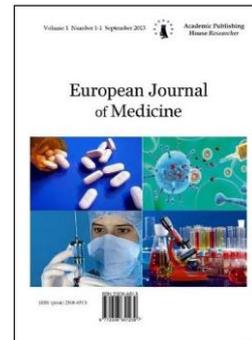


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Articles

Prejudice, Stigma and the Refusal to Offer Health Services of an Obese Pregnant Woman – An Ethical Viewpoint

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Abstract

Obesity in pregnancy is a medical condition that has short- and long-term negative consequences for the mother as well as for the child. Therefore, it is a necessity that these women are informed and educated about their condition as well as should be actively encouraged to reduce weight. Because of the negative social stereotype that follows obese persons, they face daily prejudice and stigma in their work, everyday life, and when receiving health services. This paper aimed to present a case, the refusal of the obstetricians to perform a cesarean section on an obese pregnant woman. The refusal was based on the fear of complications during or after the operative intervention, and subsequent consequences that they may imply. Refusing to treat this patient, regardless of the high risk of complications, was unjustified, unfair, and ethically unacceptable. There are no circumstances where the individual status of the patient should be a reason not to offer them the medical services that they need. The medical staff in these cases should have in mind any special medical precautions needed and apply their knowledge aiming an adequate and accurate medical service for every patient. Therefore human values are essential to good medical practice. Health personnel should not claim special moral status that would allow them to deny the patient's right to medical treatment and always show respect for patient autonomy.

Keywords: pregnancy, obesity, stigma, prejudice, discrimination, medical ethics.

1. Introduction

From the start of the 20th century, the surveillance and management of pregnancy and labor are constantly evolving thanks to the advances in technology and modern medical practices. It is known by every obstetrician that timely operative intervention can make the difference between life and death for the baby as well as for the mother. This paper aims to present a case of prejudice, stigma, and discrimination towards a pregnant woman in our Clinic. The stem of bioethics consists of 4 main principles: the autonomy of the patient, acting on the interests of the patient, making sure to do no harm, medical services without bias, or other injustices. We use these four principles in our everyday clinical work when we are faced with a potential ethical question that needs resolving (Beauchamp, Childress, 2001). At the professional level, it is unfair and unethical to

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refuse medical services to an obese person. It is well known that obesity can be accompanied by stigma, prejudice, and discrimination in society, as well as from medical staff, and these can lead to subpar and inadequate medical treatment. Regardless of the weight of the patients, it is the doctors' duty to apply his/her knowledge and best clinical practices while offering medical services to any of their patients, including an obese one. Obesity in itself requires a multidisciplinary approach for its treatment, and an obese pregnant woman can be challenging for the obstetrician. He/she should be familiar with obesity complications during pregnancy, offer a safe treatment while avoiding name-calling (e.g. the fat one, the obese, etc.). Obesity is defined as a condition of being fat with a BMI of over 30 (Shields et al., 2011) and it is classified into 3 classes (Flegal et al., 2013). Over the past decade the number of obese people has dramatically increased throughout the whole globe. The latest studies show that two in five women in the USA are considered overweight (Hales et al., 2017), while 22 % of pregnant women in the UK are obese, 28 % overweight, and 47 % are considered in the normal range of BMI. Discrimination and stigma of a person with obesity in health institutions can have a negative effect while offering medical services, especially in obstetrics and gynecology, because of the nature of gynecological examination (Aldrich, Hackley, 2010). Obesity significantly increases the risk of complications, this includes but not limited to arterial hypertension, hypercholesterolemia, diabetes mellitus, cardiovascular problems, stroke, surgical site infection, etc. (Kundu et al., 2018). During pregnancy, obese women are at an increased risk for recurrent abortions, pregnancy-induced hypertension, pre-eclampsia and eclampsia, gestational diabetes, preterm labor, intrauterine demise, fetal anomalies, fetal macrosomia, difficult labor (shoulder dystocia, technical difficulties while performing operative labor), as well as increased risk of complications after labor (wound infections, vein thrombosis etc.)(Dudenhausen et al., 2015). Having all this in their minds, it can sometimes happen; not wanting to deal with postoperative complications as well as possible legal implications, obstetricians might not always make the right decision for their obese patient, raising here ethical issues. A similar case we had at our clinic, where some doctors refused to perform Cesarean section in an obese patient, mainly trying to avoid possible legal consequences afterward.

2. Methodology

The case study is a method of empirical inquiry appropriate to the description of phenomena and contributes to understanding phenomena in a holistic and real-life context. This case study is a description of a specific case, where the patient is prejudiced, stigmatized to the point of refusal to be treated by doctors, due to her obese condition. The patient was a pregnant woman and was admitted to our clinic for delivery. Interviews were used as a tool for data collection. The patient is informed in advance about the purpose of the interview and approval was obtained for the publication of data.

Case Presentation

A 37-year-old woman presents to our clinic at 39 + 5 weeks of pregnancy (according to the first day of the last menstrual period). There was no associated pain. During the pelvic exam, she had no extra-uterine bleeding or amniotic fluid leaking. Medical history shows that the patient had no prior births, but she had two spontaneous abortions, which occurred during the first trimester. The patient was treated for infertility for five years. Social history shows that the patient had finished primary education but was unemployed, with a low economic income and no health insurance. She was obese, without physical activity and a heavy smoker (20 pack-years). About the 23rd week of pregnancy, she started treatment with methyldopa for pregnancy-induced hypertension (PIH). The patient states that she has been tested for diabetes in the 26th week of pregnancy, and it resulted negative. The blood pressure was 150/95 mmHg while the heart rate was 91/min. The respiratory rate was 18 breaths per minute, and the body temperature is 37.2 C (99F). On physical examination, her body mass index (BMI) was 39.7 kg/m², with bodyweight; 108 kg and length; 165cm. She had slight acne on her face and chest. Asked about her body weight, she stated that she gained thirty kilograms (bodyweight) during pregnancy, but even before pregnancy she was overweight. She had tried to lose weight several times but with no success, was demotivated and unwilling to try again. She believes her obesity has its connectivity with her family history, although there was no documentation of any confirmed pathology. During vaginal examination; was found normal uterine activity, the cervix anterior presentation, strong and

completely closed, fetal heartbeat evident and regular. Ultrasonographic examination of the fetal biometry showing an intrauterine growth restriction (asymmetric IUGR) and Doppler velocimetry of umbilical and middle cerebral artery had pathological values. Laboratory analysis: hemogram at the limits of reference values. Urine: no proteinuria. Biochemistry analysis: double transaminases (ALT: 71 U/L, AST: 64 U/L, LDH: 847 U/L), Creatinine: 103 $\mu\text{mol/L}$, other biochemical analyses at the limits of reference values. Cardiotocography: with decreased variability and no acceleration. Based on the Doppler velocimetry fetal umbilical and middle cerebral artery which was pathological, (asymmetric IUGR), history of infertility and recurrent abortions, as well as other risk factors such as smoking, obesity, pregnancy-induced hypertension, after adequate information on the advantages, disadvantages and possible complications during and after surgery, Cesarean delivery was proposed and consent was given. The operative team is sent for surgery, but after seeing the degree of obesity of the patient, they refuse to give birth to the woman with the Cesarean section, due to fear of the law if any serious complication occurs. The baby was born via Caesarean section two hours later by another operative team: a female infant; bodyweight 2350 grams, 46 cm; Apgar score: 7/8. Five days after the birth by cesarean section, she and her baby were released home in good health with advice and therapy. This refusal to treat a pregnant woman due to obesity is not justified, it was considered unfair and ethically unacceptable.

3. Discussion

In a meta-analysis of papers, Puhl and Brownell concluded that in general all medical staff, including students, has a negative perception for the obese patient (Puhl, Brownell, 2001). In the USA 66 % of obese persons are discriminated against (Andreyeva et al., 2008). This discrimination comes in many forms, not only while receiving health services but also in other settings, like work where they are considered lazy, lacking motivation for work, and less competent (Roehling, 1999). It is thought that this attitude of medical staff comes from the fact that obesity is considered in its core a lack of self-control (over-eating, no or little physical activity etc.) and persons' lack of willingness to do something about it, to work towards weight loss. Regardless of the personal responsibility, many studies show that treatment of obese persons is a multi-factorial process and it should account for noncompliance of the patient, lack of motivation and discipline (Thuan, Avignon, 2005). This mixture of obstacles in treating obesity often translates to a negative perception from medical staff, where they see it as a waste of their time, without an acceptable result. In a study that included 600 medical doctors in France, it was shown that 57 % of them consider their work non-effective on treating patients with obesity (Bocquier et al., 2005). We presented a case where a pregnant woman was avoided by the obstetricians to perform C-Section, due to her obesity. Stigma on treating obese women seems to be a global issue. In their study, Puhl and Brownell presented that in 69 % of obese women felt stigmatized at least once during their medical examination, and 52 % have had this happen more than once. Overall, medical services ranked second on the list of 20 places where these patients felt most stigmatized. This attitude of medical workers towards obese women can have a secondary effect, on these women avoiding regular visits (Breast and/or Cervical cancer screening etc.). Therefore, we consider it essential for our medical co-workers and staff to make sure they are offering these patients the necessary and best services possible and to make sure there is no prejudice or discrimination in any form or usage of name shaming, as we should not for any patient. Furthermore, we have to help educate society that health care is a fundamental human right, and as such should be offered without exceptions.

4. Conclusion

It is confirmed that obesity is a medical condition that has a direct negative effect on the health of pregnant women, the fetus, and the social impact. In clinical practice, obese patients often have to deal with stigma, prejudice, and discrimination that can go as far as a refusal to receive medical treatment. We consider it inhumane, in any circumstance, to refuse medical treatment to any person in need. The medical caregivers should have individual principles and make sure to honor their oath for their duty to every person to the best of their knowledge; furthermore, they should refrain from taking a higher moral stance. The treatment of any obese patient, including pregnant women, requires patient and careful treatment. Our refusal to treat them is against our call and unethical. It is necessary to inform obese pregnant women about their condition and what it means for the pregnancy and the baby. Careful explanations of the mode of birth also help

prepare her for possible in-labor and/or post-partum complications. All of this should be done while encouraging and helping lose weight. Good communication between patients and their caregivers should be supported by good and proven medical practices. The situation, as in our case, should not happen and should not be allowed to repeat itself. This sort of refusal is unjustified and ethically unacceptable. Society should embrace the notion of health as an inalienable fundamental human right and as such it should be our (medical staff) duty and privilege to make sure this right is respected.

5. Author's contributions

Astrit M. Gashi; analyzes the case, reviews the literature, and compiles the manuscript. All authors have read and approved the final version of the manuscript.

6. Conflict of interest

The authors report no conflict of interest in this case presentation.

Additional information

Informed consent

Informed written consent is provided by the patient to publish the case details.

No institutional approval is required to publish this case.

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