Understanding Overweight and Obesity: An Update on Aetiology, Clinical Guidelines, and Person-Centred Care for Nurses

Abstract

This article aims to provide nurses with an updated overview on evidence-based and compassionate approaches to understanding overweight and obesity. It will summarise a range of recent evidence and guidelines to enable nurses to provide patient-centred, weight-inclusive care that acknowledges the complexities of overweight and obesity and aligns with current national and international standards of practice.

Learning Outcomes:

- Recognise the limitations of individual-focused interventions within the complex web of biological, psychological, environmental, and social factors influencing weight.
- Understand the principles of person-centred care and adopting a health-focused rather than a weight-focused approach.
- Identify weight bias in healthcare settings and understand its effects on patient outcomes and quality of care.
- Apply the updated National Institute for Health and Care Excellence (NICE) guidelines on overweight and obesity.
- Evaluate and modify physical spaces and administrative processes to create weight-inclusive healthcare environments.

Introduction

Overweight and obesity are key public health challenges (House of Lords, 2024), which significantly impact nursing practice across healthcare settings. National survey data show that the prevalence of overweight (including obesity) is 62% in Wales and 64% in both England and Scotland (Deakin et al., 2024; Department of Health and Social Care, 2025; Welsh Government, 2023). This reflects a general upward trend and it is estimated that by 2050, prevalence of obesity in the UK could be as high as 72.6% for women and 79.6% for men (GBD 2021 Adult BMI Collaborators, 2025). A significant barrier to

treatment for obesity is the lack of training for nurses and other healthcare professionals (HCPs) (World Obesity, 2025). Given this, it is essential for nurses to continue to develop their knowledge of obesity-related theory, practice and clinical guidelines. This will enable nurses to provide compassionate, evidence-based care and provide appropriate support to patients.

Defining Overweight and Obesity

Recent years have witnessed a profound transformation in how researchers, HCPs and policy makers conceptualise obesity, marking a departure from a traditional perspective that emphasised individual responsibility and moral failings. The definition of obesity remains a subject of debate in clinical practice, and more broadly, given that how obesity is defined has significant implications for clinical practice and patient care (Rubino et al., 2025). Obesity is widely understood to be a *"prevalent, complex, progressive and relapsing chronic disease, characterised by abnormal or excessive body fat (adiposity) that impairs health"* (Wharton et al., 2020). There is now growing recognition that obesity results from a complex interplay of genetic, environmental, socioeconomic and psychological factors and are beyond personal choice, such as lifestyle and willpower.

Aetiology of Overweight and Obesity

There are over 100 interconnected factors that interact to influence the aetiology of overweight and obesity, as captured in the Foresight Obesity System Map (Government Office for Science, 2007). These represent a wide range of variables covering individual psychology and biology, dietary intake, physical activity, the built environment, the production and availability of healthy foods, the food environment, and wider societal influences. Many of these factors are far beyond an individual's control. For example, there are strong biological forces that influence weight status, with genetics determining as much as 70% of the risk of developing obesity (Loos & Yeo, 2022).

Regardless of genotype, the single most important modifiable risk factor for overweight and obesity is diet (Bray, 2025). Diets high in energy and fat and low in fibre are implicated in the aetiology of obesity (Johnson et al., 2018). These diets are characterised, for example, by low intakes of fruits, vegetables, and legumes, and high intakes of

chocolate, confectionery, baked goods and processed meat. Although the majority of adults in the UK fail to meet national dietary recommendations (Culliford et al., 2023), it is important to acknowledge that some people face greater barriers to accessing affordable, healthy food. Diets that meet dietary recommendations cost around a third more than diets that do not (Jones et al., 2018). This means the lowest income households would need to spend 70% of their disposable income on food to meet the recommendations (The Food Foundation, 2025). This is reflected in the national statistics, with higher rates of obesity in the most deprived areas of the country (Department of Health and Social Care, 2025).

The interplay between a person's genetics, their socioeconomic status and the food they eat is just a small part of the highly complex system of factors that influences weight status.

Time Out 1

Review the Foresight Obesity Systems Map (Government Office for Science, 2007). Reflect on areas of the map that challenge your current beliefs and/or practices. Are there any factors on the map that surprise you? Do you notice any emotional response to any aspects of the map?

Measuring Abnormal or Excessive Adiposity

Body mass index (BMI) is the most widely used measure of weight status (The Lancet, 2025). BMI is useful as a screening tool to identify trends across populations but has limited utility for clinical application due to a lack of sensitivity and specificity and no information provided on the health of the individual, such as fat distribution (Rubino et al., 2025). Excess adiposity should be confirmed by at least one other anthropometric criterion such as waist circumference or waist-to-hip ratio. Both of these measurements provide an indication of central adiposity and health risk (Table 1) and are relatively simplistic to measure following guidance by NICE (2025).

Table 1: Adult BMI, waist circumference and waist-to-hip ratio classification criteria for different ethnic groups (adapted from NICE (2025))

BMI classification (kg/m²)		
	South Asian, Chinese, other Asian, Black African or African-Caribbean background	All other backgrounds
Healthy weight	18.5 to 22.9	18.5 to 24.9
Overweight	23.0 to 27.4	25.0 to 29.9
Obesity class 1	27.5 to 32.4	30.0 to 34.9
Obesity class 2	32.5 to 37.4	35.0 to 39.9
Obesity class 3	≥37.5	≥40+
Waist circumference (cm)		
	African Caribbean, South Asian, Chinese or Japanese background	All other backgrounds
Low risk	Men: <90 cm Women: <80cm	Men: <94 cm Women: <80 cm
High risk	N/A	Men: 94 to 102 cm Women: 80 to 88 cm
Very high risk	Men: >90 cm Women: >80 cm	Men: >102 cm Women: >88 cm
Waist-to-hip ratio		
Healthy central adiposity	0.4 to 0.49	
Increased central adiposity	0.5 to 0.59	
High central adiposity	≥0.60	

Excess adiposity can have vastly different health implications at the individual level (Rubino et al., 2025). For example, a person with obesity can be 'metabolically healthy', where there is no evidence of metabolic syndrome (Petersen et al., 2024; Stefan, 2020). However, higher adiposity has been associated with increased risk of a range of conditions including type 2 diabetes, coronary heart disease, some types of cancer and

poor mental health (NICE, 2025). A less common but clinically significant condition is cachexic, or sarcopenic, obesity (Baracos, 2024). Patients may appear overweight based on BMI but have significant muscle wasting, weakness, fatigue, and poor functional capacity. This combination is associated with poor outcomes as patients face health risks of both obesity and cachexia. It is important that practitioners do not assume nutritional adequacy based on body size alone, as malnutrition may go unrecognised (Ng et al., 2019). Assessment of the patient's history may indicate use of the Malnutrition Universal Screening Tool (MUST) (Todorovic et al., 2011).

Time Out 2

Consider how your personal and professional experiences have shaped your understanding of weight management and current practice:

- If weight management has been an issue for you personally: Are you more empathetic toward similar patients? Do you hold them to standards based on your own journey? Do you share personal anecdotes or advice based on your experience that may not serve your patients' unique circumstances?
- If weight management has not been an issue for you personally: How might this affect your understanding of barriers faced by patients with obesity?

Weight Bias and Stigma

People experience weight-related bias and stigma throughout their lives and in many different places, including in healthcare settings (Puhl & Heuer, 2009). Weight bias are the negative attitudes and beliefs made about a person based solely on their body weight or size (Rubino et al., 2020), often driven by the belief that obesity is within an individual's control and they simply need to be disciplined or have more will power to lose weight (Spahlholz et al., 2016). Such bias leads to harmful stereotyping, conflating overweight with negative traits such as greed, laziness or unintelligence; attitudes that are widely prevalent (Beaumont et al., 2025). Weight bias is often explicit, but individuals may not be aware of the extent of their unconscious bias about people with larger bodies. An example of unintentional bias may occur when a practitioner assumes that a presenting symptom is caused by a person's weight instead of investigating other potential causes.

Such discriminatory acts – considered weight stigma – contribute to the social devaluation that people in larger bodies encounter (Rubino et al., 2020). This has significant repercussions for healthcare, with those experiencing weight-based stigma in a healthcare setting reporting reduced trust in and avoidance of healthcare (Brown et al., 2022; O'Donoghue et al., 2021).

Time Out 3

Take the Weight Implicit Association Test (IAT) via Project Implicit (2011). What is your initial reaction to your score? Reflect on how your personal history, family/cultural background, professional training, and media consumption may have contributed to forming any implicit associations.

Some have utilised a 'tough love' approach, believing this may leverage feelings of shame and blame to achieve weight loss (Callahan, 2013). Apart from the ethical implications – it is clearly wrong to invoke feelings of distress, shame and guilt – there is evidence that such approaches are counterproductive (Vartanian & Smyth, 2013). Weight stigma is damaging to emotional and physical health, negatively impacts quality of life and can cause a vicious cycle of weight loss and regain (Alimoradi et al., 2020; Pearl et al., 2020; Vartanian et al., 2018). Individuals who internalise weight stigma may develop negative attitudes and beliefs about their own body and experience feelings of shame and low self-worth, which can lead to avoidance of healthy behaviours, such as exercising in public, and social isolation (Pearl, 2024).

Time Out 4

Recall an interaction that you have had with a patient living with obesity. How might your implicit attitudes, as revealed by the IAT, have influenced your interpretation of their symptoms or the concerns expressed by this patient? Could your interaction with and care for this patient have been affected by your beliefs?

Weight bias and stigma represent a significant barrier to accessing and receiving effective care. An analysis of healthcare experiences across England found that perceived quality of care was lower for people who self-identified as living with

overweight or obesity; these patients reported experiencing a lack of empathy and compassion, insensitive comments, being treated with a lack of dignity, and delayed or refusal of care or treatment (Flint et al., 2021). Research also shows that HCPs with healthy weight status were more likely to perceive fewer barriers to weight management and hold more negative attitudes towards people living with obesity compared to HCPs with overweight or obesity (Zhu et al., 2011). Patient experiences within healthcare settings are critically important given influence whether they will seek future care and shape patient-practitioner relationships and overall care quality.

Time Out 5

Identify two specific, actionable strategies you can implement in your practice to mitigate the potential impact of implicit weight bias. What 'bias check' could you incorporate into your practice?

Person-Centred Care

Traditionally, health promotion campaigns have focused on individual behaviour change, such as 'eat less, move more', rather than addressing wider systematic factors that impact health (Theis & White, 2021). Increasingly, obesity charities, patient advocacy groups and professional bodies are challenging the stigmatising narratives that place the responsibility for weight status solely with the individual (Weghuber et al., 2023). In January 2025, NICE (2025) updated their clinical guideline (NG246), aligning with international best practice and taking a holistic approach to the prevention and management of overweight and central adiposity. HCPs are encouraged to take a person-centred approach and consider the wider determinants of health which impact individuals and the context within which individuals have accumulated excess weight. This approach aims to remove the stigma and blame often felt by those living with overweight and obesity. Person-centred care is about delivering care with dignity, compassion and respect. The Canadian Practice Guidelines are seen as a blueprint for improving the health of people living with obesity (Batterham, 2021). This approach focuses on overall health rather than weight, recognising that individuals can experience good health across weight status categories and should receive respectful, non-judgmental care.

Time Out 6

Read sections 1.1 and 1.2 (General Principles of Care) of the NICE (2025) guidelines. What is your response to these principles? In what ways do you think you will change your practice in the future?

Practical Guidance for Compassionate Care

Compassionate care for people with obesity requires a holistic approach that prioritises the individual's presenting symptoms or conditions without allowing their weight status to overshadow critical diagnostic factors (Box 1). NICE (2025) guidelines recognise this and specifically state that practitioners should avoid attributing presenting symptoms to weight. Where feasible, the patient's immediate health concerns should be addressed first before considering whether weight-related discussions are necessary or appropriate.

Box 1: Principles of compassionate care.

- Encourage an open, non-judgemental environment which considers wider determinants of health, uses non-stigmatising language, and provides appropriate resource and equipment for people living with obesity.
- Treat the patient and the symptoms first, consider weight second.
- Ask permission to discuss weight or take weight-related measurements and discuss results in a non-judgemental manner.
- When approaching weight, discuss weight-related comorbidities, providing guidance on the severity and risk of their overweight or obesity.
- Be familiar with the referral options and services available in your local area and know how to refer to these services, including services addressing wider determinants of health, such as housing conditions or long-term pain.

Building trust and rapport is essential before broaching weight-related topics, and the language used to initiate such conversations must be carefully considered and ensuring this respects patient dignity. Effective communication is central to compassionate care,

however initiating sensitive conversations can be challenging, and HCPs may understandably have concerns about offending a patient (Auckburally et al., 2021). Language has evolved, from being judgemental and stigmatising towards person-first language. For example, it is no longer considered acceptable to refer to 'an obese person', but rather a 'person living with obesity'. HCPs should seek explicit permission from patients each time before discussing weight or taking weight-related measurements. Schutz et al. (2019) provide practical tips for starting conversations about weight with patients. Any conversation about lifestyle should emphasise enhancing health and quality of life for people of all sizes; weight itself is not a behaviour and should not be treated as a target for behaviour change.

Creating a Safe, Non-Judgmental Environment

Nurses should be cognisant that patients with overweight and obesity may have previous negative experiences of healthcare and have a duty to ensure that patients can receive care in a non-stigmatising environment. This extends to creating weight-inclusive physical environments where all equipment including gowns, beds, chairs, blood pressure cuffs, scanning equipment, wheelchairs, weighing scales and toilet facilities should enable dignified care delivery for every patient. These should be provided in a discreet and non-judgemental way to ensure that each patient receives the appropriate resource and support without compromising their safety or wellbeing. Where possible, patients should be invited to take their own weight measurements. NICE (2025) recommend that patients with a BMI below 35kg/m^2 can be given advice on how to measure their own waist circumference and waist-to-height ratio.

Conclusion

The aetiology of overweight and obesity is complex, with social and economic factors such as poverty, inequality and lack of access to healthy foods and physical activity opportunities being key factors. As HCPs committed to improving patient outcomes and reducing health inequalities, it is important for nurses to understand the wider context in which overweight and obesity exist. Patients report negative experiences of healthcare and fear of judgement, which causes many to avoid seeking medical help, delaying diagnosis and treatment. Nurses have a pivotal role in challenging weight stigma and

ensuring that all patients, regardless of their body size, receive compassionate, patient-centred, high-quality care.

Time Out 7

Undertaking this CPD article can be used as evidence for revalidation, or the equivalent in the country where you work. Now that you have completed it, reflect on your practice in this area and consider writing a reflective account. Guidelines are available at https://rcni.com/reflective-account, or you could complete the reflection worksheet at [link TBC].

Conflict of Interest

None declared.

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