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Keywords: obesity, stigma, training, midwife, nurse, attitude, woman-centred care

Introduction

The management of obesity in pregnancy is high on the public health agenda and is identified as one of the greatest current issues facing midwifery (Royal College of Midwives, 2013).

Having a maternity care workforce skilled in providing optimal, person-centred care to women with obesity is of national and international concern. What is less certain however is how well this public health priority is currently being taught to student midwives. Keyworth and colleagues (2013), present unsettling evidence in this journal showing that student nurses, for example, not only hold negative but discriminatory attitudes towards patients diagnosed as having obesity; these students tended to see obesity as evidence of lack of self-control.

Sadly, these attitudes have also been reported elsewhere in the health professions (Phelan et al, 2015). A recent survey study using established stigma questionnaires found unacceptable levels of weight bias in student dieticians, doctors, nurses and nutritionists (Swift et al, 2013a). Regarding midwifery, both qualitative and quantitative research with midwives (Schmied et al, 2011; Mulherin et al, 2013) and pregnant women with obesity (DeJoy, Bittner & Mandel, 2016; Mulherin et al, 2013) show that weight stigma exists in maternity care.

Fillingham's et al (2014) review of training for caring of patient's with obesity concluded that training quality is low and there is uncertainty whether current training adequately equips students to care for patients with obesity. The need for a more sensitive approach to obesity management training is clearly urgent, as anti-obesity prejudices affect the quality of care pregnant women with obesity receive (Schmied et al, 2011).

Higher education institutions training midwives have a responsibility to ensure that the maternity care workforce in this country is suitably skilled in sensitive, appropriate and non-judgemental support for pregnant women with obesity. The aim of this commentary is to explore some of the complexities educators face when facilitating training in obesity and its

management. The ultimate objective of the paper is to raise awareness of the potential stigmatising effect current practices can have on pregnant women with obesity accessing the maternity care services. The proposition being made in this commentary is that the way we teach obesity management matters and that if improved, then ultimately, this would impact positively on pregnant women with obesity's experience of the maternity care services.

Teaching students about obesity and obesity management involves the teacher and learner confronting the thorny impasses inherent in any risk related health education. We argue that the impasses of obesity training revolve around four themes:

- The reductionism of the medicalisation of obesity
- The translation of epidemiological risk into woman centred care
- The implicit and explicit stigma underpinning obesity management
- The insensitivity of the language of obesity management

By exploring each of these themes in turn in relation to midwifery education, we hope to contribute positively to the growing literature around how health professionals could be trained to provide supportive care to individuals with obesity.

The reductionism of the medicalisation of obesity

By categorising a person's weight in terms of the pathological label of obesity, high body weight (which the individuals themselves may feel content with) is translated into a medical problem. Once defined as such, health experts are positioned as agents of change tasked with curing the identified pathology either through direct intervention – such as obesity surgery – or behavioural change – such as health education. This translation of something that was once considered to be a natural part of human diversity into a medical pathology is something

Illich described forty years ago (Illich, 1976). According to Illich's theory, the obesity epidemic might be described as a form of social iatrogenesis where the proliferation of diseases is caused by the extension of medical categories on everyday life.

Illich's work sits within a substantial body of literature that offers a robust critique of the medicalization process (Foucault, 1973; Wray & Deery, 2008). Central to this critique is the problematisation of the dualistic way in which mind and body are conceptualized in medicine and positivist research – reducing bodies to quantifiable machines that operate as passive receptors of health and illness, the levels of which can be accurately measured through the application of medical investigations such as BMI calculation. Recognising the power of the medicalisation of weight and its reductionist implications is therefore of great importance to obesity education. Furthermore, with the growing body of work, found in a broad array of academic disciplines, drawing attention to both the uncertainties of biomedical knowledge as well as questioning the effectiveness of some behavioural change interventions on obesity, it is essential that a critically informed approach underpins how obesity management is taught in higher education classrooms. No matter how well intentioned obesity interventions may be, they should never be considered to be socially neutral.

The translation of epidemiological risk into woman centred care

Central to understanding obesity is a thorough knowledge of the epidemiological features associated with the condition. In other words, those caring for pregnant women with obesity must be fluent with the risk profile it is associated with. In the case of maternal obesity, there are known links with residing in areas of deprivation, being unemployed and being Black African or Black Caribbean (Heslehurst et al, 2010). Such information is useful when assessing service needs and implementation of appropriate care planning. However, there are

implicit dangers with this approach that need to be acknowledged – namely, the fostering of a stereotypical and presumptive approach to obesity care. The implicit dangers of exploring obesity in the higher education classroom using an epidemiological lens are further exacerbated by the ‘inverse care law’. Evidence shows that health practitioners, including midwives, tend to engage more effectively with those individuals they perceive to be more receptive to their advice (Wanzer et al, 2004). Research with midwives suggests that there is an underlying sense of discomfort to care for pregnant women with obesity, with some midwives regarding caring for women with obesity a burden (Schmied et al, 2011). A vital part of obesity training therefore should include explicit references to the dangers of stereotyping and the inequity of health opportunity such attitudes can perpetuate.

The implicit and explicit stigma underpinning obesity management

Stigma originated in Ancient Greece to describe a physical mark made on the body of an individual that outwardly displays social undesirability. It was a mark to expose criminals, traitors, slaves and the like. Today stigma is in many ways less explicit but no less visceral and can be defined as a character or physical trait that is recognized as having low social value (Phelan et al, 2015), an attribute that is deeply discrediting. According to Phelan et al (2015), obesity is associated with two distinct types of stigmatisation: implicit and explicit. The first is an unconscious form of stigmatisation that could include non-verbal communication such as a midwife loudly sighing before trying to palpate the foetal position or providing less woman-centred care. Explicit stigma includes things such as where health professionals see obesity as evidence of lack of self-control or the perpetuation of the inverse care law through stereotyping. It has been suggested that in this context maternal obesity symbolises self-indulgence and moral failure (Schmied et al, 2011). Worryingly, other

factors adding to possible obesity stigmatisation can be found in many healthcare settings where chairs and medical equipment may not be available or appropriate for individuals with obesity (Phelan et al, 2015). Reducing weight stigma is the responsibility not only of health care providers but of health care education providers as well. By changing the way obesity is taught in the classroom to include the understanding of how stigma operates will, we hope, help stem the salience of such unacceptable practice in the future. Promising educational interventions include videos explaining stigma and its effects on individual lives (Swift et al, 2013b; Poustchi et al, 2013) and obesity training focusing on the behaviours related to obesity (Chisholm et al, 2016).

The insensitivity of the language of obesity management

Successful communication is an essential part of maternity care provision. Although not simply linguistic in nature, language forms an important part of communication and research has shown that the words that health professional choose to describe a situation can have a direct impact upon how an individual feels about their health (Phelan et al, 2015). That is, words can be very powerful (Berg, 1998). In the case of obesity management we have already established that it can be associated with stereotyping and stigmatization practices. There is suggestion that this goes down to the of level language choice. Phelan and colleagues (2015) suggests that insensitive language relating to obesity made patients anxious and upset. In other words, the label itself is a stigma. Understanding the power of words therefore is crucial to providing care without stigmatisation. It also means that practical strategies taken within pregnancy obesity training sessions could improve discussions about weight-related health with women, ensuring that communication is woman-focused.

For education, this may mean discussing what language and communication style to use when caring for individuals with obesity. For example, Swift and colleagues (2013c) found that students preferred using the word 'BMI' to 'obesity' with patients, with only a third opting to start this conversation in a proactive fashion. Effective communication is a cornerstone in the Nursing and Midwifery Council's Professional standards of practice and behaviour for nurses and midwives (2015) and it is an important part in nursing and midwifery teaching. Current guidelines from the UK's Association for the Study of Obesity suggests that individuals use people first language, i.e. 'adults with obesity' instead of 'obese adults' (using weight as an adjective) and critically consider what images they use in presentations (2015).

Discussion and conclusion

It is essential that midwives gain the necessary skills to successfully fulfil their public health role regarding obesity (Royal College of Midwives, 2013). Sadly, current evidence suggests that the embedding of meaningful obesity training into the higher education curriculum is in need of urgent development as practitioners are currently practising in ways that unacceptably discriminate and stigmatise. There are challenges in implementing obesity education within midwifery education that are not easily solved. What is clear however, is that we have an urgent need to develop effective obesity education (Fillingham et al, 2014). By identifying some of the complexities involved in obesity education, namely the problems around reductionism, epidemiology, stigma and language this commentary calls for action for both improvements in current teaching provision and further research into how obesity should be taught in higher education institutions.

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