

**Labelled “high risk”
Exploring perception of risk during childbirth in
women with an increased BMI > 35kg/M²**

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BMI Classification (WHO)

Classification	BMI w(kg/m ²)	Risk of co-morbidities
Underweight	<18.5	Low
Ideal range	18.5 – 24.9	Average
Overweight	25 – 29.9	Mildly Increased
Obese	> 30	Increased
Class 1 (moderately obese)	30 – 34.9	Moderate
Class 11(severely obese)	35 – 39.9	Severe
Class 111 (Morbidly obese)	>40	Very Severe

- Obesity Global epidemic- tripled from 1975 – 2016
- Key area of public health : association with diabetes and coronary heart disease (CHD)
- 47% women booking in pregnancy within normal weight range (April 2015 – March 2016)
- 21% BMI>30 kg/m²
- CMACE/ RCOG (2010) Management of Women with Obesity in Pregnancy – discussion of associated risks at booking
- BMI classification – women **labelled high risk** in pregnancy
- Medicalised care pathway

Labelled High Risk

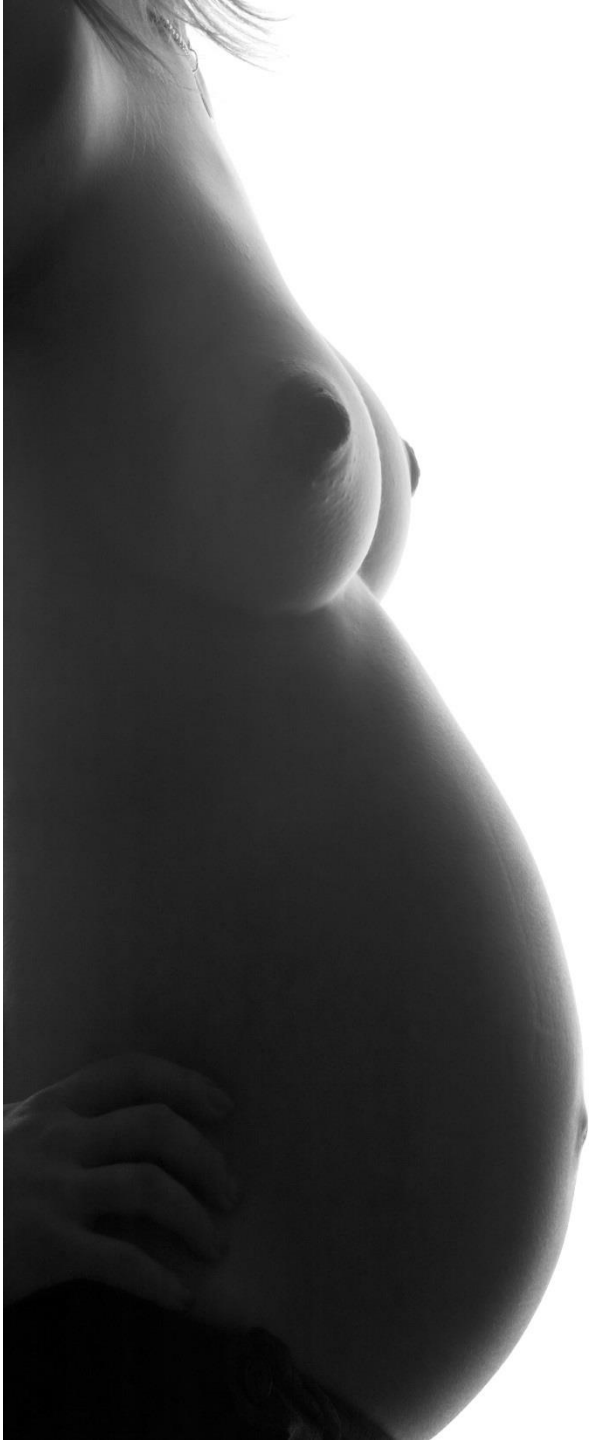
- Higher proportion of women who die in pregnancy/postpartum are obese (CEMACE 2011).
- Higher risk of miscarriage, gestational diabetes, thromboembolism, pre eclampsia.
- Increased risk of caesarean section , post partum haemorrhage, less likely to breast feed
- Baby has increased risk of : large for gestational age, stillbirth, congenital abnormalities, more admissions in to neonatal units(Scott Pillai et al 2013).
- Risks based on early pregnancy BMI (Heslehurst(2011)

Aim :

**To explore perception of risk during childbirth
in women with an increased BMI > 35 Kg/m²**

**To explore how their childbirth experience and
birth outcome impacts on risk perception over
the pregnancy continuum**

- Longitudinal study
- Interpretative phenomenological analysis (IPA) – data analysis
- IPA – phenomenology, hermeneutic and idiography



Recruitment & Data Collection



- Inclusion criteria : BMI > 35 kg/m² , over 18 years , able to speak and understand English, prim gravida or multigravida
- Exclusion criteria : unwanted pregnancy, fetal abnormality, known severe psychological disorder.
- Hospital Anxiety Depression Scale (1st visit).
- Recruitment from community midwives booking clinic.
- Risk discussion at booking
- Recruited 7 women
- Consent form & HADS questionnaire signed 3 – 5 days after wards
- Recorded semi structured interviews 20 wks, 34 – 36 wks and 10 – 15 days postnatal.
- Total 21 interviews

Birth Outcomes

- BMI range 35.9 – 43
- SVD = 2
- Emergency c/s = 3
- Elective c/s = 2
- Post Partum Haemorrhage = 2
- Pre eclampsia= 2
- Wound infection = 1
- Obstetric cholestasis = 1
- Birth weights > 4kg = 2
- Admission into neonatal units = 2
- Women breastfeeding = 2



- **Superordinate Theme 1**

- **Choice, Continuity and Control** – Felt labelled ,want to be in control V loss of control ,Fearing risk , feeling safe- welcomed medicalised surveillance, birth experience, continuity of care

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“They will try and put you down the consultant route”

“If they would let me carry him longer”

“ I did want to have a water birth.... That might not be an option,because i’m classed as high risk (Ellis, 18 – 22 weeks)

“ I’d rather go into labour ward where i know there is medical help if i need be” (Ellis, 34 - 36 weeks)

“They would force me to do something”



Continuity

- *“ My midwife was great . I thought it was great that having the same midwifeI really like that. I like ... so i could build a relationship you both trust.....It gave you reassurance ”*

(Stephanie, postnatal)

- “ My midwife’s brilliant but I just think that they’ve got to do checks, like the physical checks to make sure everything's fine. And that’s what they need to cover in that session so there is **probably isn’t enough time for all these other things.....** ”(Erin, 34 – 36 weeks)

- **Superordinate Theme 2**

Me and my body : Who me ? Obese? , Normalization of body size, Pregnancy legitimizes body shape, Feeling self conscious exposing my belly

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“ I don't feel massive ”

*“ I don't think I am that **chunky**, compared to some people... no, a little bit, but not, to some extent I know that I am **slightly overweight**, but compared to some other people who are extremely overweight and have loads of **fat** and big legs who can't get off the chair, that's not me. I get up every day, I work. I am like a normal person, just slightly bigger ” Ellis, 18 – 22 weeks*

“ ..do people actually know that I am pregnant or do they just think I'm fat ..”



- **Superordinate Theme 3**

No risky talk: Avoiding risky discussion, sensitive issue,
Health Promotion strategy

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“ I didn't ken because it's a sensitive subject, obviously , because it's usually people that are sort of bigger that they're.... It depends on how they come across... I don't know how they would put it across, but it's sort of, it's not what you say, it's how you say it” Anna, postnatal



- **Superordinate Theme 4**

Risk or no Risk : Risk and Emotion, recognition of high risk complications – finally sinking in , Accepting the risky body ?

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- *All participants at the end of this study rejected the Label “ high risk”*
- *All shared the same outcome : Live healthy baby*



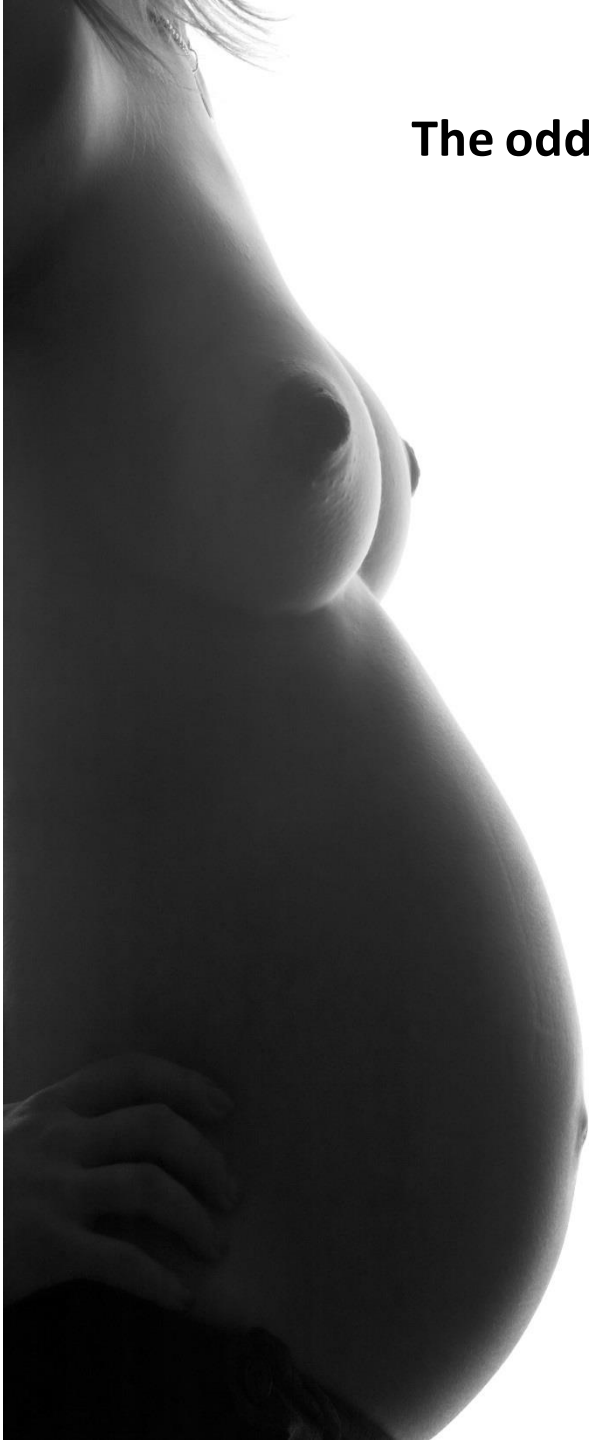
The odd ones : Negative case analysis

Participant 5 : Emily

“ ..when someone says high risk, it's , if they just said you're at risk, I would have probably been a lot calmer .But when they said high risk , **I was, going to die**, basically , my version of high risk “ 20 weeks

“ ... they kind of told you all the bad things and then didn't say , this is what could happen,it was, these are all the things that happened to people who have a high BMI and that was scary. But now i'm like , actually , **that's what can happen to some people** “ 34 – 36 weeks

“they say I'm high risk **but I don't feel like high risk** , if you know what I mean. Like at first I was like you know that's heart attack death, but now high risk is just more risky than anyone else “ Postnatal



Conceptual Framework

“My Risky Self”

- **Objective risk assessment** – women’s contrasting views
- **Me and My body** - Rejection of obesity label- avoided words *obese* or *fat*
- **No Risky Talk** – women not fully aware of the risks
- **Choice, Control and Continuity**
- **Psychometric paradigm** – dread factor/non dread and known / unknown
- **Unrealistic optimism**
- **Cognitive Heuristic**- representativeness and availability



Recommendations

- Health promotion needs to avoid self blame and stigma
- Increased awareness of complexities of obesity
- Midwives and other health professionals – requirement for training in communicating risk sensitively
- Involve women – real life experience
- Continuity of Care Midwifery Model – avoid the one size fits all approach
- Encourage breastfeeding

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