Commentaries

Tipping the Scale: Reframing Maternal Obesity as Obesity Commentary

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In June 2014, the American College of Obstetricians and Gynecologists published a Committee Opinion for physicians on the ethical treatment of obese women. The six-page document directs physicians to care for obese women according to the basic concepts of ethical medical treatment such as respect for autonomy, nonmaleficence, beneficence, and justice. Because all patients should be treated with compassion and without bias, it is interesting that the American College is compelled to remind physicians of the guiding principles of ethical medical treatment in the case of obese women. Undoubtedly obesity is stigmatized across Western society; yet, no similar list of recommendations has been devised for treating the obese patient who is male, despite comparable rates of obesity among American men and women (33.3% and 35.8%, respectively). With major sections devoted to the "medical risks of obesity," the "increased resource utilization in the care of obese women," "counseling," "consultation and referrals," and "the physician relationship and barriers to good medical care," the College largely engages with material relevant to the care of obese patients of both sexes, despite limiting their discussion to women.

If physicians really are treating female obese patients in a more judgmental manner, as the creation of this June 2014 Committee Opinion implies, it is worth examining what exactly is more complex about the female obese patient as opposed to the male obese patient. Although male obesity is a topic of importance unto itself, this commentary exclusively focuses on females in order to explore the heightened anxiety surrounding the obese woman. Of course, women fundamentally differ from men in their sexual characteristics and their ability to bear children. Indeed, more recently, researchers have focused on the range of health problems that stem from women's obesity in the preconception and perinatal periods, a condition called "maternal obesity." Pregnancy is both a crucial period of growth for a fetus that shapes development for years to come and a time of significant physiological changes for a mother that can impact immediate and long-term health. Ironically, maternal obesity is not explicitly brought to the forefront by the American College of Obstetricians and Gynecologists, despite the fact that concerns about the negative health effects of obesity in the preconception and perinatal periods permeate the entire article. Recently, maternal obesity has become its own topic of scientific inquiry, generating a continuously growing body of literature on its risks and dangers; yet, most publications are of a similar nature as the aforementioned statement, continuing to call for physicians to measure women's pre-pregnancy body mass index (BMI) while only advising that women and their fetuses are at increased risk for medical complications without weight loss.

Maternal obesity negatively affects every stage of pregnancy and development. The preconception pathophysiological effects of obesity include subfertility and infertility, which primarily relate to ovulatory dysfunction, with women having a 4% lower pregnancy rate per BMI unit. Obese women have increased risks of spontaneous abortion and recurrent miscarriages, preeclampsia, gestational diabetes mellitus, infection, and thromboembolism. Additional intrapartum management considerations for obese women arise due to possible difficulties of fetal and uterine monitoring, prior to increased risks of fetal macrosomia and Caesarean section.

Obesity also impacts obstetric outcomes as fetal structures may be poorly visualized using ultrasound, and administering anesthesia is more difficult with higher rates of unsuccessful tracheal intubations and epidural failure. Children with elevated BMIs experience an increased risk of obesity throughout adolescence and into adulthood. Health regulators have not yet established clear recommendations for how the health burden of maternal obesity can be lessened. A 2010 guideline by the Society of Obstetricians and Gynaecologists of Canada directs physicians to treat the problem of maternal obesity by counseling obese women about their weight gain, nutrition, and food choices during pregnancy. In contrast, the American College of Obstetricians and Gynecologists' 2014 Committee Opinion urges physicians to go beyond "simply counseling a woman to eat less and exercise more" by practicing a "willingness to learn about the particular causes of a patient's obesity." While such recommendations are idealistic, they are not realistic. If a physician invests the time to learn about the complex and multifaceted causes of a particular woman's obesity in the preconception period, then he or she is left to devise unique treatments options without further recommendations by the Canadian Society or the American College. A lack of clinical guidance
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has characterized the problem of obesity in the preconception and perinatal periods: a 2012 review of the literature on maternal obesity finds that there are few guidelines that assist physicians in providing “the best possible care and support for this group of women.”

Given that the June 2014 publication calls for increased physician training on treating obese patients at all levels of physician education without clarifying effective strategies to treat maternal obesity, it is evident that the discussion around the management of obesity in the preconception and perinatal periods is ineffective in its current form. Considerable rates of unplanned pregnancies, workplace demands, and a lack of counseling by physicians in the preconception period all create barriers to the treatment of maternal obesity. According to self-reports, approximately 30-40% of pregnancies are unplanned in Canada. Exercise and nutrition programs specific for soon-to-be mothers thus possibly miss a significant portion of the population. For the reduced numbers who plan their pregnancies, the various challenges associated with healthy weight loss in a limited period of time may also constitute a significant barrier for conceiving at a BMI between 18.5 and 24.9 kg/m². Modern workingwomen have less flexibility in family planning than ever before as career aspirations often dictate tight timelines. It may not be realistic for a professional to plan a maternity leave for one to two years in the future; yet, this is how long healthy weight loss takes for some individuals. Physicians need to change how they engage women of childbearing age in discussions about pregnancy and maternal obesity. Because 49.8% of surveyed Ontario physicians report that their patients do not discuss pregnancy planning with them, it is evident that physicians and policymakers need to be proactive in starting the conversation about healthy family planning earlier.

Physicians do not have a large window during which to counsel their patients about pregnancy; however, for those who are successful in talking to a woman in the preconception period, less than 8% identify diet and exercise as topics of counseling. It is too late to counsel patients about maternal obesity during pregnancy as the negative health sequelae that stem from obesity cannot be prevented or reversed, only curbed through the reduction of gestational weight gain. The problem in treating maternal obesity in the preconception period thus seems to be two-fold: physicians cannot always engage with patients prior to conception but, when they do, only a minority discuss factors relevant to the treatment of maternal obesity.

Alterations in insulin resistance, glucose homeostasis, fat oxidation, and amino acid synthesis in an obese woman’s body affect the metabolism of her child, often times predisposing him or her to childhood and adult obesity. As a result of its effects on posterity, maternal obesity should be perceived as a trans-generational health problem. The recent demand for the ethical treatment of obese women (but not men) possibly stems from an apprehension that obese women are responsible for perpetuating obesity in our society. In actuality, policymakers, physicians, and patients all play significant roles in controlling weight; yet, collectively, we are too complacent about the obesity epidemic in our society. National strategies need to educate physicians and the lay public about curbing obesity throughout life in order to help both future generations and ourselves. The type of prenatal care discussed in papers on maternal obesity should actually begin as early as possible to give parents an opportunity to adopt healthy behaviors for their offspring. Given the difficulty that many obese patients encounter when trying to lose weight, parents should intervene when children or teenagers become overweight if they ultimately want help control the weight of their grandchildren. Canadians would be born with less of a predisposition to develop obesity themselves, and the trans-generational nature of this condition could be interrupted. Unfortunately, physicians do not sufficiently engage their patients in early discussions about maternal obesity: only 44-52% of physicians report counseling women of childbearing age about nutrition and weight management.

Maternal obesity should no longer be treated as its own facet of the obesity epidemic; the window for the preconception and pregnancy periods does not afford the time for adequate treatment. Because weight accumulates during the teenage years or even earlier, maternal obesity can only be stopped through prevention and behavioral changes when someone is obese, rather than obese and pregnant. Maternal obesity needs to tip us away from our tolerance of the obesity epidemic because we are no longer talking about our own bodies, but the health of our progeny as well.
References


