Weight stigma and bias: New standards of care from the ADA

Weight stigma and bias: Standards of care in overweight and obesity – 2025 **from the Professional Practice Committee of the American Diabetes Association's Obesity Association, published in *BMJ Open Diabetes Research & Care*, forms part of the full obesity Standards of care currently under development. The document defines weight bias and weight stigma, and explains how these can lead directly and indirectly to physical and psychological harm, as well as poorer access to and uptake of healthcare services. This section of the Standards makes seven recommendations across education and training, clinical environment and practice systems, and communication and collaboration. Throughout the guidance is the reminder that healthcare professionals are responsible for significant weight bias and weight stigma, and that we must identify and, as far as possible, reduce or eliminate our contribution to this.**

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People living with obesity face significant **"weight bias"**, which can be defined as negative attitudes, stereotypes and blame from other people due to their weight. This can be explicit and obvious when it occurs, or implicit/unconscious on the part of the person responsible for the bias. It is thought to be mainly driven by the mistaken belief that weight is within a person's control and that the person living with obesity has chosen to take actions resulting in their current weight.

Weight bias can lead to **"weight stigma"**, defined as social devaluation and mistreatment of people based on weight or size. This can impact all aspects of the person's life, including their access to healthcare and employment. Even those who have not experienced significant weight stigma may anticipate it, and some people absorb negative attitudes and apply them to themselves, a situation called "self-stigma".

Weight stigma and bias: Standards of care in overweight and obesity – 2025 from the Professional Practice Committee of the American Diabetes Association's Obesity Association, published in *BMJ Open Diabetes Research & Care* (Bannuru et al, 2025), forms one of the first sections of the full Standards of Care in Overweight and Obesity currently in development. The Obesity Association is a division of the American Diabetes Association and aims to reduce the prevalence of obesity and improve health outcomes for people living with obesity.

Standards of care in overweight and obesity – 2025

Weight stigma can have a significant impact on physical and mental health, as outlined in this guidance. Perhaps the most surprising information highlighted is how common and detrimental weight bias and stigma can be amongst healthcare professionals, and the guidance outlines practical steps we can take to minimise the impact in our clinical practice.

Both the *Lancet* Commission on Obesity and this guidance highlight that weight bias is recognised to have a significant impact on effective access to and delivery of optimal care for people living with obesity. This section of the Standards of care provides seven recommendations in three important areas:

- **Education and training:**
  - All clinicians and staff should be trained on weight bias and stigma.
- **Clinical environment and practice:**
  - Implement protocols to minimise risk of stigmatisation during provision of healthcare services, including during measurements and communication.

Citation: Brown P (2025) Diabetes Distilled: Weight stigma and bias – New standards of care from the ADA. *Diabetes & Primary Care* **27**: 99–101

Practice points

1. Recognise that weight stigma has a highly detrimental effect on the health outcomes and wellbeing of people living with overweight or obesity, and is common in healthcare professionals and the general public alike.
2. All clinicians and staff should be trained on weight bias and stigma, and this knowledge should be shared with trainee staff.
3. Ensure availability of clinical equipment and furniture that accommodates all individuals, and provide privacy when taking measurements of weight and body composition.
4. Use person-centred language when discussing weight. Always **ask** if the person wishes to discuss their weight or have measurements, and respect their decision.

- ➤ Ensure availability of clinical equipment and furniture that accommodates all individuals.
- ➤ Provide privacy during measurements, including locating scales in a private place.

- **Communication and collaboration:**
  - ➤ Use person-centred and non-judgemental language that supports collaboration, including using person-first language.
  - ➤ Engage in shared decision-making, including collaborative goal setting and supporting long-term obesity care.
  - ➤ Ask permission to discuss weight and before weighing. Explore preferred terms/words to discuss weight.

These standards of care are open-access and provide a list of training resources both for clinicians and for people living with obesity. There is also a really useful checklist of minimum accommodations and resources we should provide in our surgeries and clinics to avoid further contributing to weight stigma.

Effects of weight stigma on the individual

The guideline reminds us that experiencing weight stigma can have immediate and significant effects on people's physical and psychological health (Puhl et al, 2016). Experiencing weight stigma causes stress, which translates into increased risk of binge eating, increased calorie intake, lower motivation and less physical activity, which all facilitate further weight gain. Physiological reactivity increases levels of cortisol, C-reactive protein and HbA_{1c}.

The weight stigma also results in lower adherence to treatments, lower likelihood of attending for follow-up and delay in health screening, amongst other impacts. The resulting weight gain and lower use of health services can, in turn, result in both psychological and physical health distress, including anxiety, depression, low self-esteem, substance misuse and suicidal feelings, as well as poor glycaemic control, decreased self-management of chronic disease, lower health-related quality of life and poorly controlled long-term conditions.

The guidance reminds us in detail about how we as healthcare professionals contribute to increasing weight bias and stigma, and how we may be contributing to further physical and mental health deterioration.

Education and training

Helping people to understand the complex genetic, biological, social, financial and behavioural factors that contribute to overweight and obesity may challenge beliefs and improve understanding that these conditions are not under the control of the person and, therefore, that the person must not in any way be blamed or criticised for their weight.

There is evidence from a systematic review and meta-analysis that such education has short-term, small to moderate effects on weight bias, which differed between studies (Moore et al, 2022). However, as yet, there is no clear evidence on which types of training are most effective.

Since healthcare professionals can contribute so significantly to weight stigma and bias, it is a great opportunity, when teaching and consulting with students and doctors and nurses in training, to encourage discussion and explore weight bias and stigma as early as possible, and to provide feedback in role-play or real consultations. Formal ways to test stigma and bias can also be useful, such as completing the Harvard Implicit Association Test on Fat and Thin.

Clinical environment and practice systems

It is vitally important that our clinical environment, including furniture, couches and systems, offers privacy and fully accommodates people living with obesity, and avoids any hint of stigma or bias. This can be as simple as ensuring chairs in our waiting room and consulting rooms are safe, suitable and without arms; that we have easy access to bariatric scales, tape measures and large cuffs for blood pressure monitors; and that we are completely comfortable using these and are not seen to have to hunt around for them. Likewise, for examinations, we need to be able to offer privacy, easily accessible wide couches, metal speculums, if needed, and toilet grab rails.

Lifts should be provided in venues on multiple floors, and these must be able to take a bariatric wheelchair and mobility scooters. Taking a look around our consulting space with a fresh pair of eyes can be really insightful.

Language

Language may contribute to weight stigma, and the guidance makes suggestions about language to avoid and offers less stigmatising suggestions, which we can experiment with and try out in conversations with our colleagues before using them in consultations (*Table 1*). The document *Language matters: Obesity* offers more discussion and examples of how we can use language appropriately when discussing weight and weight-related conditions (Albury et al, 2020).

The Canadian Practice Guideline reminds us that we must always **Ask** if the person wishes to discuss their weight or have measurements, and that we must respect their decision, whilst leaving the door open for them to return at a later date if they feel a weight discussion or measurements may be appropriate at a different time (Obesity Canada, 2020). Ideally, the healthcare professional and the person living with obesity can use shared decision making to arrive at a weight management plan which the person feels fully reflects their views and needs, but we should remember that some people simply do not want to receive care in relation to their weight, and again this is something we should respect.

Table 1. Examples of preferred language when discussing weight.

Avoid using	Use
Language that places blame or devalues an individual	Language that recognises the person and shows dignity
Pejorative language: "You really need to do something about your weight" "Your weight is killing you" "Your BMI means you have morbid obesity"	**Proactive language:** "Can we talk about your weight today?" "How do you feel about your weight?" "What words would you like to use when we talk about weight?"
"obese", "fat", "chubby", etc. (adjectives)	"A person with obesity" (nouns)
"morbid", "super", "ultra", "extreme", etc. (superlative adjectives)	"severe obesity", or the obesity class or stage
"weight recidivism"	"recurrent weight gain" or "recurrent excess weight"
"non-compliant", "undisciplined" or "weak-willed" person	"person with barriers to adherence"
"weight loss failure" or "failed to lose weight"	"treatment non-response"
"inadequate" or "insufficient" weight loss	"partial treatment response"

Implications for practice

Clinicians still receive minimal training on obesity, and so topics such as weight bias and weight stigma may not feature at all on the curriculum. This ADA guidance should remind us just how significant a role in weight stigma and bias we may potentially play as healthcare professionals. We may be surprised also to learn what an immediate and long-lasting physical and psychological impact bias and stigma may have on weight.

Even though we may feel confident that we are not contributing to the problem, listening again to our own language (or better still encouraging colleagues and friends to listen), and looking with a fresh pair of eyes at our practice premises and behaviour to identify any implicit or explicit weight bias can be a revelation.

Using person-centred and person-first language (person living with diabetes, person living with obesity) is recommended here and also in the *Talking about people* section of the NICE (2024) style guide, although I have met many people with chronic conditions and many colleagues who challenge this approach, for several different reasons.

As a practice team, we can listen to each other, challenge inappropriate comments and brainstorm ideas for areas we can potentially improve in our practice environment.

Instead of contributing to weight bias and stigma, let's work together to try to reduce it and provide a much improved experience for the people we support. ■

Albury C, Le Brocq S, Lloyd C et al; Language Matters Working Group (2020) *Language Matters: Obesity*. Obesity UK. Available at: https://bit.ly/4km5j97

Bannuru RR; Professional Practice Committee (2025) Weight stigma and bias: Standards of care in overweight and obesity – 2025. *BMJ Open Diabetes Res Care* **13**(Suppl 1): e004962

Moore CH, Oliver TL, Randolph J, Dowdell EB (2022) Interventions for reducing weight bias in healthcare providers: An interprofessional systematic review and meta-analysis. *Clin Obes* **12**: e12545

NICE (2024) *NICE style guide* [ECD1]. Available at: https://www.nice.org.uk/corporate/ecd1

Obesity Canada (2020) *Canadian Adult Obesity Clinical Practice Guideline*. Available at: https://bit.ly/44kXrA0

Puhl RM, Phelan SM, Nadglowski J, Kyle TK (2016) Overcoming weight bias in the management of patients with diabetes and obesity. *Clin Diabetes* **34**: 44–50

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