Ontario Dietitians in Public Health
Diététistes en santé publique de l'Ontario

Weight-Inclusive Position Statement Frequently Asked Questions

Methodology

Why did we develop a position statement supporting a weight-inclusive approach in public health?

Registered Dietitians in public health have been addressing weight bias and discrimination for decades. In 2018, after a review of the literature, Ontario Dietitians in Public Health (ODPH) adopted their first position statement related to weight stigma called "Health and Wellbeing Philosophy and Approach to Weight". The intent of this position statement was to shift the conversation away from the traditional weight-centred approach to a health behaviours approach.

In the years following, several important documents were released, such as:

- A Rapid Review on Weight Bias and Public Health by Toronto Public Health (2019) (1)
- A Weight Stigma Backgrounder by Dietitians of Canada, Practice-based Evidence in Nutrition (2019) (2)
- An Evidence-Based Rationale for Adopting Weight-Inclusive Health Policy by Hunger et al. (2020) (3)

These documents, along with an expanding body of research evidence drew attention to how health promotion and public health strategies can cause harm and perpetuate weight stigma. Additionally, as ODPH members' knowledge on this topic grew, an update to the position statement was needed to align with evolving perspectives and to shift public health practice.

References:

1. Toronto Public Health, Weight bias and public health: Review of the evidence, Toronto Public Health, 2019.
2. EN, “Weight stigma background,” 2019. [Online]. Available: https://www.pennutrition.com/KnowledgePathway.aspx?kpid=803&trcatid=38&trid=28010. [Accessed 15 July 2025].
3. J. M. Hunger, J. P. Smith and A. J. Tomiyama, “An evidence-based rationale for adopting weight-inclusive health policy,” Social Issues and Policy Review, vol. 14, no. 1, pp. 73-107, 2020.

What type of review is the position statement?

Position statements aim to assert a stance on an issue that may be contentious.The goal of the position statement was not to appraise the literature but to use our professional expertise to present key evidence and provide recommendations for public health professionals on weight stigma and discrimination.

While there is significant evidence supporting the harms of weight bias, stigma and discrimination (NCCMT Review), there is less agreement within the medical community on effective ways to reduce weight stigma and discrimination. Research on weight-inclusive approaches are not as well funded as research on “obesity” prevention and management. Our position statement offers a summary of the origins and impacts of weight stigma and an alternative way forward that centres dignity, harm reduction, anti-oppression, and fat acceptance.

References:

1. Neil-Sztramko, S.E., Burnett, T., Clark, E.C., Sala, N., Dobbins, M. (2024, June 12). What is known about the experience of weight bias and/or stigma, and how does it influence health outcomes? National Collaborating Centre for Methods and Tools’ Rapid Evidence Service. https://nccmt.ca/pdfs/res/weight-stigma

What was the methodology for the position statement?

The development of our position statement was prompted by ongoing discussions among members in response to evolving literature. Key steps in the methodology included:

1. **Survey of ODPH Members (Summer 2022)**: A survey of ODPH members was conducted, revealing strong support for a weight-inclusive approach. This feedback guided the direction of the position statement.
2. **Reviewing Literature**: The workgroup summarized current literature on the topic to ensure the recommendations were based on the most recent evidence.

3. **Development of Recommendations**: The group developed practical recommendations and scenarios for implementing a weight-inclusive approach in public health.
4. **Review Process**: Three rounds of review were sought prior to the release of the position statement.
    - **Internal Review**: ODPH members reviewed the position statement, focusing on framing the issue, substantiating the background, and defining the problem.
    - **External Review (Health Care Professionals)**: Healthcare professionals from across Canada with expertise in weight stigma (including academics, dietitians and social workers) reviewed the content, focusing on framing the issue and ensuring the background and problem definition were accurate.
    - **External Review (Professionals with Lived Experience of Weight Stigma)**: A targeted review was conducted by professionals with diverse backgrounds and lived experience of weight stigma and/or worked with people experiencing weight stigma. This round of review aimed to validate and refine the recommendations and scenarios, recognizing that the authors and previous reviewers were primarily White, thin dietitians in public health roles.
5. **Ethics Review**: The review process was ethically assessed using the Public Health Ontario (PHO) Risk Screening Tool (RST), scoring a “2-minimal risk.” It also underwent an internal ethics review in accordance with public health unit policies.

Weight Science

Why is it harmful for public health to encourage or support weight loss and weight management? Is it possible for people to lose weight and keep it off?

Our current culture oversimplifies body weight as a matter of choice, perpetuating the belief that individuals in larger bodies could easily manage their weight by diet and physical activity. In reality, body weight is determined by a complex interplay of factors including genetics, environment and the social determinants of health (1).

While some individuals may be able to achieve short term weight loss, a significant body of research has demonstrated that dieting behaviours do not typically lead to substantial and sustained weight loss for the majority of people (2,3,4). Biological

mechanisms designed to protect against starvation make sustained weight loss difficult by favouring weight regain (1,5).

In addition, there is evidence of harm when individuals engage in weight loss attempts. Attempts to control weight generally involve rigid and restrictive rules related to food and activity. These behaviours can harm one's relationship with food, activity and body image, have significant mental health consequences, and may result in weight gain over time rather than weight loss (3). Additionally, weight cycling (repeated weight loss followed by weight regain) is believed to have independent impacts on health (6, 7). Despite the lasting harm, many individuals, particularly those with larger bodies, are encouraged by their healthcare providers to persist with disordered eating behaviours under the guise of weight loss.

See Towards a Weight-Inclusive Approach in Public Health, pg. 37-39 for information on the consequences of focusing on weight loss.

References:

1. PEN, "Physiology of Body Weight, Weight Gain and Adipose Tissue Background. June 2022. [Online]. Dietitians of Canada. Available: https://www-pennutrition-com.proxy1.lib.uwo.ca/KnowledgePathway.aspx?kpid=803&trcatid=38&trid=28031#Contributors. [Accessed 12 Mar 2025].
2. Mann T, Tomiyama AJ, Westling E, Lew A, Samuels B, and Chatman J. Medicare's Search for effective obesity treatments. Am Psychol. 2007 Apr;62(3):220–33.
3. PEN, "Weight-inclusive approach background," February 2023. [Online]. Dietitians of Canada. Available: https://www.pennutrition.com/KnowledgePathway.aspx?kpid=15326&tr[1]catid=ALL&trid=29929. [Accessed 12 Mar 2025].
4. Fildes A, Charlton J, Rudisill C, Littlejohns P, Prevost AT, and Gulliford MC. Probability of an obese person attaining normal body weight: cohort study using electronic health records. Am J Public Health. 2015 Sep;105(9):e54–e59.
5. Busetto L, Bettini S, Makaronidis J, Roberts C, Halford JCG, Batterham RL. Mechanism of weight regain. European Journal of Internal Medicine. 2021. 93: 3-7.
6. Wang H, He W, Yang G, Zhu L, Liu X. The Impact of Weight Cycling on Health and Obesity.Metabolites. 2024 Jun 19;14(6):344. doi: 10.3390/metabo14060344
7. O'Hara L, Taylor J. What's Wrong With the 'War on Obesity?' A Narrative Review of the Weight-Centered Health Paradigm and Development of the 3C Framework to Build Critical Competency for a Paradigm Shift. Sage Open. 2018; 8(2).

Is there evidence that a higher weight leads to health problems?

Since the release of the position statement, a recent (2024) review by NCCMT examined the relationship between body size and health outcomes (1). This review challenges the pervasive view amongst health care professionals that higher body weight significantly impacts an individual's health risk across a wide range of health conditions.

NCCMT's review found that "compared to a smaller body size, larger body size was associated with a **small to moderate increase** in the risk of various cardiometabolic outcomes, certain types of cancer, fracture, anxiety and depression and all-cause mortality." However, in some cases, larger body sizes were linked to "**a small to moderate decrease** in risk of cardiovascular outcomes in specific disease populations, oral cavity and lung cancer, and cancer specific and all-cause mortality in certain cancers" (1). The review also noted that "the extent to which [the studies included in the review] controlled for other potentially confounding factors such as the social determinants of health and health behaviours (physical activity, sleep, smoking, nutrition) was unclear" and that "none of the included studies reported on the role of weight bias or stigma including the potential implications of delays in diagnosis or treatment, in the association of larger body size and health outcomes" (1). A further review by the NCCMT on the impact of weight stigma on health found evidence supporting that weight bias may mediate health outcomes in individuals with larger bodies (2). See Position Statement, pg. 25-26 and pg. 40-41.

References:

1. Neil-Sztramko, S.E., Burnett, T., Clark, E.C., Camargo, K., Caswell, A.M., Derrick, Z., Azarmju, F., Dobbins, M. (2024a, June 12). What is the relationship between body size and health outcomes? National Collaborating Centre for Methods and Tools' Rapid Evidence Service. https://nccmt.ca/pdfs/res/body-size-health-outcomes
2. Neil-Sztramko, S.E., Burnett, T., Clark, E.C., Sala, N., Dobbins, M. (2024b, June 12). What is known about the experience of weight bias and/or stigma, and how does it influence health outcomes? National Collaborating Centre for Methods and Tools' Rapid Evidence Service. https://nccmt.ca/pdfs/res/weight-stigma

"Obesity"

How is the term "obesity" stigmatizing?

The terms "overweight" and "obese" are commonly used terms to describe bodies and have gained credibility due to their use in medical and scientific spaces (1). The terms

“obese” and “obesity” are derived from Latin words which mean “to eat oneself fat” (2). Because of their meaning, these words stigmatize individuals with higher weights by assuming size is due solely to health behaviours and personal choice (2).

Additionally, the term “obese” (and “overweight”) has been and continues to be used to medicalize and pathologize larger bodies. It results in all people in larger bodies being labelled as “sick”, regardless of their health status, which may result in further marginalization.

Recently, “obesity” organizations have advocated for the use of person first language (i.e., person “with “obesity”) in an attempt to decrease stigma, however as Chastain points out, “the suggestion that we need to “talk around body size in higher weight people (in a way that we don’t in thinner people) is, in and of itself, stigmatizing” (1).

A systematic review of preferences for weight related terminology found that generally, neutral terminology, such as weight, is preferred and “obese” and fat are least acceptable (3); however, a recent study of larger bodied individuals found preference for “in a larger body”, and “fat” in some groups (4). This research highlights the importance of considering individual preference in terms used to describe bodies.

References:

1. R. Chastain, “Inclusive language for higher-weight people,” 3 Nov 2021. [Online]. Available: https://weightandhealthcare.substack.com/. [Accessed 14 Jan 2025]
2. PEN, “Weight-inclusive approach background,” February 2023. [Online]. Dietitians of Canada. Available: https://www.pennutrition.com/KnowledgePathway.aspx?kpid=15326&tr[1]catid=ALL&trid=29929. [Accessed 14 Jan 2025].
3. Puhl R. What words should we use to talk about weight? A systematic review of quantitative and qualitative studies examining preferences for weight‐related terminology. Obesity Reviews, 21(6), e13008-n/a. https://doi.org/10.1111/obr.13008
4. Robbins M, Rinaldi K, Brochu PM, Mesinger JL. Words are heavy: Weight-related terminology preferences are associated with larger-bodied people’s health behaviours and beliefs. Body Image. 2025; 53.

Why does ODPH not support the framing of “obesity” as a chronic disease?

Framing “obesity” as a chronic disease asserts that having a large body size is a disease, and makes changing body size the “cure”. Body diversity is natural and people should not be pathologized for being fat (1). This framing causes harm to those in larger bodies because the primary focus becomes weight loss. Please see the harms of focusing on weight loss on pages 37-39 of the position statement.

While proponents of the medicalization of “obesity” argue that framing it as a chronic disease reduces stigma, others argue that it may in fact increase stigma towards individuals in larger bodies (2,3,4). As Fox *et al* (2023) assert, “there is no way to simultaneously pathologize and destigmatize fat people” (3). There is also a lack of consistent diagnostic criteria to measure “obesity” with BMI as the most commonly-used but highly debated tool.

In 2012, the American Medical Association (AMA) asked its Council on Science and Public Health to study whether or not “obesity” should be considered a disease. Despite this committee's recommendation to not recognize “obesity” as a disease, in 2013, the AMA went against its Council’s recommendations. In 2015, the Canadian Medical Association followed suit in recognizing “obesity” as a chronic disease to “speak[s] to the importance of addressing obesity and dealing with the stigma that is often associated with the condition”. However, weight stigma cannot be addressed by focusing on obesity.

The influence of commercial interests in the classification of “obesity” as a chronic disease is significant and calls into question who benefits from decisions related to medicalization. Obesity Canada’s Clinical Practice Guidelines (released in 2020) illustrate the extent of industry entanglement (5). Six executive committee members disclose multiple industry relationships, while almost half of the broader list of authors declare industry links (5). Sponsors listed on the Obesity Canada website include Novo Nordisk, Lilly, and Desjardins, among others (6). Novo Nordisk is currently profiting heavily off of the sale of Wegovy®, a weight loss medication to treat “obesity” (7).

References:

1. PEN, “Weight-inclusive approach background,” February 2023. [Online]. Dietitians of Canada. Available: https://www.pennutrition.com/KnowledgePathway.aspx?kpid=15326&tr[1]catid=ALL&trid=29929. [Accessed 12 Mar 2025].
2. Rathbone JA, Cruwys T, Jetten J, Banas K, Smyth L, Murray K. How conceptualizing obesity as a disease affects beliefs about weight, and associated weight stigma and clinical decision-making in health care. British Journal of Health Psychology. vol. 28, no. 2. 2022. https://bpspsychub.onlinelibrary.wiley.com/doi/10.1111/bjhp.12625#bjhp12625-bib-0013
3. R. Fox, K. Park, R. Hildebrand-Chupp and A. T. Vo, “A qualitative pilot study using direct contact and narrative medicine,” Journal of Applied Social Psychology, vol. 53, pp. 171-184, 2023.
4. PEN, “Weight stigma background,” 2019. [Online]. Dietitians of Canada. Available: https://www.pennutrition.com/KnowledgePathway.aspx?kpid=803&trcatid=38&trid=28010. [Accessed 25 September 2023].
5. A. E. Bombak, L. Adams and P. Thille, “Drivers of medicalization in the Canadian

Adult Obesity Clinical Practice Guidelines," Canadian Journal of Public Health, vol. 113, no. 5, pp. 743-748, 15 July 2022.
6. Obesity Canada. Partnering Organizations. https://obesitycanada.ca/about/partners/
7. Nelson E. Novo Nordisk Annual Sales Jump on Higher Demand for Obesity Drugs. New York Times. Feb. 5, 2025. Available from: https://www.nytimes.com/2025/02/05/business/novo-nordisk-earnings-ozempic-wegovy.html

Body Mass Index

What are the problems with Body Mass Index (BMI)?

Despite its widespread use, BMI is a flawed measure of an individual's overall health status or risk.

BMI was designed in the 19th century to study population averages, not individual health, and only used white European male subjects (1). BMI categories have been influenced by commercial and pharmaceutical interests and reinforce weight stigma which leads to discrimination (2). BMI does not consider individual factors like muscle mass, bone density, or fat distribution, nor does it account for social determinants of health, oversimplifying the relationship between weight and health.

The wide use of BMI as a measure of health perpetuates the narrative that obtaining a "healthy" BMI is necessary to achieve good health. According to Chastain, "[i]t encourages a focus on body weight manipulation rather than health, for higher weight patients". (3) This has led to unintended consequences such as weight cycling, fixation on food intake, and body image disturbances. Healthcare providers' reliance on BMI can lead to broad assumptions about health and health behaviours, and can result in misdiagnosis due to health care providers attributing presenting symptoms to weight rather than fully investigating the concern. Additionally, BMI is used to restrict access to treatment, increasing health disparities for those in larger bodies.

Harms of using BMI as a surveillance tool at the population level are less established. Given the prevalence of weight stigma in our culture, it is important to consider how, where and why this data is reported and its potential to exacerbate weight stigma and discrimination for those in larger bodies. For example, reporting BMI amongst health behaviour data may imply that BMI is directly within an individual's control and lead to BMI reductions being the target of population health promotion, exacerbating weight stigma. The Association of Public Health Epidemiologists of Ontario is working in collaboration with Ontario Dietitians in Public Health members to develop guidance on reconsidering BMI use and reporting it less harmfully. See Towards a Weight-Inclusive Approach in Public Health pg. 23-24 for more information on the history of BMI.

References:

1. S. Strings, Fearing the Black Body: The Racial Origins of Fat Phobia, New York: NYU Press, 2019.
2. K. M. Flegal, “Use and misuse of BMI categories,” AMA Journal of Ethics, vol. 25, no. 7, pp. E550-558, 2023.
3. R. Chastain. “What’s the problem with BMI and how do we solve it?”, June 2022. [Online]. Available: https://weightandhealthcare.substack.com/p/whats-the-problem-with-bmi-and-how?utm_source=publication-search [Accessed 20 June 2025].

Applicability of the Weight-Inclusive Approach in Clinical Settings

Is the weight-inclusive approach applicable to clinical care?

Yes. The recommendations should be applied to clinical care in various healthcare settings e.g. public health, primary care settings, etc.

Doing so will provide more accessible and inclusive health services and minimize harm to individuals in larger bodies. Reducing weight stigma and discrimination is widely supported, including by Obesity Canada in the Clinical Practice Guidelines. While ODPH does not support framing “obesity” as a chronic disease as outlined in the Clinical Practice Guidelines, it is important to note that Obesity Canada includes using a weight-inclusive approach in nutrition management.

Does using a weight-inclusive approach improve clinical outcomes?

A weight-inclusive approach aims to improve health and well-being without aiming to intentionally change a person’s body weight, shape or size (1). Reviews, including systematic reviews, have demonstrated the potential for weight-inclusive approaches in improving health (1). **Various health measures, including blood lipids, blood pressure, self-esteem, depression, diet quality, disordered eating, and physical activity, have been found to improve with weight -nclusive care** (1). Additionally, weight-inclusive approaches have lower dropout rates than weight loss programs (1).

Reference:

1. PEN, “Weight-inclusive approach background,” February 2023. [Online]. Dietitians of Canada. Available: https://www.pennutrition.com/KnowledgePathway.aspx?kpid=15326&tr[1]catid=ALL&trid=29929. [Accessed 12 Mar 2025].

Health Equity

Why is weight stigma a health equity issue?

Health equity as per the Ontario Public Health Standards, “means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or **other socially determined circumstance**” (1).

Stigma is a socially determined circumstance. As per ‘The Chief Public Health Officer’s Report on the State of Public Health in Canada 2019 - Addressing Stigma- Towards a More Inclusive Health System’, one of the drivers of health inequities is stigma, and this includes weight-based stigma. Many people live with multiple stigmas, therefore, stigma must be addressed using an intersectional approach (2). Please see ‘Core Principles for Developing Anti-stigma Interventions’ in the Addressing Stigma report.

References:

1. Ministry of Health and Long Term Care. (2018). Ontario Public Health Standards Health Equity Guideline, 2018. Available from https://www.ontario.ca/page/ontario-public-health-standards-requirements-programs-services-and-accountability
2. Public Health Agency of Canada. (2019). The Chief Public Health Officer’s Report on the State of Public Health in Canada 2019 – Addressing Stigma: Towards a More Inclusive System. Available from https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-toward-more-inclusive-health-system.html [Accessed April 30 2025]

How does Western culture influence body standards?

Diversity of body shapes and sizes has always existed across populations. In Western culture, however, thinness has been lifted up as the standard of beauty and is another way for the privileged population to exert power and control over peoples that are already marginalized, including women and racialized groups (1). As Sabrina Strings points out, thinness is branded as morally superior and more disciplined, further strengthening the exceptionalism of thin bodies and marking other body types as abnormal (2). In Western society, thinness is often linked to positive traits like sociability, happiness, self-control, discipline and motivation (3,4).This has led to stigma and discrimination against larger bodies.

Ultimately, Western culture’s fixation on thin physiques is not simply about a trend, but it stems from deep cultural norms and systemic biases that are heavily influenced by colonialism and maintained through dominant culture.

Diet culture maintains these Western standards of beauty by endorsing body modification to achieve an ideal weight, shape or appearance in order to become desirable and gain social worth (3). Media messages further pressure individuals to conform to unrealistic beauty standards in order to navigate through social spaces and avoid stigma (1).

References:

1. Boutt R. L., Johnson, A., Goel, N. J., Simpson, C. C., & Mazzeo, S. E. (2025). Racialized body dissatisfaction in Black Women: Development of the Black Feminist Model of Body Image. *Journal of Eating Disorders*. (2025) 13:38. https://doi.org/10.1186/s40337-025-01190-5
2. Strings, S. (2019). *Fearing the Black body: The racial origins of fat phobia*. NYU Press.
3. Russell-Mayhew, S., Estefan, A., Moules, N. J., Lefebvre, D., Morhun, J. M., Saunders, J. F., Wong, K., & Myre, M. (2024). The optics of weight: Expert perspectives from the panopticon and synopticon. *Psychology & Health, 39*(6), 823–837. https://doi.org/10.1080/08870446.2022.2117810
4. Puhl, R., & Heuer, C. (2009). The stigma of obesity: A review and update. Obesity, 17(5), 941–961. https://doi.org/10.1038/oby.2008.636

How do Western values influence nutrition guidelines?

Western society reflects European ways of knowing because of Europe's influence through colonialism. Western values include but are not limited to scientific reasoning, individualism, capitalism, and Christianity.

The Western knowledge system is based on positivism which asserts that knowledge is objective and relies on scientific evidence (2). Storytelling, lived experience, intuition, and ancestral knowledge are not valued as ways of knowing. Western knowledge is evident in the biomedical healthcare model and the largely individualistic culture of Western societies (1). In Western culture, scientific evidence is considered a gold standard. While attempts are made to remove bias in research and assess bias through critical appraisal of research, the reality is that bias still exists in what is funded, researched, and published. This is because people have their own inherent biases that influence their research.

Nutrition research is not immune to this bias. Modern nutrition practices are based on scientific evidence which often dismisses traditional diets from other cultures and ways of knowing. This results in nutrition practices/eating behaviours that emphasize foods and behaviours that are Westernized (2, 3).

For example, Canada's Food Guide is based on scientific evidence and emphasizes individual responsibility over food choices (4). It does not represent the food choices of

all cultural groups in Canada. This inadvertently leads to assumptions that foods not incorporated in the guide are “unhealthy” (4).

Furthermore, the Mediterranean diet has been considered as a gold standard diet to be used in dietetic practice (3). However, this dietary pattern is inherently biased as it only considers foods from certain Mediterranean countries (i.e. European Middle Eastern countries) that are palatable to Western society. This in turn dismisses the nutritious nature of other cultural diets because they have not been researched with a Western perspective (3).

For further learning on this topic, visit Indigenous Foodways, Cultural Humility & Safety in Dietetics.

References:

1. Kimmerer, R. W. (2013). *Braiding sweetgrass: Indigenous wisdom, scientific knowledge and the teachings of plants*. Milkweed editions
2. Coveney, J. (2011). Social and cultural theories of nutrition and dietetics. *Journal of Critical Dietetics*, *1*(1), 14-19.
3. Burt, K. (2021). The whiteness of the Mediterranean Diet: A historical, sociopolitical, and dietary analysis using Critical Race Theory. *Journal of Critical Dietetics*, *5*(2), 41-52.
4. Wilson, T., & Shukla, S. (2020). Pathways to Revitalization of Indigenous Food Systems: Decolonizing Diets through Indigenous-focused Food Guides. *Journal of Agriculture, Food Systems, and Community Development*, *9*(4), 201–208. https://doi.org/10.5304/jafscd.2020.094.003

Readiness to Adopt

How can I start shifting my practice to a more weight-inclusive approach?

If you have already read the position statement, you are well on your way! Consider committing to ongoing learning and reflection by reviewing the additional resources within the position statement. The weight inclusivity checklist can also help you take meaningful action in your organization. You can also consider discussing the position statement and recommendations with colleagues and exploring ways to continue unlearning, learning and shifting your practice together.

Some of the content in the position statement makes me uncomfortable. How do I get past this?

The position statement explores a variety of truths that conflict with mainstream teachings, beliefs and norms about health and weight. It's normal to feel discomfort when learning about new concepts that challenge our worldviews and deeply held beliefs. It's important to approach this learning with an open heart and mind and ongoing reflection. Leaning into discomfort is an essential part of growing and doing better as a public health practitioner.

Use of Weight-Inclusive Approach

Are there physicians who support the weight-inclusive approach?

There is a growing movement of physicians and other health care providers adopting a weight-inclusive approach in their practice. Recently, the Association of Weight and Size Inclusive Medicine was launched to provide mentorship, education and advocacy to advance weight-inclusive care. Medical Students for Size Inclusivity is a community of medical students raising awareness about the harms of weight discrimination in healthcare.

A few notable physicians in Canada who practice with this approach include Dr. Katarina Wind (British Columbia), Dr. Stephanie Hart (Alberta), and Dr. Michelle Tubman (Alberta). Resources highlighting the practice of these physicians include:

- Why I no longer prescribe weight loss, calculate BMI, or use the term "obesity" | This Changed My Practice (TCMP) by UBC CPD
- CFP Podcast: Third Rail: The stigma of obesity in medicine
- Incorporating a Health at Every Size approach in Canadian medicine | British Columbia Medical Journal

The following articles and resource outline the need for weight-inclusive healthcare:

- Lalonde-Bester S. Embracing a Weight-Inclusive Approach in Healthcare: A Call for Change. Alberta Medical Association Medical Students. 27 Oct 2024.
- Mauldin K, May M, Clifford D. The consequences of a weight-centric approach to healthcare: A case for a paradigm shift in how clinicians address body weight. Nutr Clin Pract. 2022 Dec;37(6):1291-1306. doi: 10.1002/ncp.10885. Epub 2022 Jul 12.