De-moralising clinical targets: Rethinking diabetes care to reduce stigma

Clinical indicators such as HbA_{1c}, time in range and body weight are foundational to providing effective, evidence-based care of people living with type 2 diabetes. They guide risk stratification, inform treatment decisions and allow monitoring of therapeutic response. Landmark trials have shown that maintaining an HbA_{1c} around 53 mmol/mol (7.0%) reduces the risk of microvascular complications (DCCT Research Group, 1993), while weight loss of at least 5% improves glycaemic and cardiometabolic outcomes (Wing et al, 2011). Therefore, clinical targets have an important role in maintaining long-term health and quality of life.

However, when clinical care is organised primarily around achieving predetermined biomedical targets, the person behind the measurement can become secondary. In this context, biomedical priorities may eclipse the psychological, social, economic and structural factors that shape an individual's capability, opportunity or motivation to achieve them, such as diabetes distress, healthcare access and affordability of medications.

For decades, researchers, clinicians and people living with diabetes have advocated for diabetes care that extends beyond biomedical management and outcomes (Jones et al, 2015; Young-Hyman et al, 2017). From a stigma perspective, the concern is not only that target-driven care oversimplifies diabetes, but that it may also reinforce blame, judgment and shame within healthcare.

From targets to stigma: mechanisms and consequences in type 2 diabetes care

Type 2 diabetes already has a profound framing problem. There is an entrenched, inaccurate societal perception that type 2 diabetes is a consequence of "poor lifestyle choices" and lack of self-control (Speight et al, 2024; Ekpor et al, 2026). Such narratives imply that "successful" management depends entirely on individual willpower.

Target-driven models of care may inadvertently legitimise these assumptions by reducing the complexities of type 2 diabetes management to the pursuit of biomedical outcomes. Thus, the limited time available in clinical consultations becomes focused on "lowering HbA_{1c}" or "losing weight" (Ekpor et al, 2026). This positions type 2 diabetes management as linear and easily controllable. When targets are not achieved, individuals may be labelled, albeit unintentionally, as "non-compliant", "difficult", "unmotivated" or "lazy", or their diabetes as "uncontrolled".

The language used to describe clinical indicators can further reinforce this framing. Diabetes *Language Matters* guides have highlighted that use of terms such as "good control" or "poor control", commonly used to describe whether clinical indicators are within recommended targets, can convey judgements about a person's self-management efforts (Holmes-Truscott et al, 2026).

Consequently, clinical indicators risk becoming moralised as "pass/fail" tests of personal responsibility, transforming measures designed to inform and support care into metrics by which people themselves are evaluated (Ekpor et al, 2026). People living with diabetes have consistently described the overemphasis on target attainment, and the judgmental terms used to describe this, as dismissive of their lived experience, obscuring the substantial emotional, social and practical demands of self-management whilst fostering perceptions that outcomes reflect personal commitment or motivation. These experiences can translate into shame, self-blame, reduced trust in healthcare professionals, and avoidance or disengagement with clinical/self-care, all of which are responses associated with adverse clinical outcomes, including higher HbA_{1c} (Schabert et al, 2013).

The moralisation of clinical targets may, therefore, undermine achievement of the very outcomes those targets are intended to improve.

Emmanuel Ekpor
Graduate Researcher and RGN, Deakin University, Geelong, and The Australian Centre for Behavioural Research in Diabetes (ACBRD), Carlton, Victoria, Australia

Elizabeth Holmes-Truscott
Senior Research Fellow, Deakin University, Geelong, and Deputy Director, The Australian Centre for Behavioural Research in Diabetes (ACBRD), Carlton, Victoria, Australia

Eileen Lam
Lived-experience author, ACBRD Lived Experience Project Advisory Group: Type 2 Diabetes Community Involvement, Melbourne, Victoria, Australia

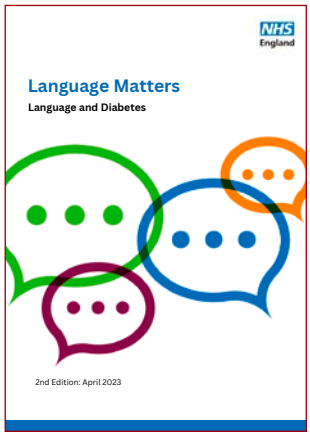
Samuel Akyirem
Assistant Professor of Nursing and RGN, University of Kentucky, Lexington, KY, USA

Jackie Sturt
Professor of Behavioural Medicine in Nursing, King's College, London

Jane Speight
Professor of Behavioural and Social Research in Diabetes, Deakin University, Geelong, and Foundation Director, The Australian Centre for Behavioural Research in Diabetes (ACBRD), Carlton, Victoria, Australia

Citation: Ekpor E, Holmes-Truscott E, Lam E, Akyirem S, Sturt J, Speight J (2026) De-moralising clinical targets: Rethinking diabetes care to reduce stigma. *Diabetes & Primary Care* **28**: 191–2

Useful resources
(click the thumbnails to access)







De-moralising clinical indicators

Clinical indicators should be de-moralised. In practice, this means they should inform shared, individualised decision-making rather than serve as markers of motivation, effort or success. Moving from target-driven to person-centred use of clinical metrics would preserve their clinical value while recognising that the same result can arise from very different circumstances and may warrant very different responses.

The implication is not to abandon biomedical indicators such as HbA_{1c} or body weight, or to replace them with another metric. Alternative metrics, such as time in range or "time in tight range" (TITR), can also reinforce stigma if they are absorbed into the same reductionist logic. Concerns have already been raised that TITR, developed to encourage "stricter" glycaemic management, may itself imply that time in range is somehow "lax", fostering feelings of judgement and failure if this is not realistic for the individual (Wang et al, 2025). The challenge, therefore, lies not in what is measured but in how measurements are framed, interpreted, discussed and acted upon.

Practical starting points and next steps

Several initiatives offer practical starting points for this shift towards de-moralising clinical targets. Notably, diabetes *Language Matters* guides provide recommendations for person-centred communication about clinical indicators (Holmes-Truscott et al, 2026). We can also learn from and adopt initiatives such as the Type 1 Consultation Tool, designed to support clinicians and people with type 1 diabetes to collaboratively establish personalised HbA_{1c} goals (Choudhary et al, 2021). However, these guidelines and tools require evaluation to determine whether, how and under what circumstances they influence communication, clinical decision-making and experiences of stigma.

More fundamentally, research is needed to examine how target-driven care models may facilitate diabetes stigma and the systems that may sustain them (e.g. funding, audit and performance frameworks that prioritise measurable biomedical outcomes). Without addressing these systems, person-centred communication and individualised targets risk becoming superficial adaptations within structures that continue to privilege target attainment over people's lived circumstances and priorities. ■

Choudhary P, Edwards F, Patel NH et al (2021) *Type 1 Consultation (T1C) Tool: User guide*. Health Innovation Network, London. Available at: https://bit.ly/3Vk3ZwT

DCCT Research Group (1993) The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* **329**: 977–86

Ekpor E, Manallack S, Garza M et al (2026) Experiences of type 2 diabetes stigma in healthcare settings: A mixed-methods systematic review. *Diabetes Res Clin Pract* **236**: 113283

Holmes-Truscott E, Ekpor E, Litterbach E et al (2026) From Language Matters to stigma-free communication in diabetes: Evolution, challenges, and next steps. *Diabet Med* **43**: e70311

Jones A, Vallis M, Pouwer F (2015) If it does not significantly change HbA_{1c} levels why should we waste time on it? A plea for the prioritization of psychological well-being in people with diabetes. *Diabet Med* **32**: 155–63

Schabert J, Browne JL, Mosely K, Speight J (2013) Social stigma in diabetes: A framework to understand a growing problem for an increasing epidemic. *Patient* **6**: 1–10

Speight J, Holmes-Truscott E, Garza M et al (2024) Bringing an end to diabetes stigma and discrimination: An international consensus statement on evidence and recommendations. *Lancet Diabetes Endocrinol* **12**: 61–82

Wang R, Kyi M, O'Neal D et al (2025) When glucose time in range is not tight, is it lax? Considering new terminology for CGM targets. *Lancet Diabetes Endocrinol* **13**: 270–2

Wing RR, Lang W, Wadden TA et al; Look AHEAD research group (2011) Benefits of modest weight loss in improving cardiovascular risk factors in overweight and obese individuals with type 2 diabetes. *Diabetes Care* **34**: 1481–6

Young-Hyman D, de Groot M, Hill-Briggs F et al (2017) Psychosocial care for people with diabetes: A position statement of the American Diabetes Association. *Diabetes Care* **39**: 2126–40