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When midwives ask permission to discuss weight with pregnant women with high body weight: a qualitative study

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Abstract

Background In 2021, 15% of pregnant women in Denmark had a Body Mass Index (BMI) of 30 kg/m^2 or more, which is associated with complications for both mothers and children. Healthcare professionals often feel insecure when discussing weight with pregnant women with high body weight, and people with high body weight are exposed to stigmatisation. To counter this, different tools have been developed to support respectful weight-related conversations, often recommending asking permission to talk about weight. This study explored the experiences of both pregnant women living with a BMI equally or above 30 kg/m^2 and midwives when asking for permission to discuss weight during the initial midwife consultation.

Methods We observed nine midwifery consultations and, by way of purposive sampling, interviewed six pregnant women with high body weight, while nine midwives participated in two focus group interviews. A hermeneutic-phenomenological approach by Max van Manen was applied for the analysis.

Results We identified three themes in this study. "Addressing weight triggers risk and ambivalence", which explores the lived experiences of pregnant women, their personal history with their body weight and midwives' hesitancy to initiate weight-related conversations with pregnant women who have a high body weight. "Asking for permission - for whose sake?" highlights the experiences of asking permission among midwives and that pregnant women with a high body weight did not perceive the question as an opportunity to decrease weight-related conversations. "Weight conversation – a cue to feel wrong and guilty or to feel recognised as an individual?" emphasising that trust and shared decision-making are crucial factors for a relevant weight-related conversation but also that the conversation might trigger feelings such as guilt and self-doubt.

Conclusion Pregnant women with high body weight had a long history with their body weight that affected all aspects of their lifeworld and influenced weight-related conversations in the midwifery consultation. Some midwives hesitated to address weight, but seeking permission eased this challenge. Despite the midwife asking for permission, some of the pregnant women felt uneasy during the conversation, leaving them with a feeling of self-doubt. Relevant conversations occurred when women engaged in decision-making and trusted the midwife.

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Background

A Body Mass Index (BMI) of 30 kg/m^2 or more is considered a risk factor for various diseases and conditions, as well as posing psychosocial challenges resulting from stigmatisation [1]. Data from the Danish Medical Birth Register show that 15% of women who gave birth in 2021 had a BMI equally or above 30 kg/m^2 [2]. In this article, a BMI equal to or above 30 kg/m^2 is defined as high body weight, as this is preferred terminology according to studies on weight-terminology [3]. Pregnant women with high body weight have an increased risk for complications during pregnancy and childbirth [4]. Furthermore, recent studies have focused on weight stigma as a major problem in clinical settings [5, 6]. An American review highlighted that healthcare professionals often feel uncertain when discussing weight with pregnant women with high body weight [7]. Pregnant women also describe how they experience weight as a sensitive issue, often leaving them with a feeling of guilt and embarrassment about their body size [8, 9].

A multidisciplinary group of international experts has developed a joint consensus statement with recommendations to eliminate weight bias and the stigma of high body weight [10]. This group emphasises that individuals with high body weight face discrimination and stigmatisation, which can cause physical and psychological harm and undermine human and social rights. In a qualitative study exploring pregnant women's experiences of gestational weight gain conversations the participants suggested that healthcare professionals should address weight by seeking permission to initiate the topic [11–13]. Internationally, tools have been developed to reduce stigmatisation by supporting healthcare professionals in addressing high body weight respectfully. The Canadian non-profit organisation Obesity Canada has developed the 5As of Obesity Management, which among other things consist of asking permission to discuss weight before addressing it [14]. Several other international associations recommend asking permission to discuss weight including the European Association of the Study of Obesity [15], the English non-profit organisation Obesity UK (United Kingdom) [12] and the Rudd Center for Food Policy and Health at the University of Connecticut [16]. To our knowledge, there have been no studies exploring the experiences of pregnant women regarding being asked for permission to discuss weight during midwife consultations.

The present study draws on the experiences of the development and implementation of a communication intervention from a midwifery clinic in a major Danish city in 2023. The intervention drew inspiration from the multiple international organizations that recommend asking permission before discussing weight. Accordingly, the midwives were instructed to first seek consent from pregnant women before addressing weight in relation to pregnancy. Furthermore, the midwives were encouraged to explore what was important to pregnant women regarding weight and pregnancy, drawing on techniques from motivational interviewing [17]. The approach was implemented to enhance midwives' competencies in addressing high body weight in pregnancy in a non-judgmental and respectful manner while ensuring that weight is discussed.

The present study is the first study that has examined how pregnant women with high body weight experience being asked for permission to discuss weight. In the present study, we explored how pregnant women living with a high body weight and midwives experience the act of midwives seeking permission to discuss weight during the initial midwife consultation.

Methods

Study design

In the present qualitative study, we defined the phenomenon as the experience of a weight conversation when the midwife asked for permission to discuss weight. This study consisted of participant observation and semi-structured individual interviews to explore pregnant women's experiences with the phenomenon as well as focus group interviews to explore midwives' experiences with the phenomenon. Guided by Max van Manen's hermeneutic-phenomenological methodology, we explored the lifeworlds of pregnant women and midwives, capturing their lived, pre-reflective experiences with the phenomenon before making them subjects to interpretation [18].

We aimed to bracket our preunderstanding by making it explicit and acknowledging how our professional background contributed to a broader perspective and openness towards the empirical data.

Setting and recruitment

In Denmark, all midwife consultations are free. As a standard, five consultations of 20–30 min' duration at the midwifery clinic are offered. The purpose of the initial midwife consultation includes discussing the family's well-being, conducting risk screening, and providing support for lifestyle changes if needed.

Pregnant women

We used a purposive sampling technique to recruit a sample of six women through a Danish midwifery clinic. The inclusion criteria were Danish or English-speaking pregnant women with a pre-pregnancy BMI ≥ 30 kg/m2 attending their first midwife consultation at 16–20 weeks' gestation, referred to standard maternity care. Standard maternity care refers to the routine care that pregnant women are referred to if it is determined that no additional services are needed. Nine pregnant women were approached and consented for observation. Three of the nine women subsequently declined to participate in an interview. Of the three women who declined to participate, one woman stated she had nothing to contribute to the study. Another pregnant woman initially agreed to participate in an interview, but the interview was subsequently cancelled due to personal circumstances. A third pregnant woman wanted to consider whether to participate in the interview but later wrote that she did not wish to participate and did not want to elaborate the reason.

Midwives

All midwives working with standard maternity care in the clinic were introduced to the intervention. We used a purposive sampling technique to recruit a sample of nine midwives working with standard maternity care, who were invited via email to participate in focus group interviews. The key element in the intervention was asking permission to discuss weight by posing the following question: "Would it be okay if we talk a little about weight in relation to your pregnancy?". From the observations, we noted that the midwives often formulated the following: "How is it for you to talk about body and weight?". This was used by the midwives as a variation of asking for permission.

Data collection

The data were collected between February and March 2023. The first author, SG, an experienced midwife, led the implementation of the intervention in the midwifery clinic by introducing all midwives working with standard maternity care to the intervention, where they were instructed to ask pregnant women with high body weight permission to discuss weight. To address the potential challenge of midwives feeling evaluated by a colleague, the second author, ASK, performed all the participant observations. Similarly, ASK led all the individual semi structured interviews with the pregnant women, and SG participated in the interviews to support the data analysis and interpretation. SG was a moderator during the two focus group interviews with the midwives.

The experiences of the pregnant women were explored through a combination of participant observations during the initial midwife consultation ($n=9$), field notes, and subsequent semi-structured individual interviews with each pregnant woman who consented to participate in an interview ($n=6$). All pregnant women meeting the inclusion criteria during the study period were approached for consent to participate in observations, with none declining. Participant observations were subsequently utilized to identify and recruit the pregnant women for the interviews, with those who provided consent comprising the study population ($n=6$).

We wrote extended field notes immediately following participant observations to sharpen the observation of specific actions and words and to create an artificial memory [19]. This was used during the interviews to help the pregnant women recall the initial midwife consultation and elicit pre-reflective descriptions. The semi-structured interviews took place within two weeks after the midwife consultation. The pregnant woman chose the location and date of the interview. Two interviews took place in the midwifery clinic, and four interviews took place in the homes of the pregnant women. The interviews were recorded, and a pre-written interview guide assisted in exploring the women's lifeworld and eliciting pre-reflective descriptions, for example, through the following questions: "How was your experience discussing weight with the midwife?" followed by "Did you notice that you were asked for permission to discuss weight?" and "How did you experience it?". During the interviews, we paid particular attention to pauses and sought to be receptive and attentive to elicit lived experiences and the participants' own formulations [20]. The interviews lasted between 32 and 70 min.

We investigated the midwives' perspectives through two focus group interviews ($n=9$). By employing a tight model of structuring and moderator involvement [21], we focused on the content of conversations with pregnant women rather than interactions among midwives. The model is suitable when the moderator has extensive knowledge of the field, and since SG was an experienced midwife, it was appropriate for her to be the moderator [21]. An interview guide assisted in exploring the midwives' descriptions of the phenomenon, for example, through the following question: "How do you experience asking pregnant women permission to discuss weight during the midwife consultation?". During the focus group interviews, SG paid special attention to involving all midwives in the conversation to elicit as many descriptions as possible. ASK participated in the focus group interviews to support the data analysis and interpretation. Both focus group interviews lasted 45 min and were recorded.

Data analysis

We applied Van Manen's methodology, which guided our research process during both the observations, the

individual interviews as well as the analysis and development of themes. Van Manen's methodology is particularly suitable for studies that seek to find meaning and significance in the lived experience by describing experiences pre-reflectively, before they are subjected to interpretation [22]. The approach contains elements of both hermeneutics and phenomenology, understood in such a way that throughout the process there is an interpretative understanding of the phenomenon while maintaining the openness of phenomenology. With the lived experience, we attempt to describe the pre-reflective experiences of the pregnant women and midwives [22]. This is also reflected in our interview guide and generally in our approach and questioning technique during the interviews (see supplementary files).

We transcribed the empirical data from the interviews verbatim and employed van Manen's three approaches in the analysis while maintaining phenomenological openness, and curiosity to achieve a comprehensive description of the phenomenon. The first step in the process was a holistic approach, in which we directed our research questions towards our data to develop an overall understanding. In the selective approach, we divided the text into smaller units, and we looked for statements and passages that described the phenomenon [18]. In the detailed approach, we interpreted each thematic expression or phrase and sought to capture its phenomenological meaning.

Our themes drew inspiration from poetry, embracing wordplay and rhythm to evoke a deeper understanding in the reader beyond the intellectual recognition of the theme's content. We incorporated van Manen's lifeworld existential lived space, which involves how space and surroundings influence the human lifeworld [23].

Ethical considerations

We were aware that body weight is a sensitive issue. Interviews were performed in regulation of The Code of Ethics of the World Medical Association [24]. In accordance with Danish legislation, interview studies are not required approval from the National Committee on Health Research Ethics. The project was registered as a Quality assurance project in The Central Denmark Region (J.no 1-16-02-190-24). Participants received written and oral information about the study and gave written consent prior to interviews. We ensured that the data were pseudonymised in accordance with the GDPR [25].

Results

We conducted six individual semi-structured interviews with pregnant women who had a high body weight, as well as two focus group interviews with a total of nine midwives. The characteristics of the pregnant women are described in Table 1, and those of the midwives are presented in Table 2.

Table 1 Participant characteristics for pregnant women

Name	Age (years)	BMI (kg/m^2)	Parity
Astrid	25	32	0
Bea	29	30	0
Celina	23	33	0
Dorte	31	34	1
Emma	31	48	1
Frida	32	34	0

Table 2 Participant characteristics for midwives

Name	Seniority (years)
Josefine	>10 years
Inge	<10 years
Gitte	<10 years
Hanne	>10 years
Olivia	>10 years
Karen	<10 years
Nete	<10 years
Lotte	<10 years
Marie	<10 years

Six pregnant women participated in both the observation and subsequent individual interviews. The age range was between 25 and 32 years, with an average age of 28 years. The group included two multiparous and four primiparous women. During the interviews, they were all between gestational weeks 17 and 20. Their pre-pregnancy BMI ranged from 30 to 48 kg/m^2, five had a pre-pregnancy BMI between 30 and 34 kg/m^2, and one had a pre-pregnancy BMI of 48 kg/m^2. All pregnant women were alphabetically assigned fictitious names beginning with letters from A to F.

The recruitment of midwives resulted in two focus group interviews with four and five midwives, who were recruited into one of two groups depending on their work schedule. All nine midwives were affiliated with the same midwifery clinic, from which the pregnant women were recruited. Their age range was 25–64 years. The midwives' seniority varied between 1 and 40 years, with an average of 12 years of work experience. All midwives were alphabetically assigned fictitious names beginning with letters from G to O.

Table 3 illustrates the analysis process in which we employed van Manen's three analytical approaches: the holistic approach, the selective approach, and the detailed approach. The analysis findings are presented based on three themes: *Addressing weight triggers risk and ambivalence; Asking for permission - for whose sake?* and *Weight conversation – a cue to feel wrong and guilty or to feel recognised as individual.*

Table 3 Illustration of the analysis process employing Max Van Manen's three analytical approaches

Citation	Selective approach	Detailed approach	Theme
"It actually affected me for the next couple of days. I was thinking about it all the time, every time I had to eat something. Oh, now I have to be careful, I shouldn't eat this because then I'll gain weight, and I have to see the midwife again in about a month" (Pregnant woman, Celina, BMI 33 kg/m^2)	The conversation about weight triggered a reaction that lasted for several days after the midwife consultation. The reaction led to increased attention towards eating properly and avoiding unhealthy food	Even though the pregnant woman was asked permission, the conversation about weight was perceived as judgemental, which the pregnant woman responded to when she had left the midwifery clinic.	Addressing weight triggers risk and ambivalence
"I feel that the conversation goes well when you start with that sentence. I also think that, for my own part, I feel less uncomfortable leading up to it in that way" (Midwife, Nete, < 10 years of experience)	Asking for permission was associated with apprehension and discomfort. Asking for permission was a good way to initiate the conversation about weight.	Asking for permission addressed the midwife's apprehension about addressing weight.	Asking for permission - for whose sake?

Addressing weight triggers risk and ambivalence

Pregnant women

All the pregnant women we interviewed had experienced their weight being pointed out by healthcare professionals during childhood. In the quote below, Dorte recalls suddenly becoming aware that her body was an object of others' gaze and that others had an opinion about it being wrong.

> *It wasn't even on my radar, the idea that there was something wrong with the way I looked. I just looked like my father.*
> *(Dorte, pregnant, BMI 34 kg/m^2)*

The pregnant women recalled their bodies as a natural reflection of their parents, where the size of their bodies was beyond their control. Five women in this study remembered this perception disrupted during primary school by a health visitor. Hence, for several of these pregnant women, a history of being overweight was associated with a traumatic experience in childhood, an experience of being a failure. This caused a period in their lives where they struggled with weight loss and body acceptance as Emma described it:

> *Well, I've been on every diet that exists. The feeling of not being like everyone else has always weighed on me, especially when I was younger.*
> *(Emma, pregnant, BMI 48 kg/m^2)*

At the time of the interview, all the pregnant women we interviewed, with a BMI between 30 and 34 kg/m^2, were aware of having a high BMI but did not perceive themselves as overweight:

> *"I personally think I'm bordering on being overweight. I actually almost think I'm in the category of obesity, and I find that overwhelming to think about. Because I know I am big, but I don't see myself as big as the BMI scale does."*
> *(Bea, pregnant, BMI 30 kg/m^2)*

As discussed below, pregnant women's history with weight and how they perceive their own weight today had an impact on their lifeworld and their experience of being asked for permission to discuss weight during the initiative midwife consultation.

Midwives

The synonyms "to sense," "to perceive," and "to feel" were central words throughout the interviews with midwives and appeared more than 110 times. From the midwives' perspective, this theme was based on how they sensed, perceived, and acted based on these sensations when initiating the conversation about weight. Therefore, the midwives sought signals, moods, and body language from pregnant women with a high body weight as soon as they entered the consultation room:

> *"A couple that I remember very clearly, where I could just sense from her that her eyes were piercing, and she was like…' don't you just come here'… There, I really had to be cautious. I leaned back in my chair and tried not to appear too forward, or else she would storm out the door again."*
> *(Inge, midwife, < 10 years of experience)*

Like Inge's quote, many midwives described that conversations about weight with pregnant women with high body weight could be associated with apprehension. Karen, a midwife, described how she wanted to avoid conversation about weight out of fear of stigmatising:

> *"I would definitely prefer it if it were someone who wasn't overweight. I can just sense that all the thoughts about how I should approach this start running through my head before I call her in. Because how do I say it in a way that makes her feel as if it's actually okay to be in this room?"*
> *(Karen, midwife, < 10 years of experience)*

The midwives' apprehension and uncertainty related to how they experienced that the pregnant women

perceived it when the midwives addressed weight. It was therefore the aspect of addressing weight that was particularly challenging among the midwives.

Asking permission - for whose sake?

Pregnant women

Not all the pregnant women we interviewed were asked for permission to discuss their weight, as three of the pregnant women mentioned this topic during the midwife consultation. For two of the pregnant women we interviewed, the question "How is it for you to talk about weight?" did not impact the conversation, and they did not remember being asked the question:

> *"Now I can't really remember how she asked it, but I also thought it was fine for me."*
> *(Pregnant woman, Celina, BMI 33 kg/m^2)*
> *"I can't quite remember that. But I think I missed an understanding of why it should be such a big deal. Why is it so important at the first midwife consultation? Why is my weight such a significant factor when I myself attach so little importance to it?"*
> *(Pregnant woman, Frida, BMI 34 kg/m^2)*

Neither Celina nor Frida remembered the question from the conversation and did not have the experience of being asked for genuine permission to discuss weight or an experience of being able to influence how much the weight conversation should be emphasised during the first midwife consultation. The question could thus be perceived as unnecessary because the pregnant women were prepared for the midwives' interest in discussing weight with them, though they were not prepared for the scope of the topic:

> *I knew I had to be weighed, but I didn't know it would take up so much focus.*

(Pregnant woman, Celina, BMI 33 kg/m^2)

Another pregnant woman, Bea, who was asked for permission according to the formulation of the intervention, remembered that the question was asked but perceived it as an elaboration that weight should be a sensitive issue. Bea described that the question made the weight conversation feel like a taboo that required extra caution, which she herself could not relate to. The question became a way of addressing something that was not a particularly sensitive issue for her to discuss:

> *"It was a bit strange that she had to ask permission because that's just how I am. I think it just made me more aware that it's wrong to be overweight."*
> *(Bea, pregnant, BMI 30 kg/m^2)*

From the quote, the question could contribute to emphasizing the topic as taboo, as Bea started to feel wrong based on the question. Asking permission could therefore be a tool that could be experienced as stigmatising.

Midwives

The interviewed midwives considered asking permission to discuss weight a valuable tool that they had sought after. Asking permission helped them address the apprehension associated with addressing weight. It was convenient for the midwives to implement it in the midwife consultation, and they found it natural to ask permission to discuss a sensitive issue such as weight. Midwives described asking permission as something that gives pregnant women a degree of control over the weight conversation, as the perspective of the pregnant woman becomes crucial for the conversation and how it unfolds. The midwives experienced the conversation as a dialogue that added a positive dimension to the weight discussion, as it became more personal and relevant. It could thus be seen as a tool to make the conversation relevant. Nete described this in the following quote:

> *"I think it's a lovely way to ask permission. It's very considerate. By asking permission, it's not just about my needs that we're focusing on. It invites dialogue rather than just one-way communication. Then I don't feel like I'm crossing her boundaries."*
> *(Nete, midwife, < 10 years of experience)*

The midwives' description of asking permission also expressed the assumption that pregnant women would decline if they did not want to engage in the weight conversation, giving them a genuine choice. Midwife Inge described how she perceived the tool helpful in ensuring that pregnant women who found the weight conversation intrusive were not violated:

> *"It's a really good approach that has made the conversation respectful. They [the pregnant women] also have the opportunity to say no. And I think it's nice that they have the opportunity to decline, especially for those who find it intrusive and a sensitive topic that they don't want to delve into."*
> *(Inge, midwife, < 10 years of experience)*

Asking for permission could thus be a useful tool for midwives that could help them manage and address the challenge of initiating a conversation about weight.

Weight conversation – a cue to feel wrong and guilty or to feel recognised as individual

Pregnant women

Three of the interviewed pregnant women, who were asked for permission to discuss weight or a variation thereof, experienced that the weight conversation affected them and took them back to the feeling of being wrong because of their overweight. This seemed to occur unconsciously in the women during the weight conversation, triggering an old thought pattern from childhood to adolescence. This was described by one of the pregnant women, Frida, with a BMI of 34 kg/m^2, expressing *"[it's] strange because it's been 100 years since I felt that way."* Celina, with a BMI of 33 kg/m^2, described in the following quote how the weight conversation could trigger this thought pattern. A thought pattern that she had otherwise been able to unlearn in terms of body acceptance, which she has partially achieved as an adult:

> *"There are many memories in it, and it (the weight conversation) frustrated me. I went back 10 years in terms of being careful about what I eat."*
> *(Celina, pregnant, BMI 33 kg/m^2)*

The experience of feeling like a failure and not being good enough resurfaced by emerging again after being submerged since Celina's early twenties, but this time, it was related to motherhood. A similar experience was described by Frida, who said,

> *"I had to go on a diet and be restrictive and stuff like that again because otherwise, I wouldn't be good enough to have a baby."*
> *(Frida, pregnant, BMI 34 kg/m^2)*

A sense of guilt was once again associated with weight, this time in relation to motherhood and the unborn child. The focus on weight during the midwife consultation could trigger these feelings. However, reactions from pregnant women were not reported during the actual midwife consultation. The pregnant women who experienced the weight conversation as judgemental described that they only realised it when they got home. Frida described the following after coming home:

> *"I can't remember much concrete from the meeting. Actually, I remember more how I felt when I got home. I had to go home and work again but actually; I was completely overwhelmed. And in the end, I had to call my mom after work, and I was really... sobbing."*
> *(Frida, pregnant, BMI 34 kg/m^2)*

The physical space thus seemed to have an impact on the pregnant women's feelings and reactions to the weight conversation. The pregnant women experienced the hospital and home as two distinct types of lifeworld, and the emotions that the conversation triggered were first expressed at home.

From participant observation, we know that in the specific consultations that caused a reaction in the pregnant women, the midwives used a variety of asking permission. At the same time, the midwives did not perceive any rejecting body language or tense atmosphere. In an informal conversation after the observed consultations, the midwives felt that the weight conversation had been beneficial. Two of the interviewed pregnant women described a positive experience of the weight conversation, where they felt that they had a say in how much the weight conversation should be emphasised during the first midwife consultation. Moreover, the pregnant women described it positively when they felt that the midwives trusted them and believed what they said about themselves. In those situations, the pregnant women felt that the weight conversation was relevant, and they felt recognised as individual.

> *"Well, I remember it as if she (the midwife) just wanted to hear who I was and how I felt, and if there was something specific, I wanted to talk about. Like seeing me as a person, and not just seeing something written on a piece of paper. To be interested in me as an individual, and not just, now I have to ask these 10 questions, and then you have to leave."*
> *(Astrid, pregnant, BMI 32 kg/m^2)*

With the above quote, Astrid described that she felt that the weight conversation was based on her needs, where she felt seen as a human being and an individual, making the conversation relevant to her. From the observations, we know that the starting point for this weight conversation was when the midwife asked the following question: "Is there anything you need to talk about regarding weight, diet, exercise?". This could be considered a variation of the question "What is important to you?",

which is part of the intervention that the midwives have been introduced to according to the background.

Discussion

In the present study three themes emerged: *Addressing weight triggers risk and ambivalence; Asking for permission - for whose sake?* and *Weight conversation – a cue to feel wrong and guilty or to feel recognised as individual.* We found that pregnant women and midwives perceive the initiation of weight discussions differently during initial midwife consultations. For some of the pregnant women the weight conversation and being asked

permission triggered a feeling of guilt and made them feel stigmatised. The midwives perceived addressing weight as challenging and asking for permission was a useful tool to help them manage the challenge of initiating a conversation about weight.

Midwives

Midwives' concerns about addressing the weight conversation and their desire to avoid it are well known from similar studies among midwives and healthcare professionals [26–31]. We found that this fear diminished when the midwives asked permission to discuss weight. The midwives perceived this tool as accessible and respectful to pregnant women, which is consistent with several Canadian studies examining healthcare professionals' experiences with asking permission to discuss weight [32, 33]. In a Danish study by Lindhardt et al., the practice of asking permission was investigated among healthcare professionals in antenatal care [34]. The study found that the tool is perceived as a gate-opener, making it easier to address weight in conversations with pregnant women with a BMI of 30 kg/m^2 or higher [34], which is similar to the present study. Unfortunately, Lindhardt et al. did not investigate how pregnant women with high body weight experienced being asked permission, leaving their voices unheard.

Pregnant women

To our knowledge, no studies have examined the experience of being asked for permission to discuss weight among pregnant women with high body weight in their encounters with healthcare professionals. We found that some pregnant women did not perceive the question as meaningful or a genuine opportunity to reject the weight conversation. An important finding from our analysis in this regard is that the physical space may have an impact on how being asked permission to discuss weight is experienced by the pregnant women. This could explain why asking for permission was not associated with the experience of having a real opportunity to reject a weight conversation. The influence of lived space, interpreted as the physical environment and the atmosphere of the room, in clinical settings aligns with findings from a qualitative study by Norlyk et al. [35]. This study illuminates how patients perceive the hospital and the home as two very different types of lived space. The hospital is characterised as an unfamiliar territory where the role of a good patient, defined as a compliant and cooperative patient, is put into play. The home represents feelings of calmness and security and a place where people can be themselves. Norlyk et al. suggested that adopting the role of a compliant and cooperative patient may result in patients feeling a limited sense of authority due to the asymmetry between the patient and the healthcare professional [35]. For the pregnant women we interviewed, the consultation room can be seen as the hospital where they try to present themselves as good patients. This may explain why they do not speak up during the weight conversation and decline to address weight despite being asked for permission. Norlyk et al. reported that although the home is generally associated with positive feelings, it can also become a space for overwhelming emotions such as insecurity and discomfort [35]. This supports how the pregnant women in our study reacted at home and how conversations about weight can trigger an old pattern and the feeling of being a failure. An American review further describes how weight stigma can lead to weight gain. This occurs through increased eating behavior and elevated cortisol secretion, driven by behavioral, emotional, and physiological mechanisms [36]. This model may also help explain why two pregnant women experience emotional responses after the conversation, as weight stigma can be stressful [36].

Findings from the analysis indicated that the question "What is important to you?" can have an impact on the experience of a relevant weight conversation. This finding is consistent with findings from a qualitative Canadian study, which concluded that conversations about weight should be individualised through an understanding of pregnant women's health priorities and life circumstances [6]. Similarly, a Swedish study revealed that thoughtfulness and interest from healthcare professionals can help reduce discomfort during conversations [37]. The question "What is important to you?" may show interest and start from the individual pregnant woman and her standpoint. Further research is needed regarding this question in relation to weight conversations with pregnant women.

We found that being asked permission could be perceived as an unnecessary emphasis on high body weight being undesirable among pregnant women. This may therefore contribute more to perpetuating weight stigma rather than being a destigmatising approach. This finding contrasts with that of a qualitative Canadian study, where pregnant women suggested healthcare professionals should initiate conversations about weight early in pregnancy by asking for permission to discuss weight [11]. Since our investigation of asking permission is part of an intervention and few of the participants had experienced being asked for permission, there is a need for future studies that specifically examine the question and include more pregnant women who were asked for permission.

Limitations of the study

As this is a hermeneutic-phenomenological study, our preunderstanding may have influenced our findings. Our education has shaped a preunderstanding that emphasizes weight loss when considering high body

weight. However, current research has revealed that much about high body weight remains unknown. This knowledge helped us bracket our preunderstanding and become more curious about what high body weight means for each individual. Throughout the study, we have attempted to address this by maintaining an ongoing dialogue between all the authors, challenging our preunderstandings, and gradually transforming them. Similarly, our involvement may have influenced the data collection and had an impact on our findings.

We chose focus group interviews to explore the perspectives of midwives and had a particular focus on facilitating the focus group interviews, as individuals' lived experience can be depicted through group interactions and can enhance the study by providing a richer and more meaningful understanding of the phenomenon [38]. The midwives' experience of asking for permission is based on the intervention. Therefore, it can be challenging to separate their experience of asking for permission from the other elements of the intervention, as described in the background.

The intervention itself may inadvertently have contributed to stigmatisation of the pregnant women, which is a limitation of the study itself and a consideration that future studies investigating asking permission to discuss weight should be aware of. The BMI range for pregnant participants is narrow, with most women in the lower end of the spectrum. This may have impacted the study's results, as women with lower BMI are less likely to notice stigma [39].

Conclusion

The pregnant women had a long prehistory with high body weight, which affected all aspects of their lifeworld and had implications for conversations about weight during the first midwife consultation. Many midwives experienced apprehension when discussing weight, fearing stigmatisation of pregnant women. Asking permission to discuss weight was an accessible way for the midwives to initiate the conversation, addressing apprehension and supporting midwives in initiating a difficult and sensitive topic.

For the pregnant women with high body weight who participated in this study, the conversation about weight could trigger old thought patterns and a sense of self-doubt due to past negative experiences relating to high body weight, despite being asked permission to discuss weight. Asking permission may inadvertently reinforce the perception of high body weight as a sensitive topic, thereby contributing to the perpetuation of weight stigma. The pregnant women found it challenging to reject the conversation about weight due to the asymmetric relationship exacerbated by the physical space; thus, they did not perceive the act of asking for permission as a genuine offer. When pregnant women felt empowered in the conversation about weight and perceived that the midwife trusted what they shared about themselves, the conversation was perceived as relevant and they felt recognized as individuals. This identifies the need for further investigation of the efficacy of communication interventions including asking permission and subsequent training of midwives in achieving improvements in communication in the midwife consultation. Furthermore, the study illustrates the importance of actively involving both pregnant women and midwives in the development of communication interventions to ensure efforts do not unintentionally exacerbate stigma but instead promote understanding and support.

Abbreviations

BMI Body mass index
HCPs Healthcare professionals

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

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Author contributions

S.G., A.S.K., S.D.J. and D.H. contributed to the study's design and interpretation of the data. S.G. and A.S.K. developed the analysis plan and collected the data. S.G. and A.S.K. analysed the data and wrote the initial draft of this article. D.H., P.A. and S.D.J. provided feedback on multiple drafts and approved the final submission. All authors reviewed the manuscript.

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Data availability

The datasets supporting the conclusions of this article are not publicly available due to the individual privacy of the women but are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

Oral consent was obtained prior to participant observation, and written consent was obtained prior to focus group interviews as well as individual interviews. In accordance with Danish legislation, interview studies are not required approval from the National Committee on Health Research Ethics. The project was registered as a Quality assurance project in The Central Denmark Region (J.no 1-16-02-190-24).

Consent for publication

This article does not contain personally identifiable data from individuals or organizations. Participants consented to the publication of findings from the study.

Competing interests

The authors declare no competing interests.

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