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Abstract

With the recognition of obesity as a global epidemic (World Health Organization [WHO], 2012), there has been increased interest in the study of weight bias and stigmatization (Ashmore, Friedman, Reichmann, & Musante, 2008; Puhl, Schwartz, & Brownell, 2005). Weight bias is a highly prevalent form of discrimination, perhaps as common as racial bias (Shkolnikova, 2008). Occurring in a wide variety of settings, weight bias may produce adverse effects in social relationships, education, employment, and health care (Durso & Latner, 2008), with the result that obese or overweight persons are socially marginalized and stigmatized.

Conflict of Interest Statement

The authors declare that there is no conflict of interest.

Ethical Issues Surrounding Weight Bias and Stigma in Healthcare

With the recognition of obesity as a global epidemic (World Health Organization [WHO], 2012), there has been increased interest in the study of weight bias and stigmatization (Ashmore, Friedman, Reichmann, & Musante, 2008; Puhl, Schwartz, & Brownell, 2005). Weight bias is a highly prevalent form of discrimination, perhaps as common as racial bias (Shkolnikova, 2008). Occurring in a wide variety of settings, weight bias may produce adverse effects in social relationships, education, employment, and health care (Durso & Latner, 2008), with the result that obese or overweight persons are socially marginalized and stigmatized.

A number of studies have demonstrated that health care professionals often hold negative feelings about obese clients, attributing obesity to causes that are believed to be under individual control, and therefore, blameworthy (Puhl & Heuer, 2009; Brown, 2006; Foster, Wadden, Makris, Davidson, Sanderson, & Allison, 2003; Harvey, Summerbell, Kirk, & Hill, 2002; Harvey & Hill, 2001; Hare, Price, Flynn, & King, 2000). Even health professionals and researchers specializing in obesity management often hold these positions (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003; Teachman & Brownell, 2001). The pervasiveness of the position that obese persons are to blame has the potential to negatively impact the health care these individuals receive and subject them to additional stigmatizing experiences.

This paper has a three-fold purpose. The concept of weight stigma will be clarified, and distinguished from weight bias. Secondly, the authors will address a commonly held misperception that weight stigma can be justified, in that it motivates obese or overweight persons to lose weight (Puhl & Heuer, 2009). Instead, we will argue that weight stigma deprives persons of opportunities for health, and has deleterious health consequences. Finally, weight stigma will be examined historically, to understand weight stigma in healthcare as an ethical issue, in light of the principles of beneficence, nonmaleficence, fairness, and social justice. The authors will, thereby, raise awareness of weight bias and stigma in healthcare, and call for research into stigma reduction strategies and interventions.

Background of Weight Bias and Stigma in Healthcare

All health care disciplines educate their members to approach the client in a non-judgmental manner. For example, nurses are expected to convey compassion, integrity, and non-judgmental attitudes (Royal College of Nursing, 2003). The first provision of the American Nurses Association Code of Ethics requires the nurse to practice "with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (2001, Provision 1). However, researchers have demonstrated that nurses and other health care professionals often possess biased attitudes towards persons who are obese (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). These biased attitudes can be manifested along a continuum ranging from stereotypical beliefs to forms of overt stigmatization.

Weight bias has been reported among health professionals, including physicians, psychologists, and nurses (Friedman, 2008). There is concern that weight stigma is becoming more acceptable, being expressed openly, without fear of being labeled politically incorrect, when contrasted with racial or gender bias (Brown, 2010). Researchers from the Yale Rudd Center for Food Policy and Obesity cited egregious examples of weight stigmatization towards

obese patients including derogatory jokes or remarks made by health professionals (Friedman, 2008). In a study involving 40 physicians and 238 patients, higher client body mass index (BMI) was associated with lower respect among physicians (Huizinga, Cooper, Bleich, Clark, & Beach, 2009). A number of studies found that doctors endorsed anti-obese sentiments, such as the belief that obese patients are unintelligent, lazy, ugly, lacking in self-control, and unlikely to comply with treatment recommendations (Puhl & Brownell, 2001). These biases may lead to lost opportunities to support or encourage the client's weight management efforts, and the physician-client relationship may be affected.

Like physicians, nurses are not immune to weight bias. The literature demonstrates negative weight related biases held by nurses. It is not unreasonable to consider that this attitude may seep into and influence their patient care encounters. Peternejl-Taylor (1989) writes:

> We must remember that nurses are people first and nurses second. A nurse's response to an obese patient may be coloured by life experiences, popular myths, and cultural influences. One cannot pretend to be immune from the effects that these influences can have on the professional relationship simply by virtue of one's own profession. (p. 745)

In a review, Brown (2006) found that the literature consistently suggests that a proportion of the nursing workforce hold negative beliefs and attitudes, which are reflective of wider negative stereotypical views found in western society. Brown and Thompson (2007) found that some nurses avoid the subject of weight with their obese clients. The nurse-client interaction is often the health care encounter that provides the greatest opportunity for unhurried time with the patient. If a portion of the nursing workforce avoids even broaching the subject of obesity, the opportunity to educate clients in a non-judgmental manner is missed, and weight bias in the profession may remain unchallenged.

Research from the client's perspective provides further evidence for the pervasiveness of weight stigma in health care, and it is consistent with research on physician and nurse attitudes. In one study involving 2449 obese and overweight women, almost 70 percent reported having experienced bias from their doctors, and over 50 percent reported it had occurred more than once (Puhl & Brownell, 2006). In another study, participants reported they experienced weight stigma from nurses; in this study, the theme of "unintentional harm" emerged, as participants described stigma manifesting as "shame and marginalization" from nurse-patient encounters (Creel & Tillman, 2011).

Obese women, in particular, identify weight as a barrier to obtaining appropriate health care services. Obese women cite disrespect and negative attitudes from providers, unsolicited advice to lose weight, and small clinic equipment as contributing to these perceived barriers (Amy, Aalborg, Lyons, & Keranen, 2006). Creel and Tillman (2011) identified a major theme of "anxiety in seeking health care" among obese adult patients, who reported delaying or avoiding needed health care in order to avoid a stigmatizing event. In light of the health consequences of obesity, postponing needed care has the potential for producing additional health costs and worsening health disparities.

Conceptual Clarification of Stigma

Weight bias and stigma are closely related concepts, and have been used interchangeably in the growing body of literature. *Bias* is an "inclination or prejudice in favour of a particular person, thing, or viewpoint" (Oxford University Press, 2012a, para. 1). Bias also has a pejorative meaning, as in a prejudgment or a "stacking the deck" against someone unjustly, such as when an employer is *biased* against a qualified job applicant due to their obesity. Other pejorative meanings include controlling for *bias,* considered a confounding variable in empirical research, or the verb usage, as in, *to bias* or to unfairly prejudice or influence someone. Other concepts associated with bias include prejudice, stigma, and discrimination, which Brownell argues are "inherently evil, seen as a threat" (Brownell, 2005, p. 1) to those targeted. When applying the concept of *bias* to weight specifically, these terms are frequently interchanged.

Bias can also be considered to have a positive connotation. *Bias,* when used as causing to favor, can be distinguished from prejudice in that *"bias* is based on facts and evidence, whereas prejudice occurs without knowing or without evaluating the evidence." (Dictionaries.com, n.d., para. 1) Further, in thesaurus entries for liking and favor (both of which would normally connote a positive meaning), *bias* is a synonym for each (Thesaurus.com, n.d.). Therefore, prejudice carries a more negative connotation than *bias.*

Stigma can be differentiated from *bias,* in that stigma involves a situation that is actually experienced, "the situation of the individual who is disqualified from full social acceptance" (Goffman, 1963, preface). Discriminate must be differentiated from *bias,* in that it means to "recognize a distinction" (Oxford University Press, 2012b, para. 1), rather than the slanting or inclination towards a distinction. The concept of *bias* is defined as an interaction between humans that conveys feelings of an inclination or slant towards a particular person or viewpoint, and when applied to weight implies a negative inclination or slant towards an obese person.

The notion of stigma has been conceptualized since at least the time of the ancient Greeks. Goffman (1963) notes that the word *stigma* denoted visual bodily signs as a manifestation of something bad or unusual about the moral status of the person so marked. The skin of the person was marked (cut or burnt) to signify the person was a traitor, criminal, slave, etc., "a blemished person, ritually polluted, to be avoided, especially in public places" (p. 1).

The Holy Bible (English Standard Version) makes mention of bodily marking, associated with the bestowal of special grace. After murdering his brother, Cain was marked by the Almighty, as a protective mark to prevent vigilante justice (Gen. 4:15). Saint Paul also refers to scars from bodily torture, "I bear on my body the marks of Jesus" (Gal. 6:17). In later Christian times, two additional layers of meaning were added to the word *stigma*. The religious meaning consistent with the impartation of special grace was retained, and stigmata, supernaturally appearing marks resembling Christ's wounds, are observed on the religiously devout from 1632 (Online Etymology Dictionary, 2012). A second meaning also emerged, connoting a medical allusion to bodily signs of a physical disorder (Goffman, 1963).

In recent times, the concept of stigma is most closely associated with the discredit or disgraces itself, rather than with an outward visible sign (Oxford University Press, 2012c). Goffman's (1963) text refers to persons who struggle to maintain the secrecy of their stigmatizing status. He conceptualizes stigma in terms of identity and relationships, and defines

the term as "an attribute that is deeply discrediting" (p. 3) Further, the stigmatized person "is disqualified from full social acceptance" (preface) being "reduced in our minds from a whole and usual person to a tainted, discounted one" (p. 3). Stigma can lead to covert or overt social rejection and isolation, as well as discrimination (Sandelowski, Lambe, & Barroso, 2004).

The concept of stigma has been widely explored, and at least nine major theoretical models of stigma have been described. Phelan, Link & Dovidio (2008) argue that stigma and prejudice are essentially the same construct. The authors observe that parallel literatures have developed around these constructs, noting differences only in emphasis and focus. The focus of stigma is the "target" or victim, whereas prejudice is focused on the perpetrator. The literature of stigma is most closely associated with individual characteristics of illness or disability, and with behavioral or identity deviance. The literature of prejudice has grown around group characteristics of race or ethnicity. The concepts are beginning to coalesce, and Phelan, Link and Dovidio "encourage scholars to reach across stigma/prejudice lines when searching for theory, methods and empirical findings to guide their new endeavors" (p. 365).

Although bias may refer to either a positive or negative slant towards the obese, for purposes of this discussion, weight bias in healthcare is defined as negative weight-related actions, beliefs, and attitudes towards an obese client. If not held in abeyance, weight bias may be expressed subtly or overtly, manifesting as stereotyping, prejudice, or rejection of a client because he or she is obese (Puhl, Moss-Racusin, Schwartz, & Brownell, 2008). From the perspective of the target, weight bias may result in the obese person being stigmatized, leading to a loss of social power, relationships, and rejection.

Historical and Political Context of Stigma in Society

Although stigma has a negative connotation in modern times, historically stigma served several societal functions with both beneficial and detrimental effects to various populations. In order to understand the ethical issues involving weight stigma, it is essential to examine the primary "functions" served by stigma or prejudice, namely "exploitation/dominance, enforcement of social norms, and avoidance of disease" (Phelan, Link, & Dovidio, 2008, p. 362). By attending to these functions, our understanding of stigma will be enhanced, as will our ability to generate solutions for stigma reduction. These functions will be considered in turn.

Exploitation/Dominance:

Historically, the function or idea most frequently associated with stigma is that of exploitation. In order for one group to have more power and greater resources, it is necessary for other groups to have less. We argue that exploitation and dominance are functions of stigma that have developed against oppressed or less powerful groups, as a means to perpetuate this power gradient (Phelan, Link, & Dovidio, 2008). Because health care professionals are part of larger Western society and may be affected by societal beliefs, it follows that notions of stigma as exploitation and dominance may seep into and find expression in health care. Further, we suggest that weight stigma has arisen in the historical and social contexts in which the ideas of exploitation and dominance are inherent. These notions have given rise to stigmas expressed against other historically oppressed groups, such as women, persons of color, and low socioeconomic status, groups which have also borne a disproportionate obesity disease burden.

The foundations of most Western societies profess a belief in the equal worth of all citizens and legally guarantee equal rights, yet profound disparities continue to exist socioeconomically, and in health status and care. National health objectives call for the elimination of health disparities (U.S. Department of Health & Human Services [HHS], 2010). The World Health Organization (2012) also believes that health is a "fundamental right" of all persons. However, research indicates a widening gap in health status and care between the marginalized and those of privilege (WHO, 2008). In the U.S., the National Healthcare Disparities Report provides evidence of persistent unequal status in health care and status among subpopulation groups (HHS, 2008). As weight stigma may have contributed to unequal status in health care, it should be opposed on the basis of fairness and social justice.

The health costs of discrimination experienced by African Americans can serve as an exemplar of power imbalance, and of the exploitation and dominance functions of stigma. Feagin (2000) argues that racism developed in the United States in order to maintain the wealth of the affluent during the early years of the nation. Over time racism and segregation became embedded and systematic in the US. Segregation was forced due to "Jim Crow" laws, which purported the separate but equal doctrine. In reality, African Americans lived in a separate but unequal environment—with unequal hospitals and schools, to the detriment of the health of this population. In this context, African Americans developed a disproportionate health burden for a number of diseases, including obesity, which have been associated with poverty and lack of health care (Pomeranz, 2008).

We argue that the African American experience resembles and can inform us about the weight bias experienced by persons who are obese. We posit that weight bias may have arisen, in part to aversive racism. The prevalence of obesity in Blacks has reached 44.1%, the highest prevalence rate by ethnicity and race among Americans (Flegal, Carroll, Ogden, & Curtin, 2010). In this sociopolitical environment, it is likely not coincidental that stereotypical viewpoints of obese persons as "mean, stupid, ugly, unhappy, lazy" (Puhl, 2011, para. 5) have been documented and mirror negative stereotypical images and historical beliefs about Blacks (Pieterse, 2011). Similarly, we argue that these stereotypical views of obese persons may have arisen, to some extent, in the functions of stigma as exploitation and dominance.

Personal Responsibility versus External Factors:

A second historical function of stigma is the enforcement of social norms. Societies often find it necessary to mandate social conformity by the use of social norming (Phelan, Link, & Dovidio, 2008). When one fails to comply with the social norm, it is viewed in terms of character defects or morality, particularly in regards to voluntary behavioral choice. Stigma exerts this function through the venue of shaming; assuring that conformity to the social norm becomes more likely. Conformity to the social norm becomes a necessary requirement for the social deviant to rejoin the "in-group" (p. 362). This function of stigma can also serve the purpose of clarifying for other group members the limits of acceptable behavior, and the consequences of non-conformity.

Examples of this function of stigma are numerous, frequently involving conditions which are perceived of as involving behavioral choice, such as substance abuse. Many in the US view obesity in similar extremist terms. This view tends to link the obese with laziness and gluttony, thus transferring negative moral judgments to the obese individual. When obesity is viewed as a

consequence of laziness, poor self-control, or a lack of will power, weight stigma may be viewed as a way of motivating people to diet and to adopt the majority view of a desired body size. This view holds that if weight stigma is eliminated, obese persons will not be motivated for change. Preliminary research demonstrates the opposite. In a large study with over 2400 overweight and obese persons, almost 75% of participants reported coping with weight bias by refusing to diet and eating more (Puhl & Brownell, 2006).

A similar argument is that if someone wishes to avoid weight stigma, then he or she should conform to the social norm and simply lose weight. Research points to the difficulty inherent in this approach, as obesity is a complex problem, partially rooted in the environment. There is evidence that obesity is correlated with a number of factors which are beyond an individual's control. Obesity has been linked to living in a toxic environment that contains increased numbers of fast food restaurants, fewer food markets carrying fresh fruits and vegetables, more liquor stores, and decreased access to safe recreational facilities (Pomeranz, 2008). Further, significant weight loss is an arduous task and difficult to sustain over time. Consequently, the majority of overweight or obese persons are unable to achieve and sustain their desired weight loss goals (Friedman, 2008).

In western culture, the expression of weight stigma is frequently overlooked, allowing negative, stereotypical portrayals of obese individuals to flourish in the media. Historically, governments have avoided responding to diseases or public health problems when those afflicted are stigmatized (Pomeranz, 2008). If the person is blamed for his or her condition, then discrimination becomes socially acceptable, and, to a great extent, stigma becomes institutionalized and reinforces the desired social norm.

Avoidance of Disease:

There are a number of illnesses and disabilities associated with fear and resulting stigma, including AIDS, mental illness, and cancer (Phelan, Link, & Dovidio, 2008). These illustrate the third historical function of stigma, namely, the avoidance of disease. Although this understanding of stigma may be clear in its explanation of the development of stigma regarding contagious diseases, it is difficult to explain in relation to conditions which are not transmitted from person to person. However, there is some evidence that obesity may be supported partially by social relationships (Cohen-Cole & Fletcher, 2008). Phelan, Link & Dovidio (2008) describe this function of stigma as a theorized evolutionary explanation, referring to its past, rather than present functions. Proponents of this view argue that there are evolutionary pressures to avoid members of one's own species that appear to deviate from the normal or healthy ideal.

Weight Stigma as an Ethical Issue for Nurses

Ethical principles are incorporated into the practice of professional nursing and are critical to the provision of quality health care for the consumer. A number of these principles are central to the therapeutic nurse-client relationship, and are involved in weight stigma. These principles include beneficence, nonmaleficence, and social justice; each will be considered in turn, using findings from interviews with obese women conducted by Creel and Tillman (2011), as exemplars of how stigmatization of obese persons constitutes an inherent violation of these ethical principles.

Beneficence means that one's actions should promote good, and is akin to caring in nursing (Yoder-Wise, 2007). Watson identifies that nursing is concerned with restoring the sick to health, and that for a nurse to care for his or her client is to accept the client as they are, and in hopeful support of what they can become (Watson & Woodward, 2010). This mandates that the client must be valued, understood, and respected. Boykin, Schoenhofer, and Linden (2010) posit that nursing as a discipline is nurturing, living, and growing in caring in the nursing situation. The nurse-client therapeutic relationship implies that a duty is owed to the client. When that duty is breached or when the nurse fails to ensure that minimum standards are met in delivering care to the client (Yoder-Wise, 2007), such as when a nurse fails to provide respect and caring to an obese client, then the nurse is violating the ethical principle of beneficence, and, further, may be professionally negligent.

Many of the experiences shared by participants in a research study on stigma demonstrated the violation of the ethical principal of beneficence (Creel & Tillman, 2011). Participants told the researchers about feelings of their care being "reluctantly" given; as if they were not worthy of the care given to "normal" weight patients or their care was in some way extra and more than that which should be provided to others. Failure to care for all patients in a non-judgmental manner clearly violates the provision of sensitive care to all persons, as cited in the American Nurses Association Code of Ethics (2001), and the ethical mandate of beneficence. These preconceived negative views of obese patients have a negative impact on the nursing profession, the nurse, and the patient.

A second principle is nonmaleficence, meaning that the nurse should first and foremost "do no harm" (Yoder-Wise, 2007, p. 81). However, research is indicative that obese individuals are often suffering unintended harm in the health care encounter. The principal of nonmaleficence was violated with actions, words, and "looks." Hurtful actions included a sense that nurses were unwilling to "touch" them, hearing themselves referred to as "cow" and the participants made numerous references to nurses "looking" at them or "seeing" them as "horrible" people. Weight stigma also manifested as "shame", another example of the violation of the ethical principal of nonmaleficence. Participants made many references to "shame", including words of humiliation and self- hatred (Creel & Tillman, 2011). Actions and words by nurses that create a sense of shame in patients clearly violate the principle of nonmaleficence, as the stories of these participants dramatically indicate.

Lastly, the principle of social justice is implicated in weight stigma. The principle of justice demands that all persons are treated fairly and equally, yet research is mounting that the obese client is not receiving fair and equal treatment. Provision 8 of the American Nurses Association Code of Ethics (2001) additionally states that the nurse has a responsibility to address disparities in access to health care. Again, using research findings from Creel and Tillman (2011), the ethical violation of justice is given voice and made relevant. Two of the themes revealed can be linked to violations of the principle of justice. Participants shared stories of anxiety when accessing health care, which resulted in delays in getting medical attention. The participants undertook extreme measures to access "fat accepting" health care providers. Even when the participant had a positive relationship with a health care provider, they worried that the nursing staff could have changed, and that a new, less tolerant, less caring nurse would be on duty.

Additionally, participants experienced "marginalization." Access to health care is particularly difficult for marginalized populations. These participants described that simple procedures like vital signs or wearing appropriately sized gowns put them in the position of questioning if their care was of the same quality as the care of their "normal" sized peers (Creel & Tillman, 2011).

Social justice also demands that weight stigma in healthcare should also be considered in light of the principle of distributive justice. Distributive justice refers to the benefits and burdens associated with the allocation of resources, particularly when resources are limited (Lamont & Favor, 2007). The US must decide how it will navigate the intersection of individual autonomy with the ethical principles of fairness and social justice. Additionally the US must conceive of public policy which will address the fair distribution of scarce healthcare resources (Polta, 2010). Up to this point, US health care providers have primarily approached the obesity epidemic from an individual perspective, primarily utilizing a blame-based or personal choice approach. Since health care providers are just as likely as other members of society to assimilate stereotypical views of obesity, this can influence healthcare encounters, putting off patients, and leading to avoidance of needed services. A blame based approach can be not only unkind, but ineffective. Weight stigma persists, yet the obesity epidemic remains unchecked.

In distributing health care resources fairly, and according to principles of justice, we argue that individuals should be treated equally and with respect, particularly when there are outcomes over which they have no or limited control. Weight stigma perpetuates the idea that obese persons have total control of their weight, therefore, making them somehow less deserving of healthcare resource allocation.

Stigma or discriminatory treatment can arise from a healthcare professional's conscious and unconscious personal beliefs and attitudes about the client's personal behavior and its effects on health. Therefore, this can also impact the allocation of healthcare resources. Such stigma or discriminatory treatment is not only inappropriate, but is not legally defensible in American society. "Patient autonomy extends not only to the right to control or refuse treatment, but also to the ability to undertake activities with known risks and consequences. Our society values the individual's rights to make his/her own decisions, even when such decisions impose additional costs on society" (Andreu, Johnson, & Beard, 2009, p. 20). To impose one's own beliefs about a patient's life choices or to allow these beliefs to impact treatment is illegitimate.

The American Nurses Association's Code of Ethics for Nurses (2001) argues that it is an ethical responsibility for nurses to work for social reform. Specifically this provision calls for nurses to individually and collectively work to eradicate "the stigma of illness"; the authors call for nurses to work to eradicate weight-based stigma.

Discussion

Morally and ethically, there can never be a justification for singling out a group of people and treating them poorly. When a group or individual is stigmatized and suffers from discriminatory treatment, it is harmful on an individual and a societal level. Nurses are positioned at an opportune place in time to push for change to end discrimination based on weight, and to influence culture change towards tolerance, with subsequent improvement in public health outcomes for obese individuals.

Due to the proportionately large amount of time that nurses spend with clients, they are uniquely positioned "to challenge the institutionalized social injustices within the healthcare system" (Giddings, 2005, p. 304). Giddings argues that those who are socially marginalized are vulnerable to discrimination at the hands of healthcare providers. Nurses must realize obese patients suffer "unintentional harm" when stigmatized at their hands, and must oppose weight stigma upon the principle of nonmaleficence. Nurses must consider non-stigmatizing approaches to address the obesity epidemic and its consequences. If health care providers continue to blame the obese and hold them totally responsible for their weight, then we are absolved of responsibility for addressing other causes of obesity and can rationalize our unfair treatment of obese clients. Weight stigma and discrimination must be challenged, in order to garner peer support for action to address the myriad factors involved in obesity.

Health care institutions are encouraged to mandate weight based stigma training for all disciplines to provide awareness of weight-based discrimination and promote egalitarian treatment for obese and overweight clients. Medical, nursing, and allied health educational programs are encouraged to include content on weight based stigma in their curricula. Often a literal "walk-through" of the patient care environment will lead to discovery of structural components leading to discrimination, such as one-size-fits-all patient treatment gowns, equipment that is too small to be functional or patient scales that are located in clear view. Patient's Rights policies can include language addressing discrimination based on weight or appearance. In addition, recruitment efforts should be maximized to obtain a diverse workforce and promote tolerance (Burgess, Warren, Phelan, Dovidio, & van Ryn, 2010; Friedman, 2008). Finally, there is a need for interventional research aimed at reducing weight stigma and discrimination.

On a larger scale, efforts should be systematically aimed towards transforming the toxic environmental factors producing obesity in the public, with the goal of reversing the epidemic within one generation. While national health objectives call for obesity and other health related disparities to be addressed, it is important to avoid missing the opportunity to address weight-based stigma and discrimination. Often, the value of a society is determined by its treatment of its most vulnerable.

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