice to think that such studies will quickly impact upon the practice of professionals, but I imagine that most AIMS Journal readers will forgive me for being less than optimistic about the possibility that this situation will change quickly.

Figure 1: Furber CM; McGowan L (2011). A qualitative study of the experiences of women who are obese and pregnant in the UK. *Midwifery* 27(4):437- 444

Objective: to explore the experiences related to obesity in women with a body mass index (BMI) >35kg/m² during the childbearing process.

Design: a qualitative design was used. Data were collected using semi-structured interviews and field notes. Women were interviewed in the third trimester of pregnancy and between three and nine weeks after the birth. Transcribed data were analysed using framework analysis methods.

Setting: one maternity service in the North of England.

Participants: 19 women with BMI >35kg/m² **Findings:** these women highlighted their feelings of humiliation, and the stigma associated with being pregnant, when obese. Interactions with health professionals and the general public reinforced their discomfort about their size. The high risk status of their pregnancy increased the medicalisation of their pregnancy. The ultrasound scan was a significant source of distress if difficulties imaging the fetus were not clearly explained during the procedure.

Key Conclusions: pregnant women who are obese are sensitive of their size. The interactions with health professionals and others that they encounter may increase distress.

Implications For Practice: health professionals should be more aware of the psychological implications of being obese. Communication strategies about care should be clear and honest, and conveyed in a sensitive manner. Written comments related to size on 'handheld' notes should be explained at the time of writing.

The next of the studies[2](#) ([figure 2](#)) which was published in the same issue of *Midwifery* as Furber and McGowan's research,[1](#) throws some light on one reason why the situation may be as it is. This research looked at the experiences and concerns of health professionals who were caring for women who were obese. The study was carried out in Australia, but I imagine the experiences of caregivers in other

Western countries may not be that dissimilar. This study showed that participants (the vast majority of whom were midwives) experienced a number of tensions, and it highlights the way in which, while individual practitioners have to take responsibility for the way they speak to and treat women, a big part of the problem is the speed at which our society's focus on the 'obesity epidemic' has impacted upon systems of maternity care. This has left some midwives and other caregivers not knowing where to turn, as one midwife explains:

'The thing is that it's all become a problem in such a short amount of time, there's not been any provision to put any services in place. The most we've got is you see now signs around saying we've got big furniture, that's it. We've got big wheelchairs now. We've got big beds and we've got big this and that and the other. That's it, but it's not that there's actually any service, like having to see a dietician.' [Schmied et al 2011](#): 428

Whether having to see a dietician would be either a positive or effective service for individual women is a matter for debate, but the overall point is clear : midwives had no more warning that obesity was suddenly going to be perceived as the latest significant problem than anyone else, and they have struggled to adapt. The few educational sessions I am aware of that have been offered to professionals relating to this area have focused more on why obesity is a problem than anything else. The main emphasis in many locales has been on the creation of policies which ultimately restrict the choices of women who are labelled as obese and, perhaps as a result, midwives in this study 'identified a lack of skills and knowledge in communicating with obese women about their weight.'² One of the participants in Furber and McGowan's study also noticed how all the emphasis seemed to have been placed on furniture for larger women (which, she noted, she didn't feel the need to use). I am sure I am being overly simplistic here, but if each Trust would just use a fraction of the cost of one new bit of furniture to fund discussion sessions where midwives – who also come in all shapes and sizes – could sit alongside women and openly discuss issues of communication, language and dis/empowerment in this area, this would surely go a long way to helping everyone who is struggling with this issue?

Figure 2: Schmied VA; Duff M; Dahlen HG; et al (2011). 'Not waving but drowning': a study of the experiences and concerns of midwives and other health professionals caring for obese childbearing women. *Midwifery* 27(4):424-430

Objective: to explore the experiences and concerns of health professionals who care for childbearing women who are obese.

Background: obesity is increasing nationally and internationally and has been described as an epidemic. A number of studies have highlighted the risks associated with obesity during childbirth, yet few studies have investigated the experiences and concerns of midwives and other health professionals in providing care to these women.

Design: a descriptive qualitative study using focus groups and face-to-face interviews to collect data. Interviews were audio recorded and transcribed verbatim. Data were analysed using thematic analysis. **Setting:** three maternity units in New South Wales, Australia.

Participants: participants included 34 midwives and three other health professionals. **Findings:** three major themes emerged from the data analysis: 'a creeping normality', 'feeling in the dark' and 'the runaway train'. The findings highlight a number of tensions or contradictions experienced by health professionals when caring for childbearing women who are obese. These include, on the one hand, an increasing acceptance of obesity ('a creeping normality'), and on the other, the continuing stigma associated with obesity; the challenges of how to communicate effectively with pregnant women about their weight and the lack of resources, equipment and facilities ('feeling in the dark') to adequately care for obese childbearing women. Participants expressed concerns about how quickly the obesity epidemic appears to have impacted on maternity services ('the runaway train') and how services to meet the needs of these women are limited or generally not available.

Conclusion And Implications For Practice: it was clear in this study that participants felt that they were 'not waving but drowning'. There was concern over the fact that the issue of obesity had moved faster than the health response to it. There were also concerns about how to communicate with obese women without altering the relationship. Continuity of care, training and skills development for health professionals, and expansion of limited services and facilities for these women are urgently needed.

Of course, that idea assumes that it IS an issue that we should have near the top of our agenda, and I really don't want to make that assumption. For every issue that affects women (and perhaps midwives) on such a scale, there are usually social scientists willing to look more deeply at the social, ethical and philosophical elements of the debate, and **the third abstract³ (figure 3)** describes one such paper. McNaughton shows how there are some core assumptions at the heart of what she (rather generously in my opinion) terms 'obesity science' and that these assumptions are, not to put too fine a point on it, being used as a further means of monitoring, regulating and punishing women. I can attest (again from my very close relationship with the MIDIRS database) that there has been a massive increase in the number of papers which attempt to link obesity in pregnancy with obesity in babies and children and it is all too easy, especially while we are being constantly bombarded with messages about the extent of the problem, to forget that there remain some very important questions about whether there really IS a

problem.

Figure 3: McNaughton D (2011). From the womb to the tomb: obesity and maternal responsibility. Critical Public Health 21(2):179-190

In recent decades overnutrition and obesity have been presented as a looming threat to the health and wellbeing of children and infants, most notably in western industrialised societies. However, this threat is not simply limited to 'children' who are 'over fed' by their 'parents'. Increasingly, maternal overweight and obesity are said to inhibit conception, cause recurrent miscarriage, pose a serious threat to the development and health of the foetus and have long-term implications for the future well-being of the child. Parental responsibility looms large in these discourses, in which women in particular are held responsible for the future (fat free) health of their offspring from the womb to the tomb. In this article, it is argued that core assumptions at the heart of obesity science have been taken up uncritically in medical arenas focused on conception, pregnancy and reproduction and that this is providing new opportunities for the surveillance, regulation and disciplining of 'threatening' (fat) female bodies. It is shown that although all women of a reproductive age are being brought under the gaze of this deeply punitive medico-moral discourse, it is the bodies, lives and bedrooms of marginalised women that are singled out as posing the greatest 'risk' to their offspring and then targeted for even greater degrees of health/state intervention and surveillance.

On this note, I have become deeply concerned about some of the papers that report the birth outcomes of women who are labelled as obese, not least because I see how these women are treated differently in practice, as is also evidenced by the papers already mentioned. **So I was genuinely delighted to see this being addressed in the literature by the publication of the fourth paper⁴ (figure 4).** These researchers focused on labour (so there is still plenty of work to be done on the ways in which being constantly told that your shape is a problem during antenatal visits may impact women's sense of self and thus, for example, their ability to relax and labour well in the presence of a midwife who has previously insulted them or made them feel uncomfortable about their shape) and their results are fascinating. Women who had a higher BMI were more likely to be given an oxytocin drip and more likely to have an epidural – which we know is not always the woman's expressed choice but often something that is recommended to larger women in labour 'in order to reduce the risk of needing a general anaesthetic later should a caesarean section become necessary'. (Talk about being set up to fail!) Larger women were more likely to have an earlier caesarean section (and there is a notable and related decrease in instrumental deliveries) and the overall caesarean section rate is higher for these women – not just because they are 'at higher risk' (whatever that means) but because they are 'managed' differently by professionals, who, let's not forget, have been sold the message that being overweight is problematic and are thus probably more fearful when looking after larger women as a result. So all of the studies which show that being larger is more likely to lead to a caesarean section may be correct, but what Abenheim and Benjamin's study⁴ adds is the evidence that this may not just be because there are risks associated with being larger per se. Instead, professional and service perceptions that being obese is risky are causing individual

practitioners to practise differently when looking after larger women. This is probably one of the reasons that women such as those who were interviewed by researchers like Furber and McGowan¹ the authors of the first study I discussed, feel that their care is overly medicalised.

What a truly, horribly tangled web, and unfortunately I haven't spotted any papers which offer positive suggestions about ways in which we can begin to untangle it. What comes through for me – and I do hope that this doesn't sound defensive, because I absolutely acknowledge that there is plenty that individual practitioners can do to improve things for women – is that it is not simply about needing to educate or upskill professionals. It goes far deeper than that. At the root of all of this is the way in which obesity is perceived in our society, and, while I'm not suggesting that it is by any means an easy task, this is the issue that needs addressing. While the literature on this topic continues to spill out of every corner of the earth, it is no good to any of us if it continues to fail to address the core assumptions that are underpinning the work that is being carried out.

Figure 4: Abenhaim HA; Benjamin A (2011). Higher caesarean section rates in women with higher body mass index: are we managing labour differently? . JOGC [Journal of Obstetrics and Gynaecology Canada] 33(5):443-448

Background: Higher body mass index has been associated with an increased risk of Caesarean section. The effect of differences in labour management on this association has not yet been evaluated.

Methods: We conducted a cohort study using data from the McGill Obstetrics and Neonatal Database for deliveries taking place during a 10-year period. Women's BMI at delivery was categorised as normal (20 to 24.9), overweight (25 to 29.9), obese (30 to 39.9), or morbidly obese (= 40). We evaluated the effect of the management of labour on the need for Caesarean section using unconditional logistic regression models.

Results: Data were available for 11 922 women, of whom 2289 women had normal weight, 5663 were overweight, 3730 were obese, and 240 were morbidly obese. After adjustment for known confounding variables, increased BMI category was associated with an overall increase in the use of oxytocin and in the use of epidural analgesia, and with a decrease in use of forceps and vacuum extraction among second stage deliveries. Higher BMI was also found to be associated with earlier decisions to perform a Caesarean section in the second stage of labour. When adjusted for these differences in the management of labour, the increasing rate of Caesarean section observed with increasing BMI category was markedly attenuated ($P < 0.001$).

Conclusion: Women with an increased BMI are managed differently in labour than women of normal weight. This difference in management in part explains the increased rate of Caesarean section observed with higher BMI.

References

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