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Fat Studies

An Interdisciplinary Journal of Body Weight and Society

ISSN: 2160-4851 (Print) 2160-486X (Online) Journal homepage: http://www.tandfonline.com/loi/ufts20

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To cite this article: Deborah McPhail, Andrea Bombak, Pamela Ward & Jill Allison (2016) Wombs at risk, wombs as risk: Fat women's experiences of reproductive care, Fat Studies, 5:2, 98-115, DOI: 10.1080/21604851.2016.1143754

To link to this article: http://dx.doi.org/10.1080/21604851.2016.1143754

FAT STUDIES
2016, VOL. 5, NO. 2, 98–115
http://dx.doi.org/10.1080/21604851.2016.1143754

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Wombs at risk, wombs as risk: Fat women's experiences of reproductive care

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ABSTRACT

Using the Foucaultian concepts of biopower and biocitizenship, critical scholars of childhood "obesity" have shown how fat mothers are labeled as "risks" not only to their children, but also to the State. Such discourses are salient even for fat women who have yet to birth children, as fat women's "poor utero environments" are now imagined as "at-risk" spaces for babies particularly by the medical community. Critical theorists are only beginning to trace how such discourses of in-utero risk impact fat women who are attempting to conceive and who are pregnant. The authors add to this nascent scholarship by relating the results of a Canadian study exploring the weight-related healthcare experiences of fat women accessing reproductive healthcare while attempting to conceive, while pregnant, or while giving birth. Participants described how fetal risk was ubiquitously emphasized by healthcare professionals who continuously communicated fat women's unfitness as mothers. At the extreme, participants described experiences resonating with so-called "hard" eugenic practices, wherein participants were routinely denied certain procedures that would have allowed them to attempt conception, including the removal of birth control devices. The authors suggest, then, that current medical biopolitics of "maternal obesity" are one inflection of a "new eugenics" that not only produces and manipulates life, but also *prevents* it all together.

KEYWORDS

"Maternal obesity"; reproductive healthcare; risk; eugenics

In an August 2014 *Time* magazine online article titled "Obese and Pregnant," Alexandra Sifferlin reports on a diet and exercise program for fat pregnant women that will help reduce the presumed "risks" of what is called "maternal obesity." This intervention, the reporter notes, is integral because "obesity during pregnancy is a dangerous mix for both mom and baby." She continues: "A mother's obesity during pregnancy is linked to a greater likelihood for gestational diabetes, birth injuries, miscarriage, and a higher rate of C-sections." Sifferlin's report certainly does not emerge in isolation. A

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quick internet search for articles from the popular press generates titles such as "Autism Risk Tied to Mom's Obesity During Pregnancy" (CBS News, 2013) and "Pregnant, Obese…and in Danger" (Putam, 2015). Medical sources echo Sifferlin's warning of the same dire consequences including, through a type of in utero "genetic programing" called "epigenetics," eventual childhood "obesity" of the fetus (cf. Catalano, 2007; Pham, Brubaker, Pruett, & Caughey, 2013; Ross & Desai, 2014).

Fat studies scholars are beginning to articulate a counter discourse to the "maternal obesity" narrative presented in the popular and medical presses, arguing that it is an extension of the general panic surrounding "obesity" that is not only oppressive for those labeled "obese," but is also an overexaggeration of the certainty of the health risks attached to fatness. However, as Parker (2014) noted in this journal, "there is currently limited research that has examined what it is like for women classified as 'obese' to be on the receiving end of contemporary discourses and practices in reproductive health care that problematize – indeed that catastrophize – 'maternal obesity'" (p. 110).

This article begins to fill this gap in the literature. In it, we describe the results of a qualitative study exploring the healthcare experiences of women considered "obese" and "overweight" while attempting to conceive, while pregnant, and giving birth. Drawing on critical obesity scholarship, as well as on Foucaultian literature on biopower and biocitizenship, we show how "obese" and "overweight" pregnant and potentially pregnant women are regarded as constantly *at risk* and *as risks* to their fetuses by reproductive healthcare providers. These providers, we argue, exercise a type of biopower by not only producing and manipulating the lives of participants and their (potential) fetuses, but also in some cases by actually *preventing* life by refusing medical procedures that would allow a pregnancy to occur. We further contend that this type of biopolitics must be considered as an inflection of eugenics, whereby neoliberal discourses of risk are operationalized to not only discourage but to actively prevent a certain type of "undesirable population" from reproducing.

Before beginning, we want to address the fact that an article about fat women's experiences of reproduction may seem oddly placed in an edited collection about fat kids. The fact that childhood "obesity" is argued to be caused, in part, by the "excess" fat of mothers in utero, however, necessarily places this topic under the umbrella of "fat kids." After all, within the theoretical lens of biopower, what are kids if not potential citizens? As noted by Bethan Evans (2009), authorities have begun to anticipate childhood fatness and work pre-emptively to prevent and treat it in attempts to address the so-called surge in "obesity" rates. Such pre-emptive biopolitics, she argues, draw upon the affective potential of children, situating children as the future citizens who are in need of protection and surveillance. This serves

to reinforce and legitimize strategies and interventions that responsibilize not only children but the women who conceive and bear these children. Given that fat women are increasingly blamed for producing fat kids the pressure upon these women to regulate (meaning to reduce) their own weight even prior to conception is mounting (Denison & Chiswick, 2011; Heslehurst et al., 2008). Thus, the so-called problem of "fat kids" is simultaneously constructed as the problem of "fat mothers" leading to what McNaughton (2011) referred to as "new and disturbing opportunities for the surveillance, regulation and disciplining of 'threatening' fat female bodies" (p. 180).

Theoretical and literature review

Biopower

In this article, we draw on theories of fatness and biopower to make sense of our participants' stories of healthcare. There has been much discussion in recent years regarding how fat bodies are monitored and regulated through biopower and biopolitics (cf. McPhail, 2013; Harwood, 2009; Lupton, 2013). According to Foucault (1978), while the State no longer exerts power over life and death, it is now exercises biopower—the power to promote and preserve life. Biopower, as a type of disciplinary power, defines what is normal, what is desired, and is exercised through ongoing medicalization of life and surveillance of the population (Lupton, 1999). It is not a coercive force that is exerted on people by a sovereign state but is produced through the uptake and circulation of knowledges that are considered by subjects to be founded in some "truth."

At the same time that biopower is massifying and works on the level of population, it is also individualizing. As Foucault (1988) suggested, individuals are expected to take up normalizing practices, utilizing "technologies of the self" to discipline their bodies to fall in line with the norm. These technologies are produced and perpetuated within a neoliberal healthist framework in which health is constructed as a "supervalue" or ultimate life goal for which all individuals are responsible to strive (Crawford, 1980). The neoliberal "biocitizen" therefore is viewed as one that demonstrates a bodily discipline in striving to meet the objectives of the State by constantly undertaking disciplinary practices to achieve a "healthy" body as generally defined by biomedical science and public health. Importantly to our analysis, integral to these definitions of the healthy biocitizen is the socially constructed notion of risk. According to Crawford (2004), health risks highlight the dangers of not acting in "appropriate" ways to achieve health. Citizens are held responsible for becoming educated in risks and are expected to behave in a manner that actively reduces risks and potential for harm. In this era of the "obesity epidemic," in which fatness is coterminous with such health risks as cardiovascular disease, cancer, and other

chronic illnesses, subjects are expected to closely self-monitor and self-regulate weight (Lupton, 2013); indeed, such practices are integral to "proper" and good subjectivity and, related, "good" citizenship in Western states. The fat citizen is therefore a failed citizen (LeBesco, 2004; see also Elliott, 2007; Rawlins, 2008; Shugart, 2010).

Eugenics

This study relies also on poststructural feminist theories of reproductive embodiment and, related, theories of eugenics. For decades, feminist scholars writing in the area of reproductive embodiment have outlined the discursive and material containment of women's reproductive capacities with a focus on gender inequality (Beauvoir, 1952/1989; Chodorow, 1978/1999; Martin, 1987). Feminist poststructural scholarship, specifically, has focused on how women's sexed bodies are not only contained, but actively *produced* through systems of thought and social practices (Butler, 1999, 2003, 2004; Grosz, 1994; Oudshoorn, 1994; Longhurst, 2001, 2007; Shildrick, 2002). In her classic study of sex hormones, for example, Nelly Oudshoorn demonstrated how even the seemingly most asocial of reproductive materials, such as sex hormones, are produced through social processes, our knowledge about them changing over time to align with dominant sex/gender ideologies. Sexed bodies are in turn produced through this knowledge, as sex hormones have become synthesized into pharmaceuticals which can biologically alter the bodies of those who ingest them. Of great consequence for the study, this literature demonstrates that the ways we think of and talk about reproductive processes matter, in as much as they actively produce particular types of embodiments.

Eugenic practices are an example of this. The working class, people with disabilities, populations of color, "ethnic" populations, and indigenous peoples, for example, have been targets at different historical moments of a wide variety of eugenic practices—from so-called "hard" practices like forced sterilization to "soft" practices such as ideologies of "good" and "bad" mothering—designed to contain, regulate, and prevent their reproduction (Bashford & Levine, 2010; Davin, 1978; Grekul, Krahn, & Odynak, 2004; Smith, 2005). Eugenics, as Dikotter (1998) noted, have been implicitly gendered, as eugenic practices and policies have often targeted women's bodies, manipulating or, in the case of sterilization, actively constructing women's bodies through particular racist and classist notions of "fitness." Conceptualizing the concern regarding "maternal obesity" through feminist theories of reproduction and theories of eugenics allows us to ask questions about how "obesity" stigma and weight bias in reproductive care might be grounded in gendered, racialized, and classed ideologies about who should and should not be allowed to reproduce, about which bodies should literally be (re)produced and come to matter. Because the reproduction of "obese"

women is not only considered cause for concern but is also actively discouraged and curtailed, it makes sense to frame debates regarding "obese" women's reproduction in terms of eugenics (Jette, 2006; Jette & Rail, 2014). Such a contextualization is especially pertinent when considering that working class and racialized people are most often classified as "obese" (Lupton, 2013), and that these populations have often been the targets of eugenic projects nationally and internationally (Bashford & Levine, 2010). "Obese" women, then, face a very specific and significant type of stigma based not only on their body size, but on a long history of population control in Canada and other Western countries.

"Maternal obesity"

The intense concern in recent years about the supposed health risks of "obesity" has spilled into pregnancy and reproduction, and thus discussions related to risky "obese" maternal bodies have escalated (Parker, 2014). In the medical literature, "obesity" is thought to influence women's reproductive health in a variety of ways. "Excess" fat is thought to cause a reduction in fertility (Moran, Dodd, Nisenblat, & Norman, 2011), risks to the fetus including miscarriage and gestational diabetes (Catalano, 2007; Moran et al., 2011), as well as birth risks such as higher rates of caesarean delivery and induction (Catalano, 2007; Moran et al., 2011). Links have also been identified between maternal weight and the development of childhood "obesity" later in life (Catalano, 2007; Pham et al., 2013; Ross & Desai, 2013). These links are increasingly attributed to epigenetic changes (Heard & Martienssen, 2014), or changes in which the expression of genes are turned "on" or "off" by the external environment or health behaviors which could have occurred generations past without alteration to the underlying gene pattern. Through an epigenetic lens, the wombs of "obese" pregnant women are sources of epigenetic change that produce fat offspring due to the adiposity of the (potential) mother or grandmother (e.g., Katzmarzyk et al., 2014; Li, Sloboda, & Vickers, 2011). More controversially, some scientists argue that environments and health behaviors can be transmitted to even more distant ancestors (Heard & Martienssen, 2014). Thus, a fetus can be genetically programmed to be fat from birth, due to past generations of women who have supposedly eaten too much and exercised too little.

While risks thus seem extremely high for "obese" women and their (potential) fetuses, the medical literature on "maternal obesity" is in fact not conclusive. Some studies indicate little risk to the fetus associated with "obesity" (Adams, Hastert, Huaung, & Starr, 2011; Burstein, Levy, Mazor, Wiznitzer, & Sheiner, 2008; Khalil, Saleh, & Subhani, 2008). Other studies question the link between "maternal obesity" and childhood "obesity" (Beyerlein et al., 2012; Hinkle et al., 2012; Ode, Gray, Ramel, Georgieff, &

Demerath, 2012). In addition, and importantly for our study given the high degree to which gestational diabetes was highlighted by participants, some research has argued that weight status and gestational diabetes are not well linked in all populations (Winhofer et al., 2015).

Critical interpretations of "maternal obesity"

While medical literature is convoluted and contradictory and thus in essence critical of itself, fat studies scholars are also beginning to provide a critique of "maternal obesity" discourse. In the main, this work comprises discourse analyses of public health, biomedical, and popular press texts, and argues that the hypersurveillance and control of "obese" women's reproduction is an extension of two highly problematic sets of discursive technologies: first, those surrounding women's reproductive capacities, pregnancy, and risk; and, second, the more generalized concerns regarding fat and "obesity" risk (McNaughton, 2011). Feminist scholarship on pregnancy and risk argues that through the overlapping rubrics of fetal risk and "mother blame" (Ladd-Taylor & Umansky, 1998), pregnant women's bodies, regardless of weight and size, are ubiquitously governed and intervened upon, and any fetal stress or potential "abnormal" development is blamed on the "poor uterine environment" of the pregnant woman. The woman's personhood is sacrificed for the good of a healthy birth of a new citizen. Writing about "maternal obesity," Warin, Zivkovic, Moore, and Davies (2012) argued that this mother blame is particularly and increasingly problematic during a new era of epigenetics, in which it is imagined that women pass on their "obesity" *genetically* to their children and grandchildren. Echoing Warin et al., Cain (2013) goes as far as to argue that given epigenetics, "maternal obesity" discourse is a new inflection of eugenics in that the "obesogenic womb" and hence "obesogenic mother" is culturally imagined as bad or toxic and produces "a child of lowered quality, in terms of health, behaviour or achievement" (p. 5; see also Jette & Rail, 2014). Further, considering that racialized and working class women are most often positioned as those most likely to "mismanage risk" within "obesity" discourse (McPhail, Chapman, & Beagan, 2011; Fee, 2009; Herndon, 2009), Cain's work led us to consider how discursive practices of "maternal obesity" continue notions of "racial fitness" and "racial purity" that have, as we outline previously, founded eugenic projects of the past.

In addition to providing critical discourse analyses of "maternal obesity," scholars are also beginning to trace the impact of these discourses on pregnant women. For example, Harper and Rail (2011) have found that pregnant women's anxieties and concerns about being "good mothers" are much informed by mainstream "obesity" discourse. However, participants in Harper and Rail's study were not themselves "obese." A few researchers have

also begun to explore the experiences and effects of "obesity stigma" on "obese" women in reproductive care (Bernier, Hanson & Barber, 2012; Smith & Lavender, 2011). This scholarship shows that fat pregnant women's experiences with healthcare workers result in high levels of emotional and psychological distress (Nyman, Prebensen, & Flensner, 2010; Smith & Lavender, 2011). While this research demonstrates important relationships between stigma in reproductive care and health outcomes, it is ultimately focused on "obesity" reduction, and thus risks reifying "obesity stigma" because it positions "obesity" as unhealthy or wrong and therefore "obese" women as Other. Thus, it is crucial to expand the field of research that critically approaches "obesity" and that explores the experiences of women regarded as "obese" as they navigate "maternal obesity."

Methods

This article is based on research three of the authors (McPhail, Ward, and Allison) conducted in 2012–2013 in two mid-sized cities in Canada: Centreville and East River (for the purposes of anonymity, these are pseudonyms). The study was conceived of as a pilot to a larger study now underway. As such, recruitment targets were limited. Informed by the small literature showing "obesity stigma" in reproductive care, we wanted to know how this stigma was experienced by patients and enacted by health professionals, and how it affected the lives and identities of women. In the research described here, we employed a poststructural feminist approach to research which has at its core the explicitly political goals of gender equity and social change (DeVault & Gross, 2012; Jaggar, 2014). Such an approach incorporates Foucaultian theories of discourse, therefore regarding research data not as straight-forward, unadulterated accounts of experience (Haraway, 1988; Scott, 1991), but as reflective of the social discourses which produce, frame, and give meaning to social relations. We therefore regarded the research encounter between researcher and participant as a place where discourses were told and retold (DeVault & Gross, 2012), and where reiterations of socially organized discourses were expressed, negotiated and resisted.

We interviewed a total of 24 women who had accessed healthcare while attempting pregnancy, during pregnancy, giving birth, or some combination of the three. Eighteen participants were from Centreville, and six from East River. While we had hoped to interview an even number of women in each city, recruitment was slow and difficult in East River due, perhaps, to the resistance from some healthcare and medical practitioners we encountered while recruiting there. Posters were ripped down and our requests to advertise in medical spaces were routinely refused.

Participants were recruited through postering in key venues (e.g., medical clinics, women's hospitals, community centers), notices on listservs, and snowball sampling. Although participants were recruited broadly, with the exception of two Métis participants (people of French and Indigenous decent), one of whom was working class and lived with a disability, and another working class participant, participants in this study were all white and middle class. Two women identified as queer (part of the LGBTQ community). The homogeneity of participants is a major shortcoming of the data that we are attempting to rectify in the larger ongoing study. We interviewed participants once for approximately one hour each using semistructured interviews including questions about experiences with all types of reproductive healthcare professionals such as midwives, nurses, nurse practitioners, family doctors, obstetrician/gynecologists, and ultrasound technicians. We recorded interviews with a digital device, and the digital file was transcribed and anonymized by a professional transcriptionist. Pseudonyms were later assigned by the researchers. Transcripts were coded using NVivo (QSR International) by trained research assistants and Bombak for emerging themes based on a code list compiled by the research team. Coded transcripts were compared and then re-read to identify themes. Once these themes were identified, the researchers read and re-read passages within to identify social discourses and participants' living and resisting of them, whereby we discovered in particular the ubiquity of discourses pertaining to risk and mothering.

Findings

Consistent with the literature, women in all stages of reproductive care under study were made to feel as either *at* risk for potential problems or *as* risks to fetuses or potential fetuses. Such an assigned subjectivity—"risky"—had a variety of consequences for women up to and including the denial and deferral of care by healthcare providers.

Women at risk

Participants were sometimes warned that pregnancy at their size constituted a risk to their own health, concentrating in particular on infertility, gestational diabetes that would cause larger babies and thus difficult births and C-sections, greater risk of infection following C-section, and cardiovascular complications. For example, Gerry, a Centreville participant, had just made her first visit to a fertility clinic at the time of our interview, not because she had a history of infertility, but because she was queer-identified and was considering accessing donated sperm through the clinic. Gerry described her

first appointment as "horrifying." After an examination, the specialist immediately began to outline his concerns regarding Gerry's weight:

> He's like "So let's get down to the reality here, okay? Gals your size, okay, mortality rates are higher. …Okay? We're talking about more complications. We got high risks of - blah, blah, blah." And he's like, this and that, and he's tossing it around. And I'm just staring right at him, like, "Wow, this is phenomenal." And then he says… "So I go ahead, and intervene, help you get pregnant here. Then you go down to [birthing ward]. And then, boom! Pulmonary embolism. I've gone and started off a series of events that I now can't retract."

Thus, Gerry's story demonstrates an overall pattern in the data whereby healthcare practitioners sometimes focused on the risk to women themselves. Most often, however, women were positioned *as* risks to their (potential) fetuses.

Women as risks

Women in our study were warned primarily of miscarriage and stillbirth, developmental delays and birth defects. Samantha from Centreville, for example, dreaded her appointments with her obstetrician because she was made to feel as if she posed a danger to her child:

> as the weeks went on and you know the possibilities of more complications that could come up because you're bigger. … Like, it was always something massive. … And so I just felt, like, obviously, you know, I have brought this whole black cloud upon the situation, because of my weight. … And it was all based on the bigger you are, the more trouble you are. The bigger you are, the more dangerous you are to your child.

It was very clear to participants, then, that they were "risky bodies" who posed fetal danger. What was less clear to them, however, was *why*. Almost consistently, participants were not given details or sometimes even basic information about how their higher weights could cause harm.

Christie, for example, was told by her fertility specialist that her body mass index (BMI) was negatively impacting her fertility, with no rationale: "I did enough research to know that weight does affect fertility. I've done all my own reading. I was never told why by [the doctor]." Centreville participant Cheryl related her first appointment with her obstetrician:

> The first thing she said to me was "You know, you need to lose weight." That was the first thing she said to me. And I was like "Okay. You know, don't you generally end up gaining weight when you're pregnant? I don't know that I can [lose], but I'll try." …I got weighed every week. She was very angry with me when I gained one week. She [said] the heavier I was, the highest risk my pregnancy was. …There was no, no discussion as to what the risks were, what, you know, could happen. … And she never really said that there was any possibility that I could not be high risk.

Thus, even as medical discourses of "obesity," pregnancy, and risk have been critiqued by fat studies scholars, our participants wanted to know what the risks actually *were*, in part so that they could regain some control over their bodies and experiences of conception, pregnancy, and birth, to lessen the experience of feeling, in Centreville participant's Samantha's words, "like an *it*."

Consequences

The "high risk" label brought with it a variety of healthcare practices that participants sometimes experienced as punitive or even traumatizing. In addition to sometimes giving birth on the "high risk ward" of hospitals, in which recovery rooms were not private and patients were highly monitored, participants in Centreville described how their weight could limit access to midwifery care as midwives may be required to transfer "high risk" pregnancies, including those involving "obese" women over a BMI of 40 with "related complications" such as gestational diabetes, to obstetricians (College of Midwives, 2011). Those who managed to retain a midwife were highly aware that they could lose their healthcare provider at a moment's notice. For example, Roberta related her story with her midwife:

> I was like point zero one over the limit of what your fasting blood sugar can be, which triggered like an endocrinologist visit, like, all kinds of stuff. And I am certain that if it had been somebody else who was skinny that I would not have had to do all that shit. I never had gestational diabetes. My sugars were never a problem [after that]. I felt like I was being targeted because I was fat. I felt like I was going to lose my opportunity to have a midwife deliver my baby. Because if my sugars had been bad …they won't deliver my baby.

As Roberta was a health practitioner herself, she understood the significance of her "sugars," and felt that such a small variation was not all that significant and yet was treated by her midwife as if it was.

Participants were also denied other types of care and procedures. Those attempting to access fertility care in both research sites were routinely told to leave and return after having lost weight. This was particularly frustrating for patients who had been on the clinics' waiting lists for up to two years. Often, patients were turned away without any sort of examination which would have potentially determined whether weight was in fact at the heart of their fertility issues. Marjorie's experience in East River exemplifies this. Marjorie had been referred to a fertility clinic after surviving cervical cancer. The cancer treatments had resulted in vaginal stenosis, a narrowing of the vagina, as well as irregular periods. Despite this, Marjorie was told from her very first consultation that her high BMI was the culprit:

> The first, first thing was weight. And there was no conversation of vaginal stenosis, which was a big issue for me to get pregnant. I brought it up and it was like, just shut down, it was the weight. And I had said "But I had gotten pregnant twice." And it was back to the weight. … So they had said "We can't do anything for you until you lose thirty pounds. You've got till September."

As a result of this care denial and deferral, participants sometimes began weight loss and maintenance practices that they described as "unhealthy," that they would not otherwise have done. For example, Easter River participant Hillary, who was initially denied care at a fertility clinic, undertook a weight loss regime that she described as "not healthy" including a starvation diet with periods of binge eating, excessive exercise, and sweating off "water weight" in the sauna in order to begin her treatments.

While fertility specialists routinely denied fat women the chance to reproduce, this denial of care was not limited to fertility clinics. Shelley from East River related an emotionally intense and traumatic experience involving perhaps what was the most egregious example of a denial of care in our study, in this instance involving her longtime family doctor:

> I had had an IUD placed. And I wanted to have it out, and [my doctor] refused. She said that at my weight, it would be a disaster if I got pregnant. … So it was probably a year of me going and saying "I really want to take this out." And, her just saying "Absolutely not." …So I called Planned Parenthood one day. I went there, to get it out. And I was crying. I went into that appointment thinking that I was going to have another doctor tell me that I shouldn't do it and I must be crazy. …And she realized I was crying and she said "You know, are you okay?" And I said "Well, you know, I'm just, I want to have a baby." And I was lying down, and I figured "Maybe she can't tell that I'm four hundred pounds." And she came up by me, and she said "Of course you want to have a baby. What's wrong?" And I said "Well, my doctor wouldn't take this out." She said "Okay. What am I missing?" I said "What do you mean?" She said "Well, what's your health, like, high blood pressure?" I said "No." "How's your blood sugar?" I said "Pristine." … And she said "Do you smoke?" I said "No." And she was like, "Of course, you've got every right in the world to want this." And she was rubbing my arm and that made me cry harder. And she took it out.

Thus, though she was at first refused the chance to conceive by her first family doctor, Shelley eventually received the care she requested from a doctor who, ironically, deployed another inflection of neoliberal health governance related to smoking cessation and pregnancy (see Bell, Salmon, & McNaughton, 2011) to determine Shelley's fitness to reproduce.

In Shelley's experience, and indeed in all participants' experiences, the outright denial of the chance to conceive communicated and materialized the idea that, because of their weight, participants did not "deserve" to be mothers. In fact, the need to negotiate with moralities and expectations surrounding what a "good mother" should weigh permeated almost all interviews and was perhaps the most greatly experienced consequence of the

"risky" label—the consequence of being labeled a "bad (potential) mother." When asked what the implications were of being turned away from the fertility clinic because of her weight, Gerry stated: "obviously, that I don't care about the fetus, right? You know? That's what I took, right?" Gerry very much resisted this messaging, asking: "like how much control do I really have over the outcome of a fetus?" Other participants were also highly resistant to this discourse. Samantha stated, for example, in answer to the question of what advice she would give to healthcare practitioners in working with women they perceive as "obese":

> Some people will never understand what it's like to be bigger. And, they won't understand what it's like to be bigger and to be pregnant. Like, you're the same as everyone else. You just have a few more things to consider, you know? I don't consider myself a bad mother because I got pregnant when I was bigger. I don't consider myself to be a bad pregnant person because I was bigger.

The discourse of "obese" women as "bad (potential) mothers" was therefore soundly rejected by most participants, even at the same time they often had little or no control over its consequences.

Discussion and conclusion

"Maternal obesity" risks communicated to women thus had consequences which were lived on, in, and through the bodies of participants. These consequences are the lived realities and materialities of stigma. It is a stigma borne partially (but of course not completely) in the certainty that fat pregnant women have failed not only as citizens within the biopolitical contexts of health, risk, and citizenry, but also have failed in their time as "vessels" to potentially healthy citizens. Given that some women were actively denied care and thus the chance to have children, however, we would also argue that one consequence of inhabiting the risky body of "maternal obesity" discourse lies in *im*materiality, in the denial to materialize a new potential citizen through reproduction. Preventing "obese" women from reproducing whether through the denial of fertility care, the refusal to remove birth control devices, or the mobilization of "bad mothering" discourse is, we argue, an important example of how contemporary biopolitics not only produce and organize existing life, but can also prevent it. It is also an example of how contemporary biopolitics of "maternal obesity" can in fact operate as a form of eugenics.

Primarily, the practices participants describe could be described as "soft" eugenics whereby discourses of "bad mothering" influenced reproductive health and decisions. Practices such as the refusal to begin fertility procedures or remove a birth control devise, however, could be characterized as "hard" eugenics. This point is not uncontroversial. Rabinow and Rose (2006)

suggested that contemporary biopolitics function for different purposes than those of eugenics past. While past eugenics "was directed to maximizing racial fitness in the service of a biological struggle between nation states," they argued, the current focus is on the "interests of national economic prosperity" (Rabinow and Rose, 2006, p. 210) through neoliberal practices and the manipulation of life through biopower. Elsewhere, Rose (2007) clearly states that contemporary biopolitical practices cannot be considered eugenics, in that they do not include the practice of the mass killing of "undesirable" populations.

Despite these arguments, we agree with Cain (2013) that the mechanisms at play in current power structures that determine who is fit to conceive and deliver a child have the markings of a "new eugenics"—a "negative" and informal or unorganized eugenics that allows health practitioners to exert control over people producing offspring who possess or have the potential to possess the undesirable trait of increased body fat. In this new eugenics, while it is not acceptable to institute population measures to actively prevent reproduction in those considered "obese," the control is exerted upon women who look to the medical institution for reproductive care. Within this structure it has become acceptable to define and determine who is fit and who is unfit to conceive, deliver and care for a child (Jette & Rail, 2012). This new eugenics is driven by a truth regime that defines and measures risk and makes recommendations to thwart that risk. The rights of mothers or potential mothers therefore are overridden by medical "concern" for the unborn fetus and the population as a whole that is striving to unburden itself with "obesity."

Certainly, the discourse of risk that underpinned almost all experiences of our participants is a prime example of how biopower worked to shape the lives of citizens and potential citizens, and dictated what practices were "good" ways to materialize healthy citizens. But they also dictated *who* should materialize healthy citizens and who should not—discourses which were enacted quite physically through the immaterialization of citizens via the denial of fertility care or the refusal to remove a birth control device. Thus, while our study is limited by a relatively small sample size and homogeneous group of participants, we argue that it demonstrates the ways in which contemporary discourses, and particularly contemporary medical practices, regarding "maternal obesity" are eugenic. It provides the impetus for further research that considers how women's bodies, particularly fat women's bodies, are regulated and controlled under the guise of "risk management" and how the notion of risk is being utilized as a conduit through which new eugenic practices are permitted and practiced.

This research also falls in line with recent calls for enhanced patient engagement and attention to patient rights in an effort to improve reproductive health care (Gee & Corry, 2012; Shaw & Cook, 2012). The restrictive

and damaging approach to reproductive care that has been outlined in the literature was reiterated by the participants in our study. Health professionals must move beyond this paternalistic style of care that provides no room for the patient voice. It is crucial that those working and teaching within the realm of reproductive health care begin to critically examine their own biases in relation to health and weight and acknowledge the problematic nature of "maternal obesity" science that has been clearly articulated in the literature (Parker, 2012). It is time that practitioners begin to listen to the voices of women and move beyond binary approaches to care that assume thin women to be "normal" and fat women to be "abnormal" or in need of treatment. Finally, research that critically examines the mechanisms through which power is exerted in and through bodies within healthcare, particularly within reproductive healthcare, is vital if we are to begin to ensure care that is holistic and socially just.

Acknowledgments

Thank you to the editors of the Special Collection and to the two anonymous reviewers for their comments that helped to strengthen the article. Thank you in particular to our research participants for entrusting us with their stories.

Funding

This research was completed with funds from the University of Manitoba, University Research Grants Programme.

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