CONCEIVING STIGMA

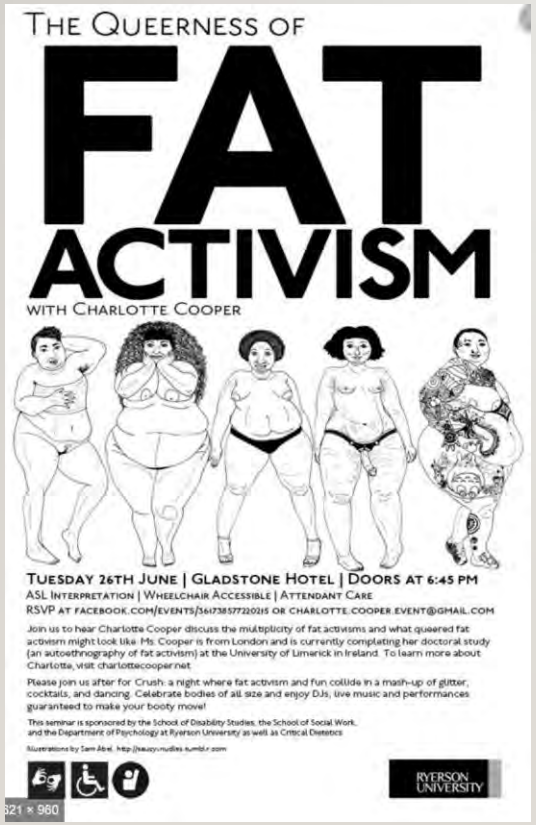
FAT WOMEN'S EXPERIENCES OF CONCEPTION CARE

DEBORAH MCPHAIL & LINDSEY MAZUR

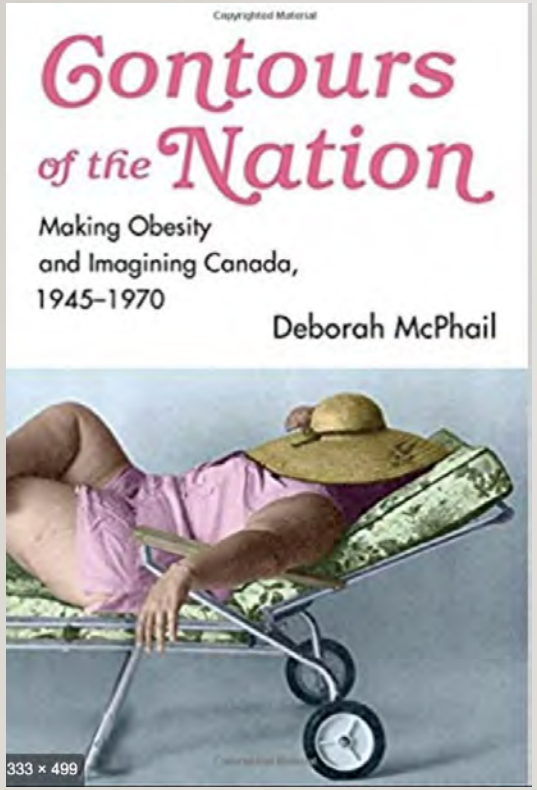
A NOTE ABOUT LANGUAGE

- Resignifying "fat"
- Questioning "obesity"

IN THE TRADITION OF…FAT ACTIVISM



FAT STUDIES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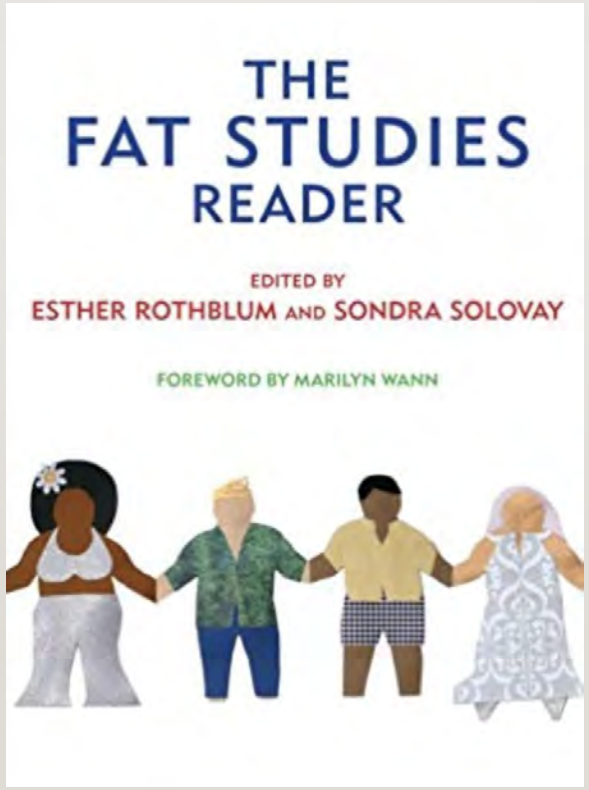
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EDITED BY
ESTHER ROTHBLUM AND SONDRA SOLOVAY
FOREWORD BY MARILYN WANN


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IN THIS PRESENTATION…

- This presentation delves into the conception stories of 25 fat women in Winnipeg

- These stories were part of the overall project, Reproducing Stigma, which explores the conception, pregnancy, and birth experiences of fat people

BACKGROUND: WHAT DOES THE LITERATURE SHOW US?

- pregnancy and fatness, as medicalized embodiments, come together in "maternal obesity" (Jette 2006, 2009; Lupton 2013; McNaughton 2010; Nash 2012; Warin et al. 2007; Warin et al. 2012; Weir 2006)
- the "obesity" of the (potential) "mother" is automatically transferred to the fetus, which is itself considered "at risk" for all sorts of ailments for which the pregnant person is held responsible
- such risk discourse is stigmatizing, who experience discrimination from (perhaps) "well-meaning" healthcare professionals who communicate that healthy pregnancies are impossible for fat people

WHAT ARE SOME OF THESE (PURPORTED) RISKS?

- Gestational diabetes
- Large-for-dates babies
- Increased risk of C-section delivery (and complications post-operation)
- Cardiac dysfunction during pregnancy
- Sleep apnea during pregnancy
- Organ system damage (such as to the kidneys) during pregnancy
- High blood pressure during pregnancy
- Infectious morbidity
- Postpartum hemorrhage
- Miscarriage
- Birth defects

RISK AND DISCRIMINATION WITHIN THE HEALTHCARE SYSTEM

- Risk discourse founds and helps to create experiences of discrimination within the healthcare system (Bernier & Hanson 2012; Nyman et al. 2008; Smith & Lavender 2011)
- interlocks with other systems of domination and oppression such as racism, colonialism, sexism, classism, homophobia/heterosexism
- But what are people's actual experiences, in their own words?

REPRODUCING STIGMA

- Interviewing people who identify as fat who have experienced: (attempted) conception, pregnancy, and/or birth
- Wanting to know their experiences of healthcare during these times

RECRUITMENT

- 4 research sites: Winnipeg, Montreal, Guelph/Toronto, UMaryland
- Recruitment occurred through social media, the hanging of physical posters, placing ads in community newspapers and kijiji, word-of-mouth and snowball sampling, and through attending mom-and-baby groups
- Some recruitment issues included a great deal of gatekeeping and resistance on the part of clinics

WHO DID WE TALK TO?

- Began data collection in 2015
- In Winnipeg, I talked to 25 people who had experienced reproductive care and 4 reproductive healthcare professionals
- 13 identified as white, 4 as Indigenous, 2 as Metis, 2 as Jewish, and 4 as people of colour. 1 identified as lesbian, 1 identified as pansexual. All identified as cisgender
- Within the second sample of 4 healthcare professionals, we interviewed 1 nurse, 1 physician, 1 dietitian, and 1 midwife
- Interviews were semi-structured and lasted from 45 minutes to 1.5 hours

WHAT DID WE FIND? SOME PRELIMINARY FINDINGS

In Winnipeg, participants told us about:

- Overwhelming communication of risk, creating stress and stigmatization in conception care, pregnancy care, and birth
- Medicalization of fatness and pregnancy – 2 states of embodiment that many argue need not be medicalized (histories of resistance, there)
- Indigenous participants experienced fat oppression always through the frame of ongoing colonial violence in the form of western medical practice (eg., the specter of diabetes, the evacuation of "high risk" pregnancies to urban centres)
- Denial of care – especially midwifery and conception care
- Resistance and negotiation of stigmatizing medical practice – asserting alternative or fat positive epistemologies and embodiments
- In quite a few participants who had histories of disordered eating, interactions with reproductive healthcare workers re-triggered some associated practices and thoughts

FOCUS: EXPERIENCES OF CONCEPTION CARE

- By conception care, I mean approaching a healthcare professional (usually a doctor) for support in conceiving a child
- This could be from a family doctor, gynecologist, or fertility specialist
- The type of conception care sought by participants depended upon income

A REFUSAL OF CARE OR DISCOURAGING CONCEPTION

- Participants were denied or deferred conception support
- If not denied, participants were often strongly discouraged from becoming pregnant while fat
- Risk discourse was operationalized to support this denial and discouragement

- Chantelle (lower-middle class, white)
- Was told she had to lose 10% of her body weight before fertility treatment could begin, bringing up for her a painful history of body-based bullying

DISCOURAGING CONCEPTION

- Much more subtle than an outright denial
- More like medical counselling for a "successful conception" and "healthy pregnancy"
- Based in the same discourses of risk and mothering as denial of care

DISCOURAGING CONCEPTION

- Breanne (Indigenous, middle class, straight)
- attempted to conceive for a number of years, bouncing from family doctor to family doctor trying to find one who would help her:

I had a lot over the years. It wasn't going anywhere. And then I had another doctor who, when I brought up trying to get pregnant, and that, you know, we weren't getting pregnant, he gave me a list of the reasons, he gave me a list of the things that being overweight, like, high blood pressure and not being able to carry the baby. I kind of feel like he talked me out of trying to get pregnant, or like, 'Maybe you should be using protection' kind of. 'Fat people shouldn't get pregnant.' *I really don't feel like anybody particularly wanted me to get pregnant.*

- *After by-pass surgery…*

I was afraid to get pregnant, because nobody would work with me on that part. I didn't feel like there was anybody around that even knew how to keep a baby from a gastric bypass person healthy, because, nobody seemed to know how to keep me healthy. If nobody understands my body, then how are they going to understand a baby inside of my body? All my doctor kept telling me was 'Your baby's going to have different nutritional requirements. You're going to have different nutritional requirements, and we just don't have the resources in Manitoba.' So, (laugh) either way [fat or newly thinner], I was going to be, like, damaging a baby if I had one.

DISCOURAGING CONCEPTION

- Janice (Indigenous, working class, straight)
- Gestational diabetes emphasized
- Risk of "squishing" the fetus, birth defects, heart issues

[the doctor] said I could get a severe case of diabetes. I can pass it on to my baby. …That's what he told me, like, just the weight and because I'm Aboriginal, I might get diabetes 'cause our system is a little different, our bloodline and so that could be a big problem too. And ah, that's what he told me about it.

DISCOURAGING CARE

- Certainly, the spectre of diabetes is specific for Indigenous people
- Indigenous bodies are not only hyper-associated with obesity, but also and relatedly with diabetes (Fee, 2007)
- Important to recognize the myriad of ways in which colonization has created and continues to exacerbate health issues in Indigenous communities, such as through the violent denial of Indigenous people's access to traditional lands and thus food sources (McPhail with Lavallee, 2016)
- conflation of indigeneity with obesity and diabetes ideologically helps to further marginalize and contain bodies in that it stereotypes Indigenous people as "too uneducated" and "too lazy" to practice so-called "good" health behaviours related to exercise and diet (Poudrier, 2016)
- In the case of gestational diabetes, whereby Indigenous people are being told as Janice was that they can "pass on" diabetes due to the double risks of fatness and their "bloodlines," such a discourse also constructs Indigenous women as inherently "bad (potential) mothers" due to the very blood and flesh of their bodies.

SUPPORTING CONCEPTION BUT FOCUSING ON WEIGHT LOSS

- Sometimes supporting conception while at the same time encouraging weight loss for and "easier time"
- Other explanations for fertility issues immediately ruled out
- Implied here: not only should fat people not have children, they *can* not

Patricia (white, middle class, straight)

P: [the gynecologist] just gave me this prescription for Metformin, and told me to start taking them and lose weight and she was going to send a referral to, um, the dietitian. She didn't explain anything. Like, the first thing she did was told me to strip from the waist down. She did a physical exam and then, you know, told me to get dressed and gave me a prescription. And she refused to basically, even, it seemed like the second she heard that we were trying to get pregnant, that's all she wanted to concentrate on, and nothing about what was actually going on, like, I hadn't had a period, but I haven't had a period in six years. Like, I, I'm having incredible cramping, and I'm in horrible pain. No, you just need to lose weight.

- Shaanvi (South Asian, lower middle-class, straight)

She was a good gynecologist. The only thing is, her thing was the same: lose weight. You won't really conceive. The good thing about her was she was much better than [family doctor] in explaining the situation. And, she also helped me talk to a nutritionist. But again, she was not willing to initiate fast enough. So in the meantime, I started exercising. I was already going for walks with my girlfriend every evening, but I added more workout in my schedule. That's what I did.

IMPLICATIONS & CONCLUSIONS

- Implications for care providers in healthcare – how do we avoid these highly stressful situations that cause health avoidance and poor health outcomes?
- In my previous work, I've been thinking about eugenics and its application to fat people's experiences of reproductive care

- This point has also been made by Cain (2013)
- Argues that "maternal obesity" discourse is an inflection of the "new eugenics," an "informal or unorganized eugenics that allows health practitioners to exert control over people producing offspring who possess or have the potential to possess [undesirable traits]" (McPhail et al., 2016)

EUGENICS: THE CONTEXT

- Anti-oppression, feminist, and anti-colonial scholars have shown how the working class, people with disabilities, populations of color, racialized populations, and Indigenous peoples, for example, have been targets at different historical moments of a wide variety of eugenic practices
- So-called "soft" and "hard" eugenic practices are outlined
- "Hard" practices include forced sterilization to "soft" practices include ideologies of "good" and "bad" mothering that ideologically and materially encourage some to reproduce while discouraging others (Bashford & Levine, 2010; Davin, 1978; Grekul, Krahn & Odynak 2004; Smith, 2005). The "new eugenics," as it's been termed, is "soft eugenics."

POTENTIAL EUGENIC PRACTICES IN THE STUDY

- The practices participants describe such as discouraging pregnancy or conception, the reliance on risk discourse, could be characterized as "soft" eugenics whereby discourses of "bad mothering" influenced reproductive health and decisions
- Refusal to begin fertility procedures could be characterized as "hard" eugenics.

WHY IMPORTANT TO THINK ABOUT THIS?

- Because of the conflation of ”obesity” with communities of people (working class, Indigenous, and racialized people) who have often been the targets of eugenic projects nationally and internationally (Bashford & Levine 2010). This is thus a historically based and crucial conversation about the ways in which race and class are literally reproduced – or not – in the name of “fetal” and “maternal” health and safety

- Thank you! Questions?