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“I’m not discriminating against you, but…”
Navigating Fertility Assistance as a Fat, Single Woman
« Je ne fais pas de discrimination à votre égard, mais… »
Faire appel à la fertilité en tant que femme grosse et célibataire

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Résumé de l'article

Dans cet article, j’adopte une approche auto-ethnographique pour explorer les processus de fertilité que j’ai subis et les difficultés que j’ai rencontrées pour obtenir des services de fertilité dans le but de tomber enceinte alors que j’étais une mère obèse célibataire par choix. Je décris ici mes expériences dans deux cliniques de fertilité, dont l’une m’a refusé des soins en raison de ma corpulence. Je réfléchis aux difficultés d’accès aux services de fertilité pour les femmes grosses, et au fait qu’on les considère comme des corps à risque qu’il faut dissuader d’être mères. Je conclus cet article en soulignant que le merveilleux accouchement de mon fils s’est bien déroulé malgré le fait qu’il était à « risque élevé ».

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Research Note

"I'm not discriminating against you, but…": Navigating Fertility Assistance as a Fat, Single Woman

by Kelsey Ioannoni

Abstract: In this paper, I use an autoethnographic approach to explore the fertility processes I underwent and the difficulties I had in accessing fertility services in an effort to get pregnant as a fat single mother by choice. Here, I outline my experiences at two different fertility clinics, one of which denied me care based on my fatness. I reflect on the difficulties of accessing fertility services as a fat woman, and indeed how fat women are viewed as risky bodies to be deterred from motherhood. I conclude this paper by situating the joyous delivery of my son against the backdrop of being "high risk."

Keywords: artificial insemination; fatphobia; motherhood; fat mothering; single mother by choice

Résumé: Dans cet article, j'adopte une approche auto-ethnographique pour explorer les processus de fertilité que j'ai subis et les difficultés que j'ai rencontrées pour obtenir des services de fertilité dans le but de tomber enceinte alors que j'étais une mère obèse célibataire par choix. Je décris ici mes expériences dans deux cliniques de fertilité, dont l'une m'a refusé des soins en raison de ma corpulence. Je réfléchis aux difficultés d'accès aux services de fertilité pour les femmes grosses, et au fait qu'on les considère comme des corps à risque qu'il faut dissuader d'être mères. Je conclus cet article en soulignant que le merveilleux accouchement de mon fils s'est bien déroulé malgré le fait qu'il était à « risque élevé ».

Mots clés: insémination artificielle; grossophobie, maternité; mères grosses; mères célibataires par choix

Author: Kelsey Ioannoni, PhD, (she/her) is a fat solo mom and a sociologist who explores the way that body size, specifically fatness, impacts the ability of fat Canadian women to access healthcare services. Her research interests are centred around the fat body, weight-based politics, and weight-based discrimination. Her current research looks at the ways in which fat Canadian women understand their bodies through the lens of the "obesity epidemic," and ways in which this lens results in antagonistic relationships with their bodies. These feelings carry over to healthcare spaces where practitioners often hold anti-fat bias, resulting in weight-based discrimination and experiences of fatphobia in healthcare. Further, Kelsey is passionate about investigating the ways in which fat women experience discrimination related to reproductive health and access to reproductive assistance.

Introduction

I'm lying on the gynaecological exam table with my feet in the stirrups, having a sonohysterogram performed so that the reproductive endocrinologist could see inside my uterus. This test is a regular part of the process leading up to artificial insemination. As the doctor is doing the exam, he says to me, "I took an oath to do no harm, helping you get pregnant could cause harm to you and to your child."

Growing up, some people dream of their weddings; I dreamt of being a mother. As a high-school student, I would joke with my friends that if I had the resources and the maturity, I would reject post-secondary school altogether and embrace full-time motherhood. It did not matter that I was both single and 17; I aspired to be a mother. Despite this strong desire for motherhood, I did not have confidence in myself or my body and instead pursued something I knew I was good at: academics. While I went on to complete my Bachelor and Master of Arts after high school, and as I was nearing the completion of my PhD in Sociology, my yearning for motherhood only increased. This desire became further complicated by my emerging career as an academic, my lack of a romantic partner, and, most relevant to this chapter, my size. At 5'3" and about 360 pounds pre-pregnancy, my body is categorized as "morbidly obese" by the medical establishment—a categorization I find both problematic and rude. Yet, my weight is a barrier I have smashed against repeatedly throughout the process of pursuing fertility treatment to become a "single mother by choice," or, as I prefer to call it, a solo parent.

Exploring the "Single Mother by Choice"

The term "single mother by choice" refers to women (or people who have been assigned female at birth) who chose motherhood without having a partner (Ajandi 2011, 421; Bock 2000, 64; Jadva et al. 2009, 175). This can be accomplished through adoption, donor insemination (using a known donor or an anonymous donor), or using in vitro fertilization (IVF) (Kelly 2012, 67).

When discussing my decision to become a single mother by using a sperm donor to get pregnant, I avoid the often-used term "single mother by choice" (SMBC) and instead use "solo parent." Personally and politically, I find the term SMBC to be problematic. Bock (2000) discusses how the appropriation of the term "single mother by choice" acts as a tool to position certain women at the top of the hierarchy of single parents (64). The use of the term "choice" separates SMBCs from those who were not "responsible" or did not make the choice to be single themselves (Bock 2000, 64). Employing a discourse of choice allows SMBCs to distinguish themselves from stereotypes of the single mother – one who is dependent on social assistance, often racialized, seen as morally unfit, and scapegoated for ills of society (such as increasing crime rates) (Ajandi 2011, 411; Bock 2000, 63; Hayford and Guzzo 2015, 72). The SMBC takes up "choice" as a way of saying, "I am not one of them," and effectively othering single mothers who are single mothers by "chance" and not by "choice."

Research indicates that the typical SMBC is in her mid-to-late 30s or early 40s, is professional, highly educated, financially secure with a well-paying job, and often white (Hayford and Guzzo 2015, 70; Kelly 2012, 78; Jadva et al., 2009, 182; Weissenberg, Landau, and Madgar 2007, 2789). I do not fit the typical understanding of an SMBC. While I am a highly educated white woman, at the time of writing I am a 28-year-old graduate student and I live with two roommates. I teach on contract at multiple post-secondary schools and I desperately wish I could describe my financial situation as secure, instead of incredibly pre-

carious. Nonetheless, I was committed to becoming a mother and successfully got pregnant shortly after my 28th birthday.

Permission to be Pregnant?

The decision to get pregnant as a single woman was not one I made in haste. After ending a long-term relationship, I spent time analyzing what I wanted for my future. Did I want to get back into dating? Did I want to take a break? Ultimately, what I wanted was to become a mother and I did not particularly care if I had a partner to accompany me on that journey. But you cannot just suddenly decide to use fertility services to get pregnant and start immediately, at least not in my experience. It took about a year of planning and referrals before I actually became pregnant: my doctor needed to refer me to an OBGYN, who then needed to refer me to a fertility clinic, and the wait times for each appointment were long. My OBGYN at the time referred me to one of Toronto's largest fertility centres, which scheduled my consultation appointment for five months later. This process was moving significantly slower than I wanted. In my ideal scenario, I would have been pregnant before that first appointment at the fertility clinic. In what follows, I reflect on my experiences at Clinic #1 and Clinic #2 as a fat mother-to-be.

Clinic #1

A colleague of mine mentioned a smaller clinic she had attended just outside Toronto and how the wait time was significantly shorter. I decided to explore that clinic while leaving my appointment on the books in Toronto. Here, I hit my first set of challenges based on my weight. Prior to this appointment, my doctor and my OBGYN were both supportive of my interest in getting pregnant. While we did discuss the realities of how I might experience pregnancy at my size, neither doctor thought that my size should be a barrier to getting pregnant. This was absolutely not the opinion of the fertility doctor I saw at the first clinic outside Toronto, and he made that abundantly clear.

At the onset of my first appointment, I informed the doctor that I am a PhD student who studies weight-based discrimination in healthcare and that, despite my weight, I am moving forward with getting pregnant and recognize that pregnancy may be challenging. It was quite clear from the start that we did not see eye to eye on this matter. First, from this appointment onward, he prefaced almost every statement with, "I am not discriminating against you, but…." He also told me his job as a doctor is to "first do no harm" and that getting me pregnant could be harmful both to me and my potential future child.

The argument the fertility doctor was making is not one that is foreign to motherhood scholars or fat studies scholars, since fat pregnant bodies are often categorized as "risky" bodies (Friedman 2014, 31; Parker and Pausé 2018, 126). This draws on narratives of fat women, and subsequently fat mothers, as lazy, inactive (Friedman 2014, 28), and likely to produce an "obese" child (Parker and Pausé 2018, 128). I actively pushed back against this notion of risk and the idea that I was ignorant to the realities of "obese" pregnancy. This doctor insisted that I needed to see a high-risk pregnancy specialist in order to get approval to become pregnant. I was not interested in pursuing this. I communicated extensively via email with the clinic about my decisions. In response to the expectation that I would first need permission from the high-risk group, I indicated that:

> I'm not interested in attending a pre-pregnancy group or facilitating my care out of [Hospital outside of the GTA]. Aside from insemination, I will be managing my care with my OBGYN in Toronto and out of her affiliated hospital.

My OBGYN made the referral to [fertility doctor] for an IUI [intrauterine insemination] which, in my

understanding, should indicate her acknowledgement that she will be dealing with my pregnancy, even though it is high risk.

What is most frustrating with this situation is that I am not asking for permission to get pregnant, and I feel that [fertility doctor] has me jumping through these hoops in order to obtain somebody's permission or allowance for me to have a pregnancy …. I came to the clinic for assistance in getting pregnant because I don't have a partner whose sperm I will use. What I am looking for at the clinic is access to sperm from a donor bank and a doctor to facilitate the IUI. Access and assistance, not permission. (K. Ioannoni, personal communication, April 2, 2019).

The fertility doctor, via his nurse, again disagreed with my perspective, arguing that:

> We are not wanting you to receive permission for pregnancy we are asking the pre-pregnancy clinic to assess risk of pregnancy with morbid obesity and associated complications. This is routine assessment of risk that is conducted for all of my patients …. Our suggestion would be to strongly be seen by high risk per-pregnancy [sic]. At this time, we do not feel comfortable to proceed without assessment of risk for your pregnancy for risk of gestational diabetes, pregnancy induced hypertension, large baby, C-section and increased maternal mortality. We would absolutely be happy to continue to assess your fertility status in the event we get the assessment from [Hospital outside of the GTA] and you are fully aware of your risks and ready to proceed. He [the fertility doctor] would not like to proceed blindly (K. Ioannoni, personal communication, April 3, 2019).

This discussion went on for multiple days. Not only did my frustration stem from the fatphobia I felt from the fertility doctor, but also because he was having me complete all the pre-insemination requirements (called cycle monitoring) without committing to following through with insemination once the monitoring was complete. Cycle monitoring aims to establish when you are going to ovulate to pinpoint the best time for insemination, and it involves frequent transvaginal ultrasounds and blood draws (every 2-3 days following the start of menstruation). After a month of cycle monitoring, you can typically move forward with an IUI.

At this stage he [the fertility doctor] agrees that the diagnostic cycle is complete and doesn't need further cycling for you until we get *clearance* (emphasis added) to move forward. I [nurse] know you are wanting that clearance to come from the OBGYN however [fertility doctor] has let me know he really would like to have the pre-pregnancy group follow up prior to moving forward (K. Ioannoni, personal communication, April 10, 2019)

Continually fighting with the fertility clinic was exhausting. I was prepared to have to advocate for myself, as doing so is not a new experience for me, but I underestimated the mental toll it would take. I also underestimated the time commitment; going to a clinic outside my city multiple times a week, without having confirmation of moving forward, was draining. Regardless, I continued to register my exasperation and frustration with the clinic via email:

> I want to re-express that I understand the need for "clearance" from anyone else. [Fertility doctor] has explained the risks to me, my OBGYN has explained the risks to me, I understand that getting pregnant while morbidly obese is risky. I am not interested in having to hear this again from another doctor or trying to get another person to give me permission to get pregnant. I should be able to make a decision about my own reproductive health without continual attempts to scare me out of said decision, under the guise of being "fully informed." … It's disheartening and exhausting to have to continue to fight to get assistance in getting pregnant. If I were to get pregnant without an IUI, I wouldn't be denied health care

> in caring for me during pregnancy, despite my weight. (K. Ioannoni, personal communication, April 10, 2019).

This communication was followed up with an unsolicited and unanticipated angry phone call by the fertility doctor who stressed to me that this was not about power and control but about not doing harm. In this, he interrupted me any time I tried to speak and expressed his frustration that I would not accept that it is dangerous to get pregnant at my size. Ultimately, I ended my affiliation with the clinic and decided instead to go through with my appointment at the Toronto clinic.

Clinic #2

By the time I made the decision to leave the first clinic, I was nearing the date of my appointment at the Toronto fertility clinic. At this point, I was incredibly anxious at the prospect of repeating the same experience. The first appointment was early in the morning and I grabbed Starbucks coffee to bring to the appointment with me. I remember waiting in line and being apprehensive of carrying Starbucks into my appointment. I tweeted out my anxiety:

> I have an important doctors appt today. Got here early, decided to grab Starbucks. Had a serious internal debate over what to get and what wouldn't look too much like a fat persons drink, as if I would further out myself in my appointment. (Kelsey_x, May 17, 2019).

Regardless of my concern about potential fatphobia from the doctor, the appointment was completely different from the first clinic I attended. The doctor I saw was still apprehensive about pregnancy at my size but approached the discussion from the perspective of "when you get pregnant" as opposed to the mentality of "if I chose to get you pregnant" that was prevalent in my previous experience. My weight was still actively discussed and still hindered the options available to me in terms of reproductive assistance but this new experience was one where the doctor treated me with respect, autonomy, and agency.

While the experience was moving forward in a much better fashion, my weight still functioned as a barrier against my available choices. Friedman (2014) highlights how the options available for reproductive assistance are limited for fat women and how many fat women are disqualified from such assistance (37). This was definitely the case for me.

There are three main ways to get pregnant using fertility assistance: a) a medicated IUI, where sperm is inserted into the uterus, timed with ovulation; b) an unmedicated IUI; c) and IVF, where eggs are retrieved from a person with eggs, inseminated, and re-inserted into the uterus. Immediately, the doctor told me that because my body mass index (BMI) was higher than 40, I could not do IVF. IVF is done in a way that requires anaesthesia and they cannot perform this procedure on women who exceed a certain BMI at the clinic. He also indicated that he would not be comfortable doing a medicated IUI, as medication acts to increase the number of potential follicles that could become embryos, increasing the possibility of becoming pregnant with multiples (twins, triplets). He did agree, however, that we could pursue an unmedicated IUI and re-evaluate the potential of a medicated IUI in the future if I were having difficulty getting pregnant. Thus, again, the cycle monitoring process began.

Similar to the doctor at the first fertility clinic, this doctor wanted me to consult with a high-risk pregnancy doctor about the realities of obese pregnancy. In contrast, though, this was not prescriptive. He was clear that it was a consultation, not a method of approval or permission. He wanted me to consult with the high risk OBGYN specifically because he hoped I would consider switching to her for my care. I begrudgingly agreed to meet the specialist.

The high-risk OBGYN is located at one of Toronto's biggest hospitals and works in the Special Pregnancy Program. Specifically, as part of this program, she runs a weekly clinic for obese pregnant women. When I met her, I expressed my displeasure at having to talk to another doctor about the "risk" of being obese and pregnant. After reviewing my medical history, she indicated that there was no reason that a healthy 28-year-old woman like myself should not get pregnant. *Healthy*—not a word I was used to hearing in association with my body. Instead of spending the consultation appointment warning me of the risks associated with obese pregnancy, she asked about my concerns and fears about being pregnant, listened to my worries about how fat pregnant bodies are dealt with, and walked me through how my care would look if I were in her clinic. Our appointment ended with her giving me a tour of the pre-natal Special Pregnancy Program and letting me know that she hoped to see me back there as a pregnant woman soon. Needless to say, while I did not have a problem with the original OBGYN I was referred to, I quickly switched to the care of the high-risk specialist.

Insemination

Upon the completion of this appointment and my cycle monitoring, I was cleared to pick a donor and start the process of an IUI. I was officially on the standard protocol of IUIs, no longer fighting for permission to get pregnant. The doctor warned me multiple times that most IUIs do not work the first time and that it was possible that my weight may impact how successful an IUI attempt might be. None of these warnings mattered though; I got pregnant on my first try in August of 2019. The doctor, while very supportive, was quite surprised with how quickly it happened. My mother, on the other hand, was not. Apparently, I come from a line of very fertile women.

The standard procedure following a successful IUI is to stay with the fertility clinic for the first ten weeks of pregnancy before "graduating" and moving care to an OBGYN. While I experienced all the joys the first trimester has to offer, medically, my pregnancy was progressing as expected, with no complications. When I hit the ten-week mark, my fertility doctor congratulated me, thanked me for convincing him to do my IUI, and told me not to stop advocating for myself. It was both nice to hear and frustrating to think about what would happen if I had not had the energy to advocate for myself. Nonetheless, this experience was a fundamental shift from the first clinic and I was proud to "graduate" and move on to the OBGYN.

Designation: High Risk

After graduating from the fertility clinic, I was referred to the Special Pregnancy Program Here, I saw my OBGYN at least once a month, sometimes twice a month. I had frequent ultrasounds and bloodwork and had access to many other support services such as peri-natal mental health and a social worker who helped me create my birth plan. My weight and my blood pressure were taken at every appointment, yet my weight was never reported to me (unless I asked) nor was I ever told to lose weight. As someone who has had continuous negative experiences in the healthcare system, where doctors would focus solely on weight loss as a solution to any problem I was having, this was a drastically different experience. The equipment in the Special Pregnancy Program accommodates large bodies, from the chairs to the exam beds and the blood pressure cuffs—a rare occurrence! I did not feel uncomfortable at the clinic even once throughout my pregnancy; I never felt judged because of my weight, which is often the case in healthcare environments. In fact, being a part of this clinic meant that I was around fat pregnant women every time I had an appointment My body felt normalized in this space.

Labour: A C-section during COVID-19

My son was born at the end of April 2020 via Caesarean-section (C-section) and in the middle of the global COVID-19 pandemic. COVID-19 was certainly the hot topic in the hospital, whether it was the lack of personal protective equipment or the constant chatter among the staff about the uncertainty of the disease. However, the impact of COVID-19 on my pregnancy and delivery were minimal. Unlike mothers giving birth later in the pandemic, I did not have to wear a mask during my labour. I was allowed to have one support person in the room during my labour and C-section but I was not allowed to have visitors during my stay in the hospital. I was discharged about 48 hours after my surgery. It was an odd experience to not have my support system around, especially as a solo parent. I anticipated having both my parents there and having friends in the waiting room; however, because of COVID-19, it was not safe to even have them visit post-discharge. This resulted in quite an isolating experience.

I categorically did not want to have a C-section. I knew the risks for C-section were higher at my size, both in terms of the chances of needing one and the risks associated with major abdominal surgery. Having a C-section at my size was scary for a lot of reasons. I had read many anecdotal stories and saw references to studies about how morbidly obese women recover poorly from C-sections and the likelihood of infection at the incision site was increased. Who would take care of my son or me? How would I dress myself? How would I clean myself? I was very scared. My doctor agreed to induce me three days before my due date and let me labour with the understanding that we would book a C-section for two days later in the event that my labour did not progress. When I was admitted to the hospital I was 3 cm dilated. Despite multiple induction attempts, 48 hours later I was still 3 cm dilated and it was time for a C-section.

The average C-section, according to the Cleveland Clinic, is about 45 minutes. My C-section took place in a specialized operating room for "obese" women, with 21 dedicated medical personnel (including multiple OBGYNs, fellows, and anaesthesiologists) and took 2.5 hours. The risks for general anaesthesia were too high based on my BMI, so I had an epidural and was awake for the procedure. They used a specialized technique specifically for "obese" women called a "transverse supra-pannus incision" (Sagi and Maxwell 2017, 271) where instead of cutting at the bikini line which would fall under my "apron" or hanging belly (medically known as abdominal pannus), they cut right under my belly button. Despite how terrifying this was, I was in awe of the skill and care of my team. I was well taken care of.

Conclusion

When I set out to write this piece, I thought that I would be writing extensively about what it is like to be pregnant and fat. As I got into the details of my experience, I realized that my pregnancy was quite boring, for a lack of a better term. The interesting and complicated part of my experience came from the intersection of choosing to be a single mother and being a fat—or, as the medical industry continues to tell me, "morbidly obese"—woman. The reality is that my pregnancy was fairly textbook, aside from my "high risk" designation.

Contrary to all the concerns laid out by the doctor at the first clinic, harm was not done to my child or me by my choosing to become pregnant. My blood pressure was normal, I put on a total of about 15 pounds, I did not have gestational diabetes, and my baby was born a happy and healthy 8 pounds 4 ounces. Despite having needed a C-section, I was not pressured to choose one. Instead, my wishes to try and have a vaginal birth were respected until that was no longer a safe option. Reflecting on my experience of being pregnant, I find it ironic that this journey has not always been positive but my experience with the Special Pregnancy Program has been my best healthcare experience, by far.

Having the opportunity to share my fertility journey, challenges and all, at the 2023 Congress of the Humanities and Social Sciences was such a rewarding experience. Seeing the theme of Congress 2023, "Reckonings and Re-Imaginings," I was hopeful that I would find a space to speak about my fertility journey and the impact of anti-fat bias and fatphobia on maternal possibility. As a sociologist, I was excited to see that the Canadian Sociological Association was hosting a series of panels on Feminist Sociology and Reproductive Lives, Bodies, and Politics." The series of panels on sociology and reproduction provided the space for me to speak about fat reproduction but also the time to reflect with other scholars in the field on how we can dismantle the oppression and discrimination faced by pregnant people of all different yet intersecting social locations.

The reproductive lives of fat women and the way their bodies are treated in healthcare spaces are fraught with anti-fat bias. In this paper I reckon with the discriminatory treatment I experienced in my initial foray into reproductive assistance and I re-imagine a future where fat pregnant people have access to the specialized, supportive care I received in the Special Pregnancy Program, without jumping through hoops or having to be "in the know" about such programs. The standard of care for pregnant people should not differ based on body size and fat futures must be acknowledged, not discouraged.

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