‘The answer is simple: be respectful’: Female general practitioner views on reducing weight stigma to improve maternity care

Jessica van den Heuvel, Katharine Wallis, Lauren Kearney, Leonie Callaway

Background and objective
Weight stigma contributes to health inequity for pregnant women living in larger bodies. General practitioners (GPs) are an important gateway into maternity care. Our aim was to explore GP views on weight stigma in maternity care to inform recommendations for non-stigmatising care.

Methods
Participants were Australian GPs providing maternity care who ranked highly on fat-acceptance survey scores. Twenty semi-structured interviews in 2024 explored GP backgrounds, beliefs and behaviours when treating larger-bodied women. Interviews were analysed using reflexive thematic analysis.

Results
Participants had experienced weight stigma both personally and professionally. Participants reported using reflective practice to reduce their weight-based biases. Recommendations for organisational improvement included revising guidelines, communication skills training, and funding for rural services.

Discussion
Findings suggest that reflective practice could be encouraged to decrease weight stigma in maternity care. Recommendations could provide a blueprint for policymakers, educators and practitioners who wish to reduce weight stigma in maternity care.

PEOPLE LIVING IN LARGER BODIES are vulnerable to weight stigma when accessing maternity care.[1] Weight stigma is defined as the negative attitudes, beliefs and stereotypes about people based on their body size, and is pervasive in the medical system.[2,3] Resting on the assumption that larger bodied people are gluttonous, lazy and lacking self-discipline, weight stigma can cause physical and psychological harm, and affected individuals are less likely to access or receive adequate care.[4] A direct contributor to ‘the global obesity pandemic’,[5] weight stigma is particularly harmful in maternity care, where it can overshadow the joy and miracle of childbirth. While maternity care providers aim to deliver the highest quality care, stigmatising attitudes about body size can negatively affect their provision of care, leading to patient disengagement and, ultimately, worse outcomes for mother and baby.[3,6]

In Australia, a general practitioner (GP) is often the first healthcare professional that a woman sees in her journey through pregnancy, the one who manages her antenatal and postnatal care, and who cares for her baby as it grows. Integral to maternity care, GPs hold responsibility for initiating non-stigmatising care for people of all shapes and sizes.

While there is increasing recognition that weight-based bias and stigma are major obstacles in efforts to advance prevention and treatment of illnesses associated with larger bodies,[7,8] there is limited evidence regarding approaches that produce sustained attitude and behavioural change among clinicians.[9] Input from GPs is key to the development of successful interventions. To date, however, there has been little research investigating the views of GPs on weight stigma in maternity care. Most research has employed quantitative surveys, focused on consumer voices, or the negative stigmatising views of healthcare practitioners.[5,10,11]

Using non-stigmatising language is important, as inappropriate language can, often unintentionally, have a detrimental impact.[2] In this paper, we have occasionally used the word ‘fat’. Many individuals and communities have reclaimed the word as a source of empowerment and resistance and as a neutral descriptor rather than a derogatory term.[12] More often however, we have used the phrase ‘larger bodied’. We have made a conscious effort to avoid terms such as ‘overweight’ and ‘obesity’, as we agree with fat activists and scholars that medicalising body shape and size adds to stigma.[9] We use the term ‘women’ as all our participants and most maternity patients in Australia identify as such. However, we acknowledge that not all people who seek and receive prenatal, antenatal and postnatal care identify with the term. We intend to be inclusive of all people who are pregnant or give birth, guided by literature where gendered language has been used.[13,14]

This study aimed to explore the views of GPs with high fat acceptance on weight stigma in maternity care, to inform meaningful recommendations for practice, policy and educational reform.

Methods

The Maternity care providers' attitudes and beliefs toward weight and body size during pregnancy (Mat-CARES) survey was conducted in 2023–24,[15] measuring the implicit and explicit weight bias of maternity care providers using the Fat Attitudes Assessment Toolkit (FAAT), a validated measure for quantifying contemporary attitudes towards fat people and fatness (Box 1).[16] Survey data enabled calculation of a Fat Acceptance Composite (FAC) score, with a higher score indicating a more positive evaluation of larger bodied people.

Box 1. FAAT and FAC

The FAAT measures contemporary fat attitudes and beliefs in a non-stigmatising manner. There are nine subscales, eight of which were used in the Mat-CARES survey: (1) empathy (7 items); (2) activism orientation (7 items); (3) size acceptance (6 items); (4) critical health (5 items); (5) general complexity (6 items); (6) socioeconomic complexity (3 items); (7) responsibility (6 items); and (8) body acceptance (4 items). We excluded the 'attractiveness' subscale, as this was not relevant to our research question. Responses utilise a 7-point Likert scale, with higher FAC scores indicating higher levels of fat acceptance and more positive evaluations of larger bodied people.[16]

FAAT, Fat Attitudes Assessment Toolkit; FAC, Fat Acceptance Composite; Mat-CARES survey, Maternity care providers' attitudes and beliefs toward weight and body size during pregnancy survey.

A total of 144 GPs responded to the Mat-CARES survey, and 49 of these indicated a willingness to be contacted for further research. Purposive sampling was utilised to select GPs with higher fat acceptance, and therefore lower implicit and explicit weight bias, to implement a strengths-based approach.[17]

The FAC scores of the GPs ranged from 25 (highest) to 7 (lowest), with a mean score of 22.74. The GPs with a score of 20 or above (n = 34) were invited via email to participate in a semi-structured interview over videoconference (Zoom Communications, San Jose, CA, USA), and 25 of these GPs agreed to interview. Between May and July 2024, 20 interviews were conducted before adequate information power was considered to have been reached.[18] Interviews were conducted by JVDH, a general practice academic registrar with a Diploma of Obstetrics and Gynaecology (DRANZCOG) and with recent experience of receiving maternity care. The question guide was developed to elicit an understanding of participants' backgrounds, beliefs and behaviours when caring for larger bodied maternity patients (Appendix 1; available online only). Interviews were recorded on Zoom with permission and transcribed verbatim.

Data analysis

Data was analysed using Braun and Clarke's Reflexive Thematic Analysis (RTA), in order to embrace JVDH's own subjectivity and creativity as assets in knowledge production.[19] Coding involved identifying comments that addressed similar issues, and then organising these around relatively core commonalities to form overarching themes. Multiple additional coders were utilised (LC, KW), not to pursue consensus, but to reflexively sense-check and explore interpretations.[19] Reasoning was inductive, attempting to create latent meaning from the data.

Ethics approval

Ethical approval was provided by The University of Queensland Ethics Committee (project ID 2023/HE001582). This research was undertaken with the informed consent of participants. In respectful recognition of their time, participants were offered a $150 gift card.

Findings

Twenty GPs from six Australian states and territories were interviewed. The mean interview time was 18 minutes (range 9–31 minutes). Seventeen participants were based in metropolitan areas, and three practiced procedurally as GP obstetricians. The median self-identified body shape was 5.5 on the 9-point Stunkard Scale[20] (Figure 1). All participants identified as female and non-indigenous and fifteen were parents (Table 1).

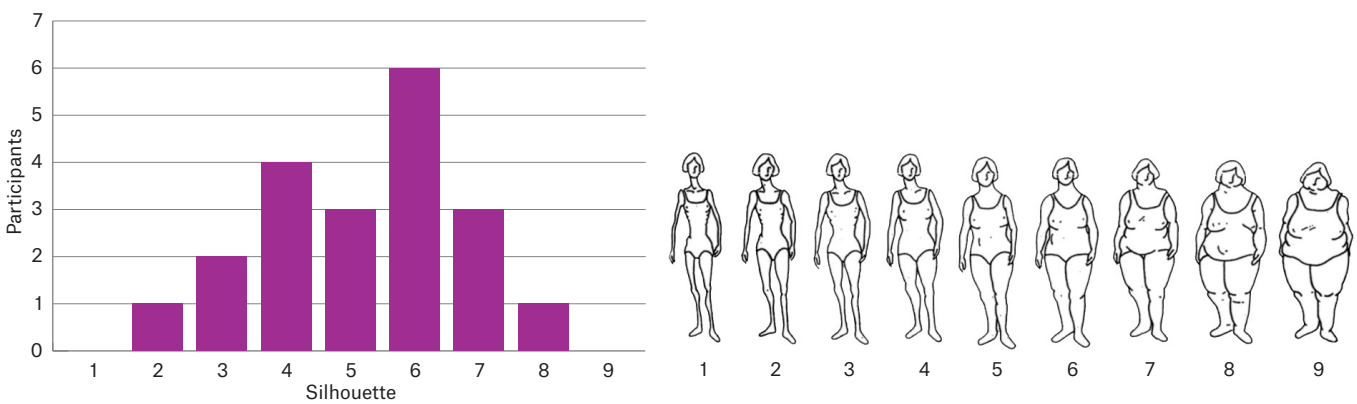

Figure 1. General practitioner participants' self-identified body silhouette using Stunkard scale.[20]

Table 1. Demographics of general practitioner participants (n = 20)

Demographic	Percentage (n)
Age range	
31–40 years	75% (15)
41–50 years	20% (4)
51–60 years	5% (1)
Profession	
GP	85% (17)
GP obstetrician	15% (3)
Location	
Metropolitan practice (MMR 1)	80% (16)
Rural practice (MMR 3–5)	10% (2)
Remote or very remote practice (MMR 6–7)	10% (2)
Years practising	
<5 years	5% (1)
6–10 years	50% (10)
11–15 years	35% (7)
>15 years	10% (2)
Children	
Has children	75% (15)
Does not have children	25% (5)

GP, general practitioner.

Six themes were constructed from the interview data: (1) personal journey; (2) socioeconomic environment; (3) uncertainty; (4) harms; (5) beneficence; and (6) recommendations (Figure 2). These are discussed below under three headings: personal experience of weight stigma; professional experience of weight stigma; and recommendations for reducing weight stigma.

Personal experience of weight stigma

Personal journey

Personal struggles with weight and body image strongly influenced GP views on weight stigma. For some (9 participants), this was due to their experience of living in a larger body:

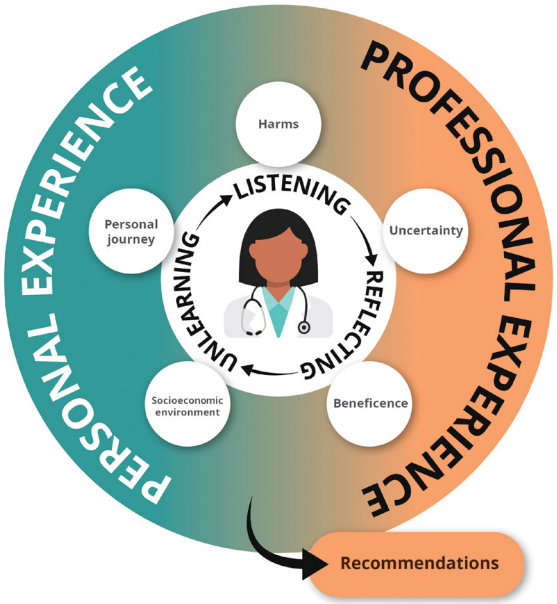

Figure 2. The general practitioner experience of weight stigma in maternity care: an ongoing journey of listening, reflecting and unlearning.

> *I've been overweight my entire life ... So I kind of experienced bias and stigma from a very young age.* (GP01)

For others, it was struggles with body image or disordered eating in earlier years, or witnessing the struggles of a loved one:

> *I have personal experiences with disordered eating. Going through that made me more receptive to a different approach.* (GP17)

For many, their interest in the issue of weight stigma was triggered by the experience of becoming a parent themselves. Pregnancy and postpartum are periods when an individual's 'body completely changes' (GP16), and bystanders might feel that they have a free pass to comment on these changes. For many, especially those who do not 'get back to pre-pregnancy size within 12 months', this can be a 'really hard time' (GP16).

Three GPs who had female children that are now either pre-teen or teen described the challenges involved with parenting in a space with a heavy influence of body image as being instrumental in their changing of attitudes:

> *Having a daughter was instrumental ... because I didn't want her to feel as bad about her body as my friends all did ... I didn't want that to happen for another generation.* (GP19)

Interestingly, these same GPs reflected on their own experience of being a daughter and having their body criticised:

> *I remember my own late mother mirroring, I'm sure, what happened to her, commenting when she thought I was looking less or more thin or less or more fit, and I didn't like it.* (GP05)

The GPs were honest about their limitations in achieving completely weight-neutral attitudes, citing that they still need to 'stop and check' themselves (GP03) when they become critical of body weight. They admitted that their journey to body acceptance remains ongoing and unfinished:

> *I'm pretty sure there's a long way for me to go, but I think that's a good start.* (GP10)

Socioeconomic environment

Multiple GPs made reflections on growing up in a society where diet culture and fat shaming are pervasive, and the negative impact of this on body image and self-worth. They reported the sentiment 'fat equals unhealthy, skinny equals healthy' (GP08) was strongly perpetuated by the media, peers and healthcare professionals during their younger years and when receiving their own maternity care. While this sentiment remains alive and well in today's society, positive changes over time were noted by an older GP, who has seen 'strong', rather than 'skinny' women become role models for today's generation.

Further quotations relating to GP personal experience are presented in Appendix 2 (available online only).

Professional experience of weight stigma

Harms

All participants commented on the harm that they have seen weight stigma cause the women they care for.

Emphasis was placed on mental health harms, in particular the damaging effect of shame on women, stemming from a society and a medical profession that traditionally links health and self-worth to a number on a scale:

> *They've got mirrors. They know that they're overweight. I'm not sure ramming it home with the number on the scale is really going to make a lot of difference. They already know. They all suffer, most of them, not* (sic) *everyone, but a lot of them suffer with a huge amount of shame anyway.* (GP19)

Witnessed stigmatising events had often taken place in hospital settings, however participants also mentioned the harm caused by doctors who recommend weight loss to larger bodied patients at every consult, even if the presenting complaint had nothing to do with weight.

Participants highlighted that psychological conditions and eating disorders are often linked with living in a larger body, and that these can be made worse by perceived judgements from healthcare professionals:

> *So that's a really big deal. If we, as healthcare providers are, inadvertently I'm sure, triggering people's eating disorders through our language and behaviours.* (GP14)

Crucially, it was emphasised that these mental harms are avoidable, and that they ultimately lead to inadequate maternity care; through missed diagnoses, overly simplistic pathophysiology, conflicting advice, and ultimately, disengagement from healthcare.

Participants expressed frustration with the lack of holistic teaching on weight and body size in medical education and the way 'weight' often serves as a proxy for 'health'. While the GPs still use body mass index (BMI) when required (eg for hospital referrals), most reported dissatisfaction with the measure: 'BMI is a terrible indicator of health' (GP03). GPs noted situations where women had been pigeon-holed, unnecessarily over investigated, or not believed by other health professionals. GP11 said, 'it's not always gonna be the fat person who gets GDM (gestational diabetes mellitus)'.

Women being given conflicting advice was raised as an issue by participants, for example in situations where women are told to delay pregnancy until they 'lose weight, but also don't start trying too late ... it's a bit of a hard ask' (GP06).

Participants emphasised that these inadequacies could become very harmful when they cause women to disengage from healthcare:

> *... we want people to engage in care, and we all know that antenatal care is an important part of providing safe care for mums and babies, and if we're pushing women away, then that can only have negative consequences.* (GP14)

Uncertainty around the right way to practice

However, participants acknowledged that larger bodies in pregnancy can be associated with increased health and/or safety risks, such as gestational diabetes and caesarean delivery. These were particularly noted by GP obstetricians who practice rurally and therefore are responsible for procedures, such as deliveries and caesarean sections, which can be more technically challenging and carry higher risks for larger bodied women:

> *I often ... become quite stressed doing antenatal clinic or deliveries for women with larger bodies as it is often more challenging.* (GP02)

Rural practitioners face additional challenges because of the lack of available resources for handling difficult emergency situations, and highlighted the stress involved in dealing with these away from collegiate and equipment support. They therefore expressed understanding of policies requiring women over certain BMI cutoffs being transferred to tertiary centres, however still felt that such policies can be stigmatising.

In the face of such challenges, both rural and metropolitan participants expressed a desire to be pragmatic; however, doing this in a space with unclear and sometimes outdated guidelines leads to stress and uncertainty. Many GPs admitted to disregarding guidelines and practising in a way that felt least stigmatising to them. This led to differences in practice between the GPs interviewed:

> *It's about marrying the two because there's formal teaching and knowing there's a gap in the evidence, so you're sort of finding a way that works for you to practice.* (GP06)

A good example of this is the practice of weighing women at every antenatal visit. Many participants never weighed, some weighed only to support a hospital referral and one weighed every woman at her initial visit. Some felt comfortable going against guidelines, while for less experienced GPs this led to further uncertainty.

Ethical duty: Beneficence

The key motivation for GPs to practice weight-neutral maternity care, even when this means ignoring guidelines, is the duty to do what is right for the patient (beneficence):

> *The answer is simple:* (it's) *be respectful. I think that's just the crux of what it should be.* (GP18)

Participants emphasised a holistic view of health, expressing that the focus of care should be on 'the whole woman' (GP08), encouraging nourishing food, enjoyable physical activity and strong social networks to support mental health; regardless of weight or size. Through this, GPs felt they have 'been able to engage in better healthcare outcomes for people because we're not focusing on a number' (GP16).

Several GPs suggested that best practice care starts with meeting women where they are at, rather than pushing their own agenda on her. They said that the role of the GP is to support the woman within the parameters that they have, particularly during the already emotionally heightened and sensitive period of life that is pregnancy.

In their desire to provide good care, some GPs saw themselves as protectors of their patients, often feeling it was their duty to warn them about, and support them through, the stigma and bias that they might receive from other healthcare professionals during their maternity care.

Further quotations relating to GP professional experience are presented in Appendix 3 (available online only).

GP recommendations for reducing weight stigma in maternity care

Critical reflection was pivotal in the journey of 'unlearning' (GP19) that led these GPs to become more fat accepting. The GPs recommended that others hoping to provide non-stigmatising maternity care could reflect on their own personal and professional experiences and how these have potentially led to anti-fat biases:

> *I've reflected on how much work I've put into this, thinking … 'no wonder other GPs don't have this view because of what we're taught.' And because it has taken such a significant amount of self-reflection and reflection on society as a whole.* (GP04)

They recommended seeking educational opportunities outside of the traditional teachings, citing frameworks such as 'Health at Every Size' (HAES), and clinician led social media groups such as 'GP Mums', which had been beneficial for them.

GPs recommended a number of organisational changes to decrease weight stigma in maternity care. These included revising evidence-based guidelines on caring for larger bodied women, research to better understand the epidemiology of obesity and pregnancy outcomes, and appropriately representing risk (relative vs absolute). They advocated for communication skills training built on language consensus, for example writing cases with larger bodied patients for difficult communication registrar training days or Objective Structured Clinical Examination (OSCE) stations. They recommended investing in appropriate equipment and upskilling clinicians to ensure safe physical clinical environments, and increased funding for rural and regional areas.

Further quotations highlighting GP recommendations are presented in Appendix 4 (available online only).

Discussion

Three key findings emerged from this study:

- GPs have experienced the harms that weight stigma causes; either to themselves, a loved one or a patient.
- Despite acknowledging the difficulties that can arise when treating larger bodied people, the GPs interviewed have been able to increase their fat acceptance through extensive reflective practice.
- GPs feel a duty to do what is right for their patients, and thus have shared recommendations, including revising guidelines, communication training and increased funding to rural and regional areas.

This is the first study to explore GP views on weight stigma in maternity care with a strengths-based approach. Nevertheless, our study has two main limitations. Firstly, our study was a purposely selected, convenience sample of entirely female and non-indigenous GPs, and therefore findings might not be generalisable. This is an important limitation, given that gender and cultural context can shape both health experiences and access to care. The predominance of women likely reflects both the topic's relevance and broader participation patterns but highlights the need for more inclusive recruitment strategies in future research to ensure diverse perspectives are captured. Purposively selecting GPs with the highest FAC score did, however, allow us to employ a strengths-based approach and focus the interviews to be solution driven. In this though, the second limitation appears. The second main limitation is that we have assumed that GPs who are the most fat-accepting are also providing more fat-accepting care, which is not a proven hypothesis. To know if this is true, we need to investigate the experience of the patients of the GPs with higher FAC score.

Box 2. Practical solutions for GPs navigating the uncertainties of treating larger bodied maternity patients

1. Understand your own level of implicit weight bias (https://implicit.harvard.edu/implicit/takeatest.html).
2. Take the time to engage in a deep critical reflection of your own background and beliefs about larger-bodied people, and how this might affect your behaviour in clinical practice.
3. Seek out educational opportunities that promote new models of thinking about weight and body size. Refer to references 22–25 for some suggested articles to start with.[22-25]
4. Consider your language use. We suggest the phrase 'larger-bodied', and welcome feedback on this.
5. Use discretion when weighing women. Regular weighing has no evidence of an effect on clinical outcomes.[25] We suggest having scales hidden from view, and only weighing if requested by the woman.
6. Use documentation to advise other clinicians not to discuss weight (eg in the chart include 'patient aware of weight, please do not discuss further without consent').
7. GP educators to teach students and registrars respectful communication skills. Suggest a weight stigma station in a difficult communication OSCE station.
8. GPs involved with guideline writing to review or rewrite maternity guidelines to:
   a) reduce use of BMI and replace with more appropriate measures[8,26]
   b) include efficient summaries of robust, up-to-date evidence on maternity outcomes for larger bodied patients
   c) use accurate representation of risk (ie use absolute rather than relative risk).
9. Call on policymakers to better support rural and regional practitioners, with investments in on-ground skilled teams, and funding for appropriate equipment.

BMI, body mass index; GP, general practitioner; OSCE, objective structured clinical examination.

Conventional weight-centric medicine is, at best, incomplete. Our results concur with those of previous studies that report the harmful presence of weight stigma in healthcare, and call for the development of clear guidelines and increased training opportunities for healthcare professionals.[5,7,9] The novel contribution of our research lies in its focus on everyday primary care practitioners with a low anti-fat bias, allowing us to learn from GPs on the frontline of maternity care. The recommendations of our participants have been summarised into practical solutions, presented in Box 2.

Reflective practice that allows healthcare practitioners to recognise their weaknesses and identify knowledge and skills gaps is crucial in overcoming weight stigma in healthcare.[21] The GPs that we interviewed appear to have reduced their own weight-based biases. Importantly, they have achieved this through an entirely self-directed journey of critical reflection, unlearning and relearning. To our knowledge, this is the first evidence that GPs have been able to reduce their own weight-based biases through self-directed reflective practice.

Conclusion

The GPs interviewed have engaged in reflective practice that has enabled them to reduce their own weight-based biases. Strategies they used to achieve this included reflecting on their upbringing and personal experiences, reflecting on the harms weight stigma caused their patients, and engaging with educational resources outside of the traditional medical curriculum. Teaching weight-inclusive maternity care alongside communication skills to medical students and general practice registrars is vital. A guideline for weight-inclusive maternity care that summarises up-to-date and robust evidence would be beneficial. Investment should be made in weight-inclusive skills and communication training, and mental health supports; especially in rural areas. Future research should determine how best to support educators, policymakers, students and practitioners to reflect on their own experiences and biases to make changes to promote inclusive maternity care for people of all shapes and sizes.

Authors

Jessica van den Heuvel MD, DRANZCOG, FRACGP, Senior Lecturer, General Practice Clinical Unit, Medical School, The University of Queensland, Brisbane, Qld

Katharine Wallis PhD, MBChB, MBHL, Dip Obst, FRNZCGP, FACRRM, Mayne Professor and Head, Mayne Academy of General Practice, Brisbane, Qld; Head, General Practice Clinical Unit, Medical School, The University of Queensland, Brisbane, Qld

Lauren Kearney PhD, RN, RM, Conjoint Associate Professor in Midwifery, School of Nursing, Midwifery and Social Work, The University of Queensland, Brisbane, Qld; Discipline Lead – Midwifery, Women's and Newborn Services, Royal Brisbane and Women's Hospital, Brisbane, Qld

Leonie Callaway PhD, MBBS, FRACP, Director of Research, Women's and Newborn Services, Royal Brisbane and Women's Hospital, Brisbane, Qld; Professor, Medical School, The University of Queensland, Brisbane, Qld

Competing interests: None.

Funding: JVDH completed this research project during an Academic General Practice Registrar post, supported by The Royal Australian College of General Practitioners (RACGP) with funding from the Australian Government under the Australian General Practice Training (AGPT) Program.

Provenance and peer review: Not commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

Correspondence to:
j.vandenheuvel@uq.edu.au

Acknowledgements

The authors thank the general practitioners very much for their willing participation in this research and their thoughtful contributions. Colleagues in the General Practice Clinical Unit of The University of Queensland gave helpful feedback on early project data.

References

References are available online only.

References

1. Niela-Vilén H, Murto T. Weight stigma in maternity care. Sex Reprod Healthc 2023;38:100923. doi: 10.1016/j.srhc.2023.100923.
2. Brown A, Flint SW, Batterham RL. Pervasiveness, impact and implications of weight stigma. EClinicalMedicine 2022;47:101408. doi: 10.1016/j.eclinm.2022.101408.
3. Lawrence BJ, de la Piedad Garcia X, Kite J, Hill B, Cooper K, Flint S. Weight stigma in Australia: A public health call to action. Public Health Res Pract 2022;32(3):3232224. doi: 10.17061/phrp3232224.
4. Rubino F, Puhl RM, Cummings DE, et al. Joint international consensus statement for ending stigma of obesity. Nat Med 2020;26(4):485–97. doi: 10.1038/s41591-020-0803-x.
5. Lawrence BJ, Kerr D, Pollard CM, et al. Weight bias among health care professionals: A systematic review and meta-analysis. Obesity (Silver Spring) 2021;29(11):1802–12. doi: 10.1002/oby.23266.
6. Nutter S, Eggerichs LA, Nagpal TS, et al. Changing the global obesity narrative to recognize and reduce weight stigma: A position statement from the World Obesity Federation. Obes Rev 2024;25(1):e13642. doi: 10.1111/obr.13642.
7. Hill B, de la Piedad Garcia X, Rathbone JA, et al. Supporting healthcare professionals to reduce weight stigma. Aust J Gen Pract 2024;53(9):682–85. doi: 10.31128/AJGP-07-23-6906.
8. Rubino F, Cummings DE, Eckel RH, et al. Definition and diagnostic criteria of clinical obesity. Lancet Diabetes Endocrinol 2025;13(3):221–62. doi: 10.1016/S2213-8587(24)00316-4.
9. Heidebrecht C, Fierheller D, Martel S, et al. Raising awareness of anti-fat stigma in healthcare through lived experience education: A continuing professional development pilot study. BMC Med Educ 2024;24(1):64. doi: 10.1186/s12909-023-04889-8.
10. Mulherin K, Miller YD, Barlow FK, Diedrichs PC, Thompson R. Weight stigma in maternity care: Women's experiences and care providers' attitudes. BMC Pregnancy Childbirth 2013;13(1):19. doi: 10.1186/1471-2393-13-19.
11. Furness PJ, McSeveny K, Arden MA, Garland C, Dearden AM, Soltani H. Maternal obesity support services: A qualitative study of the perspectives of women and midwives. BMC Pregnancy Childbirth 2011;11(1):69. doi: 10.1186/1471-2393-11-69.
12. Manne K. Unshrinking: How to fight fatphobia. 1st edn. Crown, 2024.
13. Griffiths A, Kingsley S, Mason Z, Tome R, Tomkinson M, Jenkinson B. Listening to larger bodied women: Time for a new approach to maternity care. Women Birth 2023;36(5):397–400. doi: 10.1016/j.wombi.2023.07.001.
14. Gribble KD, Bewley S, Bartick MC, et al. Effective communication about pregnancy, birth, lactation, breastfeeding and newborn care: The importance of sexed language. Front Glob Womens Health 2022;3:818856. doi: 10.3389/fgwh.2022.818856.
15. Kearney L, Jenkinson B, Robins A, et al. Maternity care providers' attitudes and beliefs toward weight and body size during pregnancy: A cross-sectional survey. Sex Reprod Healthc 2025;46:101145. doi: 10.1016/j.srhc.2025.101145.
16. Cain P, Donaghue N, Ditchburn G. Development and validation of the Fat Attitudes Assessment Toolkit (FAAT): A multidimensional nonstigmatizing measure of contemporary attitudes toward fatness and fat people. J Appl Soc Psychol 2022;52(12):1121–45. doi: 10.1111/jasp.12882.
17. Poteat TC, Logie CH. A case for strengths-based approaches to addressing intersectional stigma in HIV research. Am J Public Health 2022;112(S4):S347–49. doi: 10.2105/AJPH.2021.306659.
18. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: Guided by information power. Qual Health Res 2016;26(13):1753–60. doi: 10.1177/1049732315617444.
19. Byrne D. A worked example of Braun and Clarke's approach to reflexive thematic analysis. Qual Quant 2022;56(3):1391–412. doi: 10.1007/s11135-021-01182-y.
20. Stunkard AJ, Sørensen T, Schulsinger F. Use of the Danish Adoption Register for the study of obesity and thinness. Res Publ Assoc Res Nerv Ment Dis 1983;60:115–20.
21. McGowan M, Garad R, Wadhwani G, et al. Understanding barriers and facilitators to lifestyle management in people with polycystic ovary syndrome: A mixed method systematic review. Obes Rev 2025;26(2):e13854. doi: 10.1111/obr.13854.
22. Brenton-Peters JM, Vallis M, Grant S, et al. Rethinking weight: Finding self-compassion for 'weight management'. Clin Obes 2023;13(1):e12562. doi: 10.1111/cob.12562.
23. Louise J, Poprzeczny AJ, Deussen AR, et al. The effects of dietary and lifestyle interventions among pregnant women with overweight or obesity on early childhood outcomes: An individual participant data meta-analysis from randomised trials. BMC Med 2021;19(1):128. doi: 10.1186/s12916-021-01995-6.
24. Bacon L, Aphramor L. Weight science: Evaluating the evidence for a paradigm shift. Nutr J 2011;10(1):9. doi: 10.1186/1475-2891-10-9.
25. Dodd JM, Deussen AR, Poprzeczny AJ, Slade LJ, Mitchell M, Louise J. Investigating discrepancies in findings between rigorous randomized trials and meta-analyses evaluating pregnancy interventions to limit gestational weight gain. Obes Rev 2024;25(12):e13826. doi: 10.1111/obr.13826.
26. Zhang X, Ma N, Lin Q, et al. Body roundness index and all-cause mortality among US adults. JAMA Netw Open 2024;7(6):e2415051. doi: 10.1001/jamanetworkopen.2024.15051.

Appendices

These appendices are unedited and published as supplied by the author.

Appendix 1. Interview guide

Hi [name], thank you for taking the time to talk to me today. My name is Jess and I am a GP registrar researching weight stigma in maternity care. I would like to find out about your backgrounds, beliefs and behaviours when providing care to larger bodied women in the perinatal period. You have been identified as a general practitioner with low levels of anti-fat attitudes, which is why we are really interested in talking with you.

This interview will take about 30 minutes. We will treat this interview as strictly confidential and all identifiers (e.g. names) will be removed. We will not share any details with anyone outside the immediate researchers working on this project.

Is it okay with you for us to record this session for transcript?

Do you give your consent to go ahead with this interview?

In recognition of your time and contribution, we would like to offer you a voucher for $150. I will email this to you after our interview, unless you ask me to do otherwise.

If at any point you would like to take a break or stop the interview, please just let me know and I will do so.

Do you have any questions before we begin?

[RECORD]

QUESTIONS:

Background:

We already have some background information about you from the Mat-CAREs survey. I was just hoping to ask a few further questions about your practice.

1. Please tell me about the maternity care you provide? (e.g. GP shared care)
2. Why do you want to be involved with this interview study about GP attitudes towards larger bodied women?
3. During your medical training, what was your experience of education regarding caring for larger bodied patients?

Beliefs:

1. When thinking about larger bodied patients, what does a 'healthy pregnancy' mean to you?
2. I'm interested in your journey informing your attitudes towards larger bodied maternity patients. Could you talk to me about that?

Behaviours:

1. Does your maternity (prenatal, pregnant, postnatal) care change depending on body size of your patient? (Why/why not/how?)

Looking forward

1. The next phase of our 'Body Positive Birth' research is to develop resources to support GPMCP to provide best quality care for larger bodied patients. Do you have any suggestions that may assist us in this process?

Do you have any final comments or questions?

Appendix 2: Personal experience		
Themes		Example Quotations
Personal journey	Personal struggles with weight and body image	"My dad was very overweight, but quite healthy, and he still is, you know, in his seventies. And I think...maybe, you know...I could see him for the person he was, not just the size and... I just don't like judging people in their appearances." (GP20) Like a lot of people with a type A personality, I flirted in my teenage years with a bit of control and food restriction. That did not feel good at the time. (GP05)
	Becoming a parent	I think it was actually having a daughter was instrumental… because I didn't want her to feel as bad about her body as my friends all did… I didn't want that to happen for another generation. (GP19) It's probably just to do with my own journey of body acceptance over time and through motherhood as well. (GP09)
	Ongoing and unfinished	But for myself, personally, I still have a few hang-ups, and I struggle to manage that. So sometimes I feel a bit like a hypocrite because I'm like, 'oh, I'd love to lose 10 kilos', and then I think, 'why, no, don't be so stupid.' But yeah… I don't know how you manage that. I'm getting better, slowly. (GP14)
Socioeconomic environment	Diet culture and fat-shaming	I grew up in the eighties, and I think a lot of people remember, especially women, from their childhood and adolescence the first time people commented on body size and weight. (GP05) There's a big societal pressure to look a certain way, or that fat people are incompetent at various things, or they don't have the self-control to achieve what they want. And then, obviously, they're not going to be good at their job because they can't control their own weight. (GP04)
	Change over time	And if you go through, like, when I was working, I worked in hospitals from '96 to 2001, and you know, we didn't have bariatric beds. We didn't have anything, and when someone was inhabiting a larger body, everyone just ran away. (GP19) Victoria Beckham was the skinny, skinny, skinny woman. And she's about my age, give or take. And she's… really, that was what our generation had, whereas my daughter's generation has Taylor Swift, who's beautiful, but she's not skinny. And Beyoncé. They're strong women…they're actual, proper people that can function. (GP19)

Appendix 3: Professional experience		
Themes		Example Quotations
Harms	Mental health	That's the kind of harm that I think is just so avoidable if we actually just don't fat shame people. (GP14) I've got patients that other doctors have hurt, have caused a lot of harm… always talking about their weight. (GP20)
	Shame	"Before she [the patient] had come in, they joked about her, calling her a 'hippo'. I felt awful hearing that." (GP03)
	Inadequacies of weight-centric medicine	We had one lady who is in a larger body. She had hyperemesis, and she presented to the emergency department and saw one of our emergency doctors. A comment was made about her 10 kilos weight loss. Well, isn't that good? … she was really upset by that. And she said she almost never came back again as a result. (GP14)
Uncertainty around the right way to practice	Health risks for larger bodied patients	We need to be quite pragmatic about the resources and the skills and traditional research which highlights significantly higher complications for people living in larger bodies with pregnancies and trying to minimise that. It's a really hard space. (GP04)
	Lack of resources in rural/regional areas	Our obstetricians have 12 months of training, so they don't have a lot of exposure to all of the complications… we know that it's a much more difficult tubing a pregnant lady. We know it's a more difficult tubing a lady a larger body size. So add those two things together and it's much more difficult. (GP18) So yeah, look, I understand why [transfer to a regional centre] has to happen. It's just hard putting it into practice when you see the effect it has on people, and like having to tell someone that they have to go somewhere else because, you know, you're too big. (GP14)
	Differences in practice	We don't have the good data. And I don't currently feel comfortable telling people to lose weight. And equally, when I say don't worry about your weight, I'm not sure I'm doing the right thing. (GP04)
Ethical duty: beneficence	Providing holistic care	I think there's a standard of care which you ideally should be applying, regardless of a woman's body size. GP09
	Meeting women where they are at	And I think it's much more about supporting someone in their journey, and not for me to tell them what their journey is. (GP19)
	GPs as protectors	The reality is that the health system in general has weight stigma and bias, so part of the work as a GP is to support patients through that. (GP07) So to do better than what came before, is kind of what I am trying to do. (GP05)

Appendix 4: Recommendations		
Themes		Example Quotations
Personal factors	Reflection	I've reflected on how much work I've put into this, thinking… "no wonder other GPs don't have this view because of what we're taught." And because it has taken such a significant amount of self-reflection and reflection on society as a whole. (GP04)
	Seeking educational opportunities outside of traditional teachings	I learned about the Health at Every Size kind of movement through one of the Facebook groups. And that's when I kind of started to become aware of the evidence of, you know, how diet culture and how bad it is and how pervasive it is, and actually obesity itself is not a disease. And it's just a number, really, and that it's actually the medical conditions we should be treating, and not the weight on the scale as such. (GP14)
Organisational factors	Revise/ rewrite evidence-based guidelines	So I know my go-to is the Mater Shared-Care guidelines. So those kind of sources are where people are already looking for their resources. So if those kind of things were less weight-focussed, it would help. (GP17)
	Research into the epidemiology of obesity and pregnancy outcomes	I think a lot of doctors are only going to listen to the evidence. It's going to be really hard to overcome that kind of societal, ingrained behaviour. You know, fat is bad and fat people are lazy and should just try harderS. o I think evidence is going to be the way to try and get through to people. (GP14) Show me the evidence that stopping this woman from putting on weight helps the baby, when maybe we're actually starving the baby and making her pregnancy hell. (GP08)
	Appropriate representation of risk	Having a breakdown of what increased risk actually means and what that looks like relative to other risks. (GP06)
	Communication skills training	Ensuring communication is clear. I had a patient complain that their GP had put them on a higher dose of folic acid, but hadn't explained why, so they felt they had been mismanaged. (GP12)
	Language consensus	Having a like a language resource would be useful. Lots of women don't like hearing the words 'obese' or 'fat'. Some are fine with it, but even just having, like, how to approach the conversation of what terms do they like? (GP01) The language used is important. Advice should not make patients feel ashamed or judged. (GP12)
	Safe physical clinical environments	At the end of the day, we tailor our care every day to women with lots of different needs and body shape and size is just another thing we need to tailor our care to. (GP02) I'm more aware of making them feel comfortable in the space which is challenging. Because well, our chair… Our chairs are wonderful for elderly people, because have wonderful arm rests. But they completely prevent people who … even have wider hips… so I requested larger chairs to accommodate larger body people. And a few of my patients have noticed that one chair, and they thanked me for it. (GP16)
	Increased funding to rural and regional areas	It would be lovely…. as I sort of said, I came from a regional area… to be able to upskill the more regional and rural areas to be able to manage lower risk pregnancies who are being sent to these bigger hospitals purely because of the high weight. (GP01) We don't have bariatric beds, we don't have, you know, all of the monitoring and fancy bells and whistles that your more regional hospitals do. You don't have all of those supports, you don't have, you know, 30 doctors in the hospital at once. (GP18)