

# Improving Obesity and Health Outcomes in Canada:

## A Canadian Approach to Guidelines Across the Lifespan and System Capacity Building

Dr. Sanjeev Sockalingam  
Dr. Katherine Morrison  
Dr. Sean Wharton  
Dr. Roshan Abraham  
Nicole Pearce



# Learning Objectives

By the end of this session, participants should be able to:

1. Explain obesity as a chronic disease, including the health system impact, and the rationale for person-centred, evidence-informed obesity care across the lifespan.
2. Summarize key recommendations from the Canadian Adult and Pediatric Obesity Clinical Practice Guidelines and their role in supporting evidence-informed assessment and management across the lifespan.
3. Describe the role of implementation science and educational resources in translating obesity guidelines into practice, and identify Canadian tools, competencies, and implementation supports that can facilitate practice change and future capacity building.





# Framing the Canadian Context

**Dr. Sanjeev Sockalingam MD, MHPE, FRCPC, FACLP, DFCPA**

Scientific Director, Obesity Canada, Edmonton, Alberta

Senior Vice-President, Education & Chief Medical Officer, Centre for Addiction and Mental Health, Toronto, Ontario

Professor and Vice-Chair, Education, Department of Psychiatry, Temerty Faculty of Medicine, University of Toronto, Toronto, Ontario

# Conflict of Interest: Dr. Sanjeev Sockalingam

| Nature of relationship(s)                                                                                                                                                         | Name of organization(s)                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Any direct financial payments including receipt of honoraria/speaker's fee                                                                                                        | Obesity Canada                                                                                                                      |
| Membership on advisory boards or speakers' bureaus                                                                                                                                | none                                                                                                                                |
| Funded grants or clinical trials                                                                                                                                                  | Canadian Institute of Health Research, Brain Canada, Centre for Addiction and Mental Health, Ontario Medical Association Foundation |
| Patents on a drug, product, or device                                                                                                                                             | none                                                                                                                                |
| Salaried or contract employee within the past 5 years                                                                                                                             | none                                                                                                                                |
| All other investments or relationships that could be seen by a reasonable, well-informed participant as having the potential to influence the content of the educational activity | none                                                                                                                                |



# **Obesity Canada is the only registered charity in Canada dedicated to advancing science and challenging the stigma that surrounds obesity.**

## **RESEARCH & INNOVATION**

*Tells us what we need to know.*

- Clinical Practice Guidelines
- Clinical research
- Social impact research
- Weight bias & stigma research



## **EDUCATION & AWARENESS**

*Translates research into shared knowledge.*

- Student, trainee & HCP training
- KT for research
- Obesity in the workplace
- Public & community resources
- Conferences

## **ADVOCACY & ENGAGEMENT**

*Keeps us grounded in what matters.*

- Advocacy campaigns & government relations
- Lived experience & allied health communities



## **SHIFTING SYSTEMS**

### **Transforming systems through evidence**

Using research to reshape the policies, practices, and structures that define how obesity is understood and addressed in Canada.

## **ADVANCING CARE**

### **Empowering care through education**

Equipping health professionals and people living with obesity to turn knowledge into action and improve care for all.

## **RESHAPING NARRATIVES**

### **Changing the conversation about obesity**

Amplifying lived experience and science to reduce stigma, and build compassion, understanding, and respect.



# **Obesity Canada Strategic Priorities 2026-2029**



# Clinical Practice Guidelines built for real change — with global impact

Published in *CMAJ*, the Adult (2020) and Pediatric (2025) Clinical Practice Guidelines provide the foundation for evidence-informed, person-centred, and stigma-free obesity care — shaping practice, education, and policy across the lifespan.



*Canada's Adult Obesity CPG has been adapted, adopted or used as the foundation for CPGs in: Chile, Ireland, Netherlands, Mexico, South Africa, Greece, Spain, USA*

*...with more coming.*



# Obesity Rates Are Rising - And the Economic Toll Is Staggering.

**We need to talk about obesity.**

Obesity is **not a lack of willpower**.

Canadians living with obesity face widespread **weight-based discrimination**, as it continues to be viewed as a self-inflicted condition.

This misunderstanding contributes to the **lack of access to effective, evidence-based interventions** provided by governments and private health benefits.



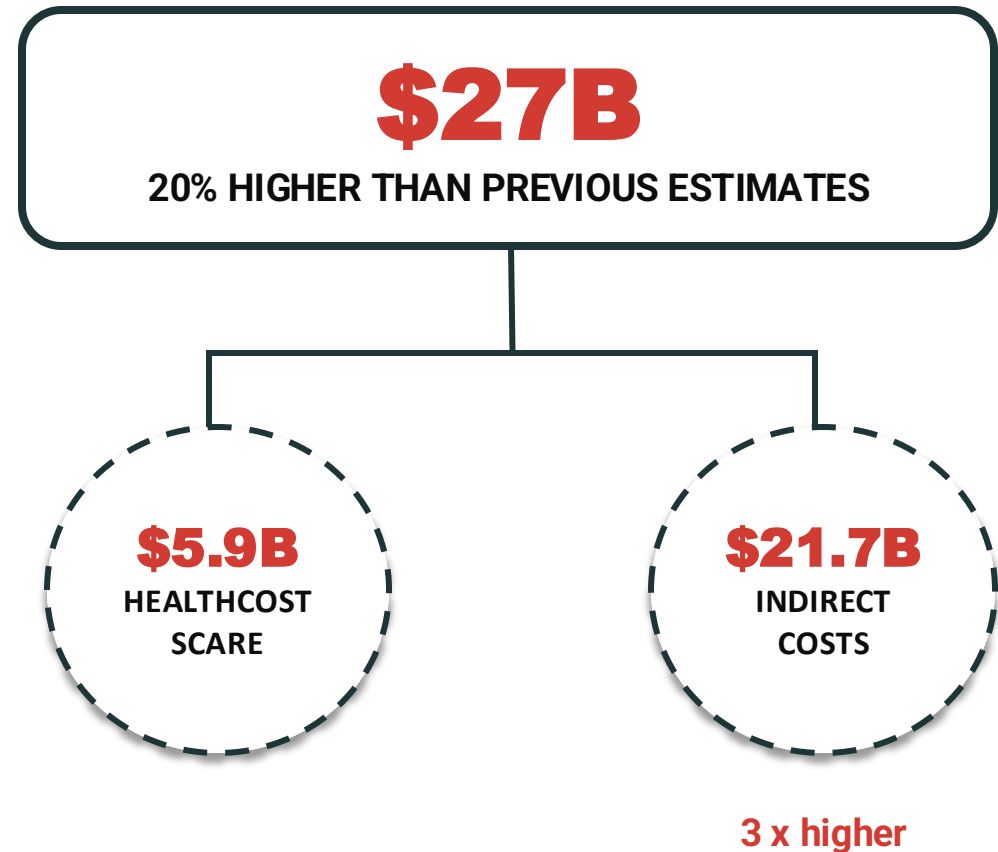


Obesity is a chronic and progressive disease that is **associated with more than 200 chronic illnesses** including cardiovascular disease, type 2 diabetes, respiratory disease, osteoarthritis, cancer and certain mental health conditions.

Nearly **one in three Canadians** live with obesity.

Failure to recognize and treat obesity as a chronic disease, and lack of effective treatment and prevention strategies, has resulted in substantial economic implications.

## The Cost Of Our Inaction In Treating Obesity In Canada



# Impact on the workforce

Workplace productivity costs associated with the failure to address obesity are

**three times higher**

than direct costs to Canada's healthcare system.



**\$6.8B**

Presenteeism



**\$8.2B**

Reduced Workplace  
Participation



**\$3.8B**

Reduced Personal  
Income



**\$268M**

Disability



**\$2.0B**

Obesity-Attributed  
Early Mortality



**We need to treat obesity like other chronic diseases.**

## Current Roadblocks

**Bias:** Many still see obesity as a personal failing instead of a complex disease.

**Policy gaps:** We have effective treatments, but most people can't access them.

**Health system inertia:** It takes time to shift clinical practice, and many providers feel unsupported.



Persons living with obesity also face social and psychological implications due to weight bias. **Over half** of adults with obesity report **facing stigma from coworkers** – impacting mental health.





# Women are impacted more



## WOMEN EXPERIENCE:

↑ Rates of absenteeism & presenteeism

↓ Workforce participation

↓ Income levels

Obesity's impact on reduced labour force participation is **greater for women than for men**

### WOMEN

↓ **5.3%**  
participation

↓ **92.9K**  
workers

### MEN

↓ **0.3%**  
participation

↓ **37.4K**  
workers

## MEN EXPERIENCE:

No impact for men

**4% lower earnings** for women with obesity

**\$3.8B**  
LOST  
INCOME

**\$807M**  
TAX  
REVENUE  
LOSS

# Six recommendations to move obesity care forward



1

**Recognize** obesity as a chronic disease across policy and systems

2

**Modernize** obesity measurement and surveillance beyond BMI

3

**Integrate** obesity care into primary care and chronic disease pathways

4

**Scale** obesity education and practical tools for healthcare professionals

5

**Fund** comprehensive, evidence-based obesity care based on clinical practice guidelines

6

**Reduce bias** across healthcare, policy, and public systems

# How You Can Advocate for **Change**

*Ways to take action:*

- **Educate yourself & those around you.**  
*Obesity is a chronic disease, not a choice*
- **Advocate** for treatment coverage & policy change.  
*Join our campaigns*
- Address **weight bias in your practice & workplaces** and demand better **clinical & workplace supports** for obesity care.  
*Check out our on-demand education*





# Managing obesity in children

**Dr. Katherine Morrison MD, FRCPC**

Professor, Department of Pediatrics

Co-director Centre for Metabolism, Obesity and Diabetes Research

McMaster University

Pediatric Endocrinologist, McMaster Children's Hospital

# Conflict of Interest: Dr. Katherine Morrison

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| Any direct financial payments including receipt of honoraria/speaker's fee                                                                                                        | None                                                                                                   |
| Membership on advisory boards or speakers' bureaus                                                                                                                                | Advisory board member for Novo Nordisk, Medison Therapeutics, Rhythm Pharmaceuticals<br>DSMB: Novartis |
| Funded grants or clinical trials                                                                                                                                                  | Diabetes Canada, CIHR                                                                                  |
| Patents on a drug, product, or device                                                                                                                                             | None                                                                                                   |
| Salaried or contract employee within the past 5 years                                                                                                                             | None                                                                                                   |
| All other investments or relationships that could be seen by a reasonable, well-informed participant as having the potential to influence the content of the educational activity | None                                                                                                   |



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Ontario / Carleton University

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Jenny Cooper, Parent Representative, Toronto

Julius Erdstein, Montreal Children's Hospital

Stasia Hadjiyannakis, Children's Hospital of Eastern  
Ontario / University of Ottawa

Jill Hamilton, Sick Kids / University of Toronto

Dawn Hatanaka, Obesity Canada

Mélanie Henderson, Université de Montréal

Bradley Johnston, Texas A&M University

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Tracy Lebel, Parent Representative, Edmonton

Sarah Moore, Dalhousie University

~~Katherine Morrison, McMaster University~~

Shawn Page, Parent Representative, Montreal

Nicole Pearce, Obesity Canada

Meghan Sebastianski, University of Alberta

Diana Sherifali, McMaster University

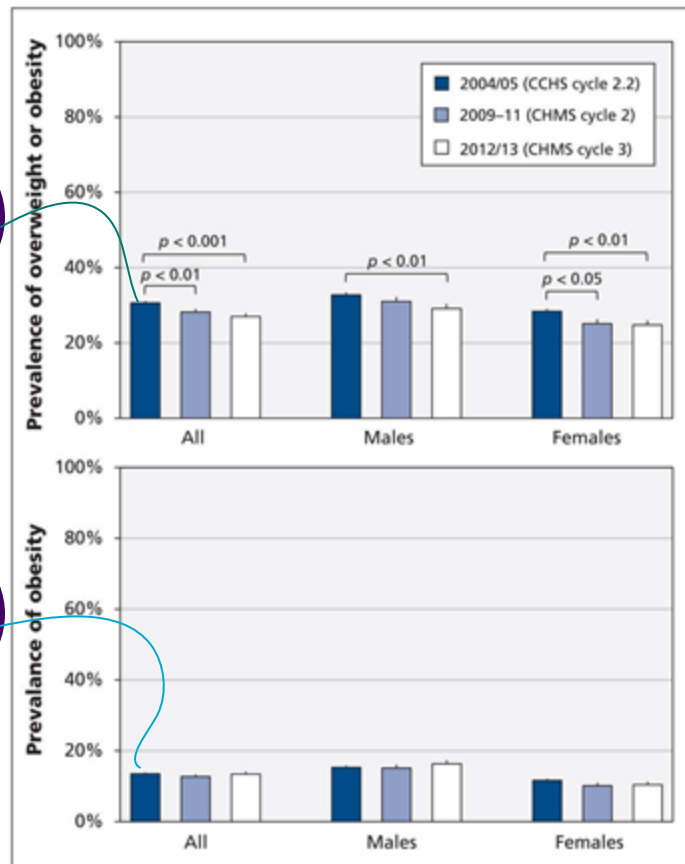
Julie St. Pierre, McGill University

Ian Zenlea, Trillium Health Partners



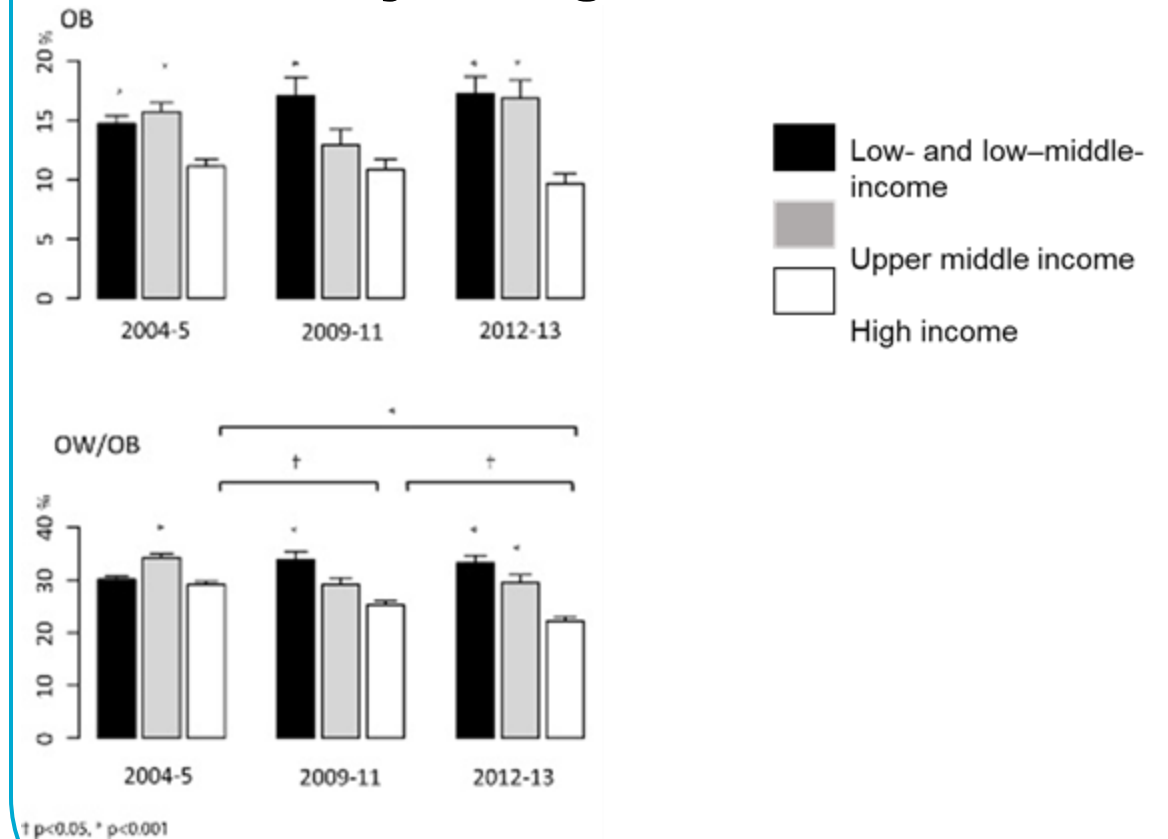
# By the numbers

## Prevalence of overweight/obesity (top) and obesity (bottom) among Canadian children aged 3 to 19 years



Celia Rodd, and Atul K. Sharma CMAJ 2016;188:E313-E320

## Prevalence of overweight/obesity (bottom) and obesity (top) by income sufficiency among Canadian children



Rodd & Sharma. Paediatr Child Health. 2017 Jun; 22(3): 153-158.

# Edmonton Obesity Staging System – Pediatrics

## The 4Ms of Pediatric Obesity

**Stage 3** — Established chronic disease

**Stage 2** — Clinical comorbidity

**Stage 1** — Preclinical factors

**Stage 0** — No apparent risk factors or associated illness

### Mental Health

- Anxiety
- Depression
- Body Image
- ADHD
- Learning Disorder
- Sleep Deprivation
- Eating Disorder
- Trauma

### Mechanical

- Sleep Apnea
- MSK pain
- Reflux Disease
- Incontinence
- Encopresis
- Intertrigo

### Metabolic

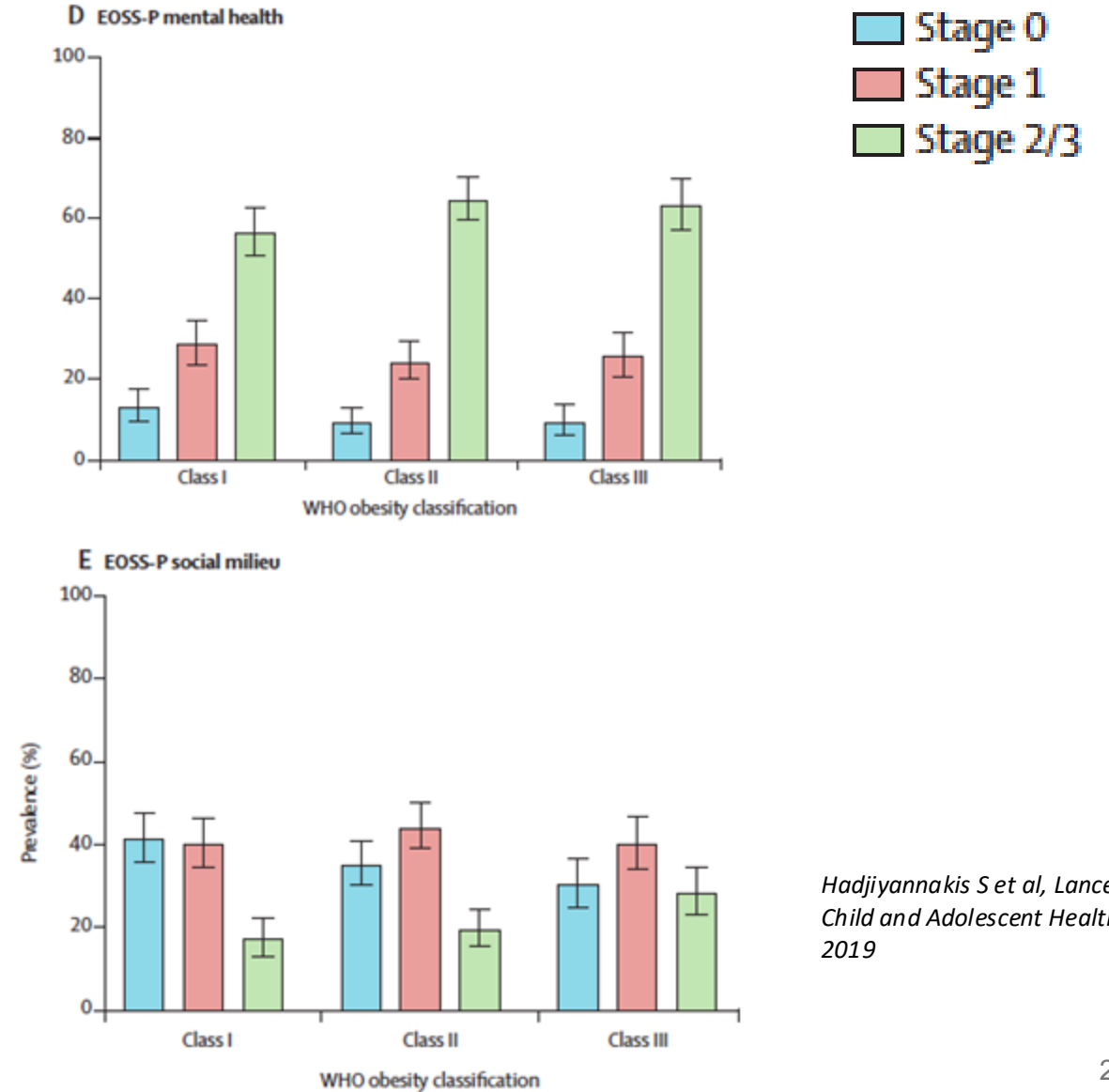
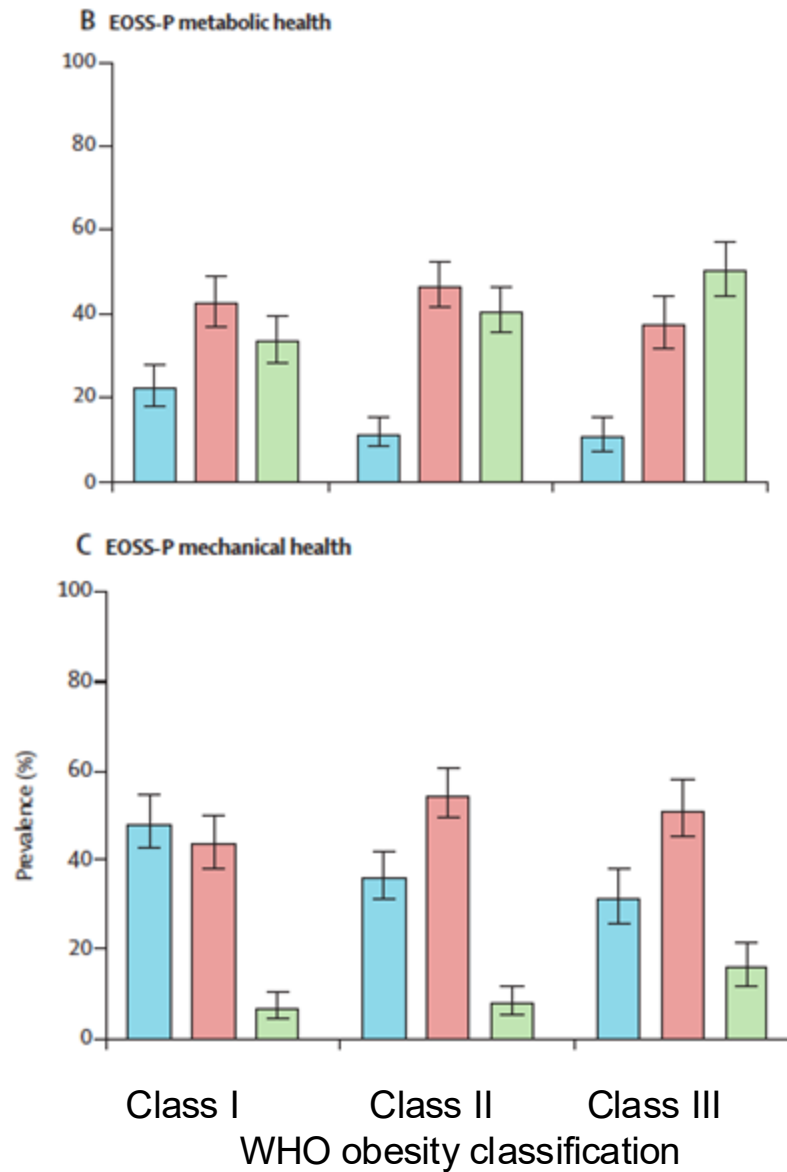
- Type 2 Diabetes
- IGT
- Dyslipidemia
- Hypertension
- Fatty Liver
- Gallstones
- PCOS
- Medication

### Milieu

- Parent Health/Disability
- Family Stressors
- Family Income
- Bullying
- School Attendance
- School Support
- Neighbourhood Safety
- Medical Insurance
- Accessible Facilities



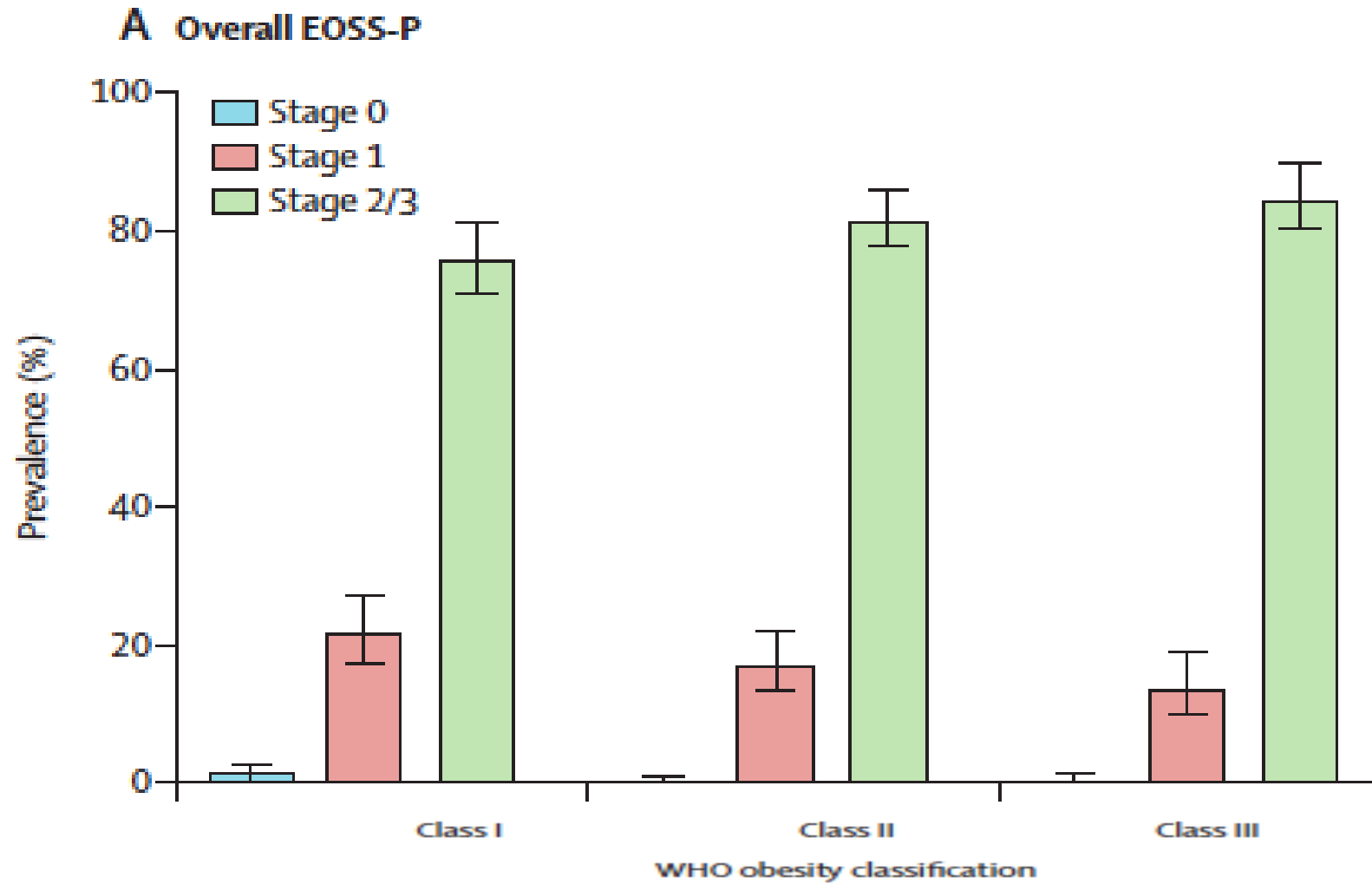
# CANPWR – Baseline health



*Hadjiyannakis S et al, Lancet Child and Adolescent Health, 2019*



# CANPWR – Baseline health



# Developing our CPG



-  1. Raise Awareness
-  2. Partner with Obesity Canada
-  3. Establish Steering Committee
-  4. Manage Conflicts of Interest
-  5. Publish Protocol
-  6. Survey Partners to Prioritize Outcomes
-  7. Conduct Series of Literature Review
-  8. Recruit + Work with Panelists
-  9. Draft Recommendations
-  10. Complete Internal + External Reviews
-  11. Submit to Journal + Translate into French

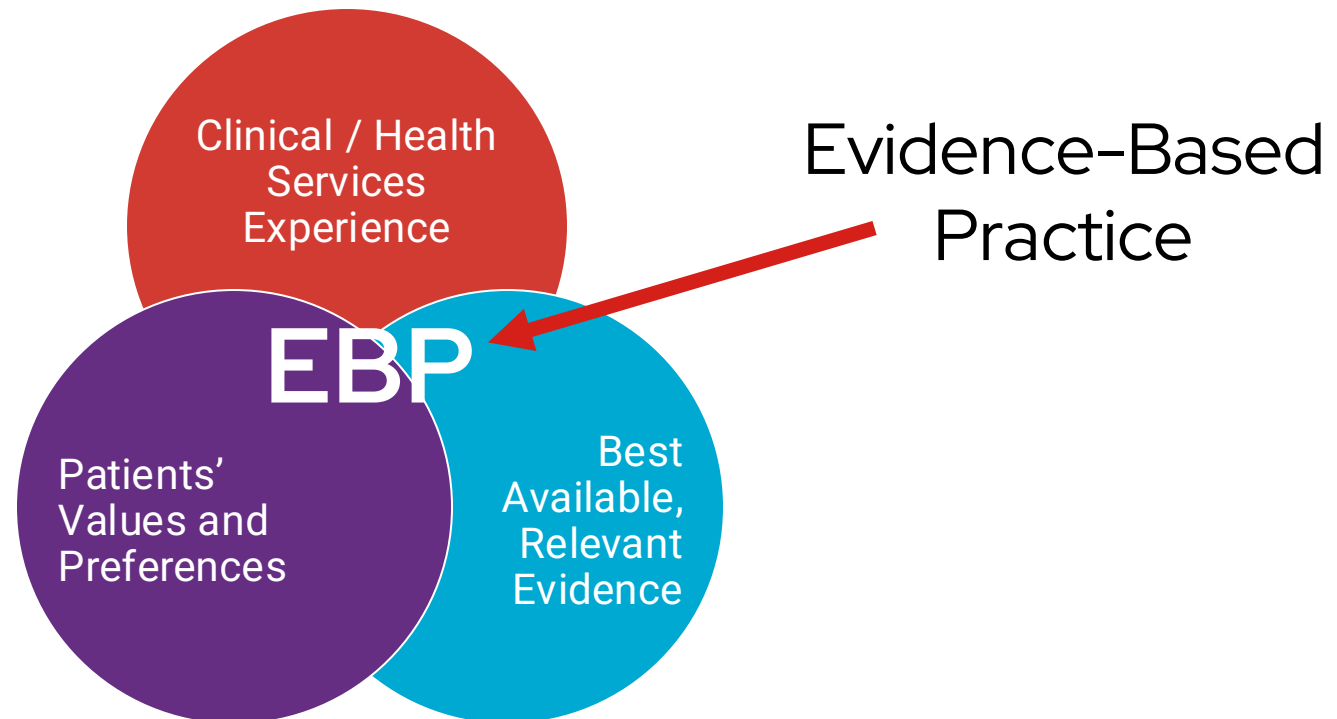


# Key methodological approaches

## GRADE

Grading of Recommendations Assessment, Development & Evaluation is a system for rating the certainty of evidence on an outcome-by-outcome basis, moving from a body of evidence to strength of recommendations

- ✓ Transparent
- ✓ Reproducible



# Key methodological approaches

**Publish the Protocol**

**cmaj**OPEN

Research

## **Updating the Canadian clinical practice guideline for managing pediatric obesity: a protocol**

Bradley C. Johnston PhD, Roah Merdad MBBS MSc, Diana Sherifali PhD RN, Maryam Kebbe PhD, Catherine S. Birken MD MSc, Annick Buchholz PhD, Long Ge PhD, Nicole D. Gehring MSc, Stasia Hadjiyannakis MD, Jill Hamilton MD, Dawn Hatanaka MA, Mélanie Henderson PhD MD, Tracy Lebel, Sarah A. Moore PhD, Katherine M. Morrison MD, Ximena Ramos Salas PhD, Meghan Sebastianski PhD, Ian S. Zenlea MD MPH, Geoff D.C. Ball PhD RD

CMAJ Open 2022 March 1.  
DOI:10.9778/cmajo.20200289





# Key methodological approaches

Survey stakeholders,  
including those with  
lived experience, on  
relative importance of  
health outcomes



| HEALTH OUTCOMES                                               | PRIORITY LEVEL             |
|---------------------------------------------------------------|----------------------------|
| Patient reported outcomes                                     |                            |
| Health-related quality of life (HRQoL)                        | Critically Important       |
| Depression                                                    | Critically Important       |
| Anxiety                                                       | Critically Important       |
| Anthropometric measures                                       |                            |
| BMIz                                                          | Very Important / Important |
| BMI                                                           | Very Important / Important |
| Body weight                                                   | Very Important / Important |
| Adverse events (AEs)                                          |                            |
| Serious AEs                                                   | Critically Important       |
| Minor and moderate AEs                                        | Important                  |
| Cardiometabolic outcomes                                      |                            |
| Blood pressure (SBP and DBP)                                  | Important                  |
| Total cholesterol                                             | Important                  |
| Density lipoprotein (HDL and LDL)                             | Important                  |
| Triglycerides                                                 | Important                  |
| Fasting insulin                                               | Important                  |
| Homeostatic Model Assessment for Insulin Resistance (HOMA-IR) | Important                  |
| Alanine transaminase (ALT)                                    | Important                  |

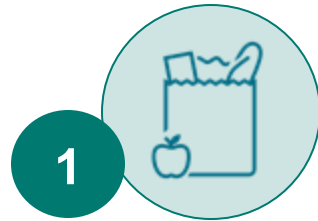


# **Key methodological approaches**

Report outcomes based on clinically meaningful differences – or minimally important differences



# Obesity Management: 3 Systematic Reviews



## Behavioural & Psychological

Received: 04 May 2024 | Revised: 18 September 2024 | Accepted: 10 September 2024  
DOI: 10.1111/ob.13103

ORIGINAL RESEARCH

Effectiveness of behavioural and psychological interventions for managing obesity in children and adolescents: A systematic review and meta-analysis framed using minimal important difference estimates based on GRADE guidance to inform a clinical practice guideline

(Henderson et al., 2025)



## Pharmacotherapy

Received: 17 January 2024 | Revised: 10 May 2024 | Accepted: 03 July 2024  
DOI: 10.1111/ob.13104

REVIEW ARTICLE

Effectiveness of pharmacological interventions for managing obesity in children and adolescents: A systematic review and meta-analysis framed using minimal important difference estimates based on GRADE guidance to inform a clinical practice guideline

(Wahi et al., 2024)



## Surgery

Received: 7 November 2023 | Revised: 11 February 2024 | Accepted: 19 February 2024  
DOI: 10.1111/ob.13105

REVIEW ARTICLE

Effectiveness of surgical interventions for managing obesity in children and adolescents: A systematic review and meta-analysis framed using minimal important difference estimates based on GRADE guidance to inform a clinical practice guideline

(Oei et al., 2024)

All 3 Systematic Reviews examined the effect of an intervention on the following outcomes:

- PROMS: HRQoL, Anxiety, Depression
- Cardiometabolic Outcomes: BP, Insulin Resistance (Fasting Insulin & HOMA-IR), Lipid Profile (Total Cholesterol, HDL-C, LDL-C & Triglycerides), ALT
- Anthropometric Outcomes: BMI Z-score, BMI, Weight
- Adverse Events (AE)



# Behavioural and psychological interventions



# Methods

## Systematic Review

- RCTs with a placebo (usual care) control group
- Any behavioural or psychological intervention with outcome data reported  $\geq 3$  months post-baseline

## 5 intervention types:

- Physical activity only
- Nutrition only
- Psychological only
- Technological only
- Multicomponent ( $\geq 2$  of the aforementioned intervention types)

## Subgroup analysis for the following age groups:

- 3-5 years, 6-12 years, 13-18 years, and all ages combined



# Studies

- 29,521 unique studies
- 99 studies included:
  - Physical activity only (n=32)
  - Nutrition only (n=13)
  - Psychological only (n=11)
  - Technological only (n=11)
  - Multicomponent (n=32)
- Total number of participants = 8249 participants



# Recommendations

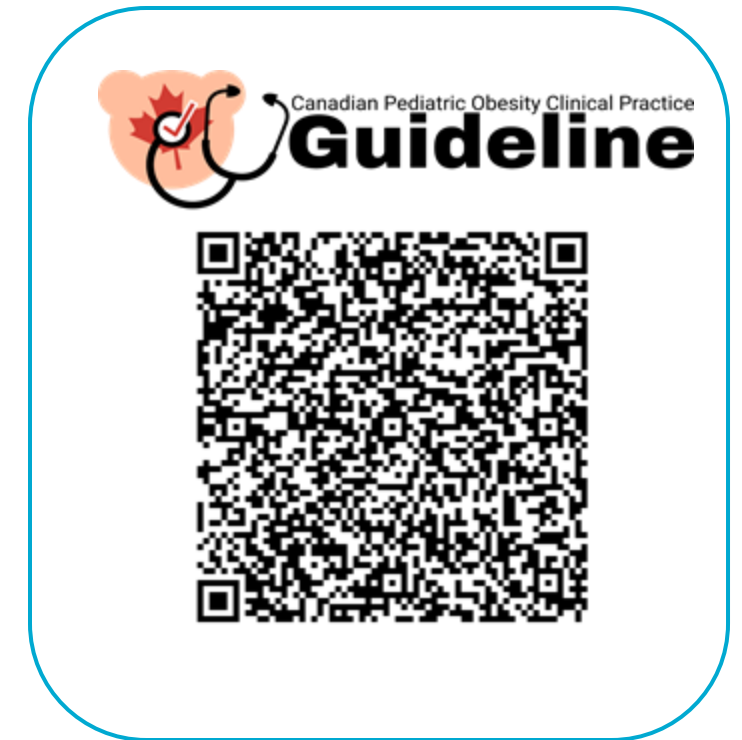
| Recommendations                                       |                                                                                       | Strength of recommendations | Certainty of evidence |
|-------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------|-----------------------|
| <b>BEHAVIOURAL AND PSYCHOLOGICAL INTERVENTIONS</b>    |                                                                                       |                             |                       |
| Multicomponent interventions ( for )                  |    | Strong                      | very low to moderate  |
| Nutrition interventions ( for )                       |    | Conditional                 | very low to low       |
| Physical activity interventions ( for )               |    | Conditional                 | very low to low       |
| Psychological interventions ( for )                   |   | Conditional                 | very low to moderate  |
| Technological interventions<br>(not for nor against ) |  | Conditional                 | very low to low       |

Geoff D.C. Ball et al. CMAJ 2025;197:E776-E796



# Gaps and Limitations

- Dearth of RCTs in young children (0-5 yrs)
- Inability to study certain sub-groups (e.g. gender, disability)
- Limited data considering PROMs
- Limited data on certain cardiometabolic markers, in particular ALT
- Optimal intensity and duration of intervention remains unknown
  - no evidence of sustained benefits to weight-related outcomes compared to usual care over time



# Pharmacotherapy



# Systematic review: Pharmacotherapy

Received: 17 January 2024 | Revised: 30 May 2024 | Accepted: 10 July 2024

DOI: 10.1111/ijpo.13169

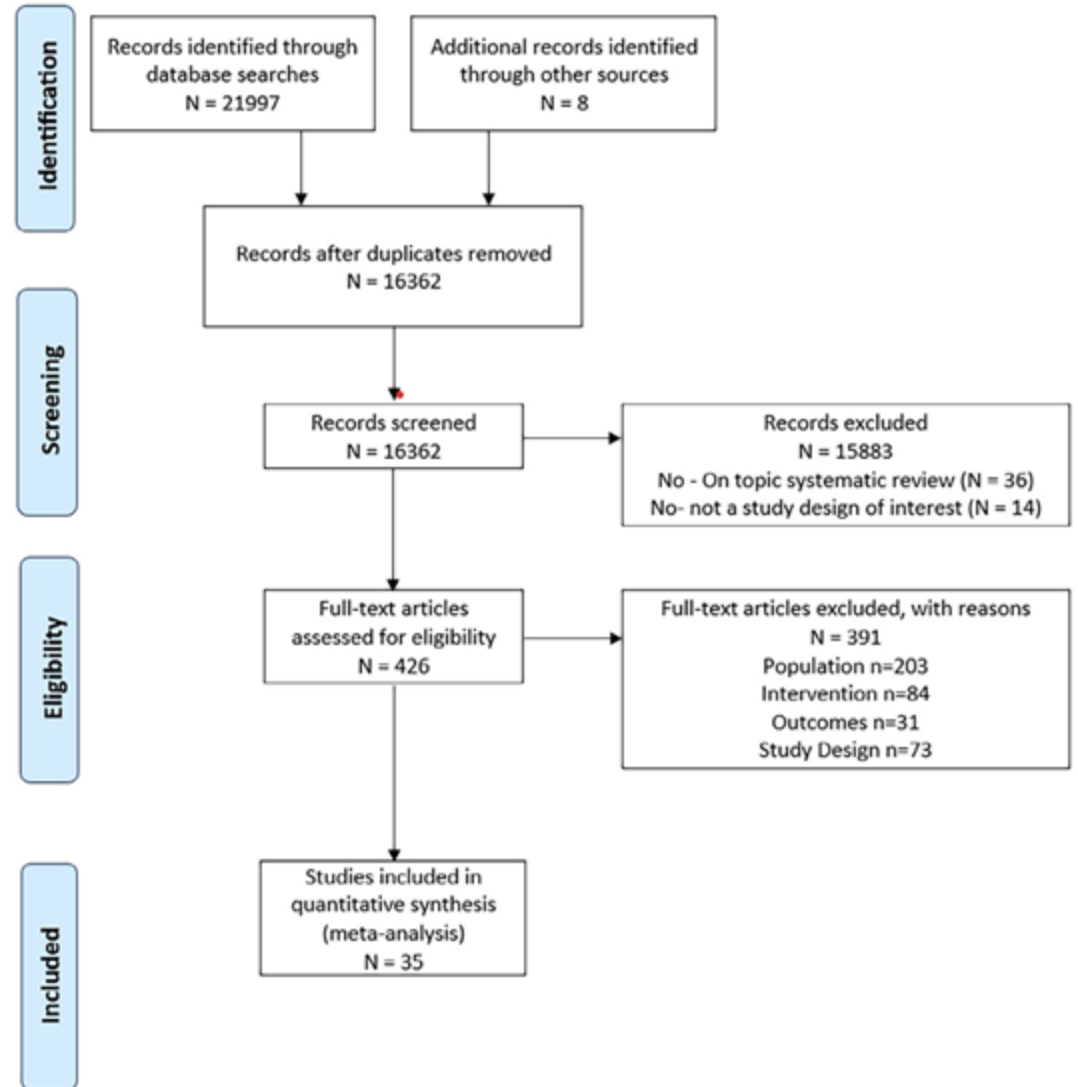
## REVIEW ARTICLE

Pediatric  
OBESITY

WILEY

## Effectiveness of pharmacological interventions for managing obesity in children and adolescents: A systematic review and meta-analysis framed using minimal important difference estimates based on GRADE guidance to inform a clinical practice guideline

Gita Wahi<sup>1,2</sup> | Julie St-Pierre<sup>3</sup> | Bradley C. Johnston<sup>4</sup> |  
Donna Fitzpatrick-Lewis<sup>1</sup> | Ali Usman<sup>1</sup> | Diana Sherifali<sup>1</sup> | Roah Merdad<sup>5</sup> |  
Zahra Esmailinezhad<sup>4</sup> | Catherine S. Birken<sup>6,7</sup> | Jill Hamilton<sup>6,7</sup> |  
Mélanie Henderson<sup>8,9</sup> | Sarah A. Moore<sup>10</sup> | Geoff D. C. Ball<sup>11</sup> |  
Katherine M. Morrison<sup>1,2</sup> | the Steering Committee for Updating Canada's Clinical  
Practice Guideline for Managing Pediatric Obesity



# Studies

- 35 studies:
  - Orlistat – 2 (n=562 )
  - Metformin – 26 (n= 2185)
  - GLP1 receptor agonists (n= 668)
    - Exenatide – 4 (n= 163 ).  
*One study in children with hypothalamic obesity*
    - Liraglutide – 2 (n=304).  
*One study in children with Prader-Willi S.*
    - Semaglutide – 1 (n=201)



# Recommendations

| Recommendations                                                                                                                       | Strength of recommendations | Certainty of evidence |
|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------|
| <b>PHARMACOLOGICAL INTERVENTIONS</b>                                                                                                  |                             |                       |
| Glucagon-like peptide-1 receptor agonists ( for )  | Conditional                 | very low to low       |
| Biguanides ( for )                                 | Conditional                 | low to moderate       |
| Lipase inhibitors ( against )                     | Conditional                 | low                   |

Geoff D.C. Ball et al. CMAJ 2025;197:E776-E796



# Important Considerations

- It is likely that discontinuing medication will lead to weight regain and regression of improvements to health outcomes
  - Long-term management
- Pharmacological recommendations apply only to children  $\geq 12$  years of age
  - existing evidence
- Medication cost, access, availability, and acceptability will influence medication initiation and continuation.



# Gaps and Limitations

## MANY GAPS IN OUR UNDERSTANDING!

- So far, studies are:
  - Relatively short-term – no knowledge of long-term impacts
  - Relatively few numbers – one trial using semaglutide for instance
  - Relatively little information on some important health outcomes including quality of life, cardiometabolic health

MANY question also remain about how these are best used:

- After intensive lifestyle intervention? In whom? At what point in their treatment journey?
- What should the follow-up be?



# Bariatric Surgery



# Methods

## Systematic Review

- Studies limited to 1 RCT and observational studies

## 5 surgical techniques:

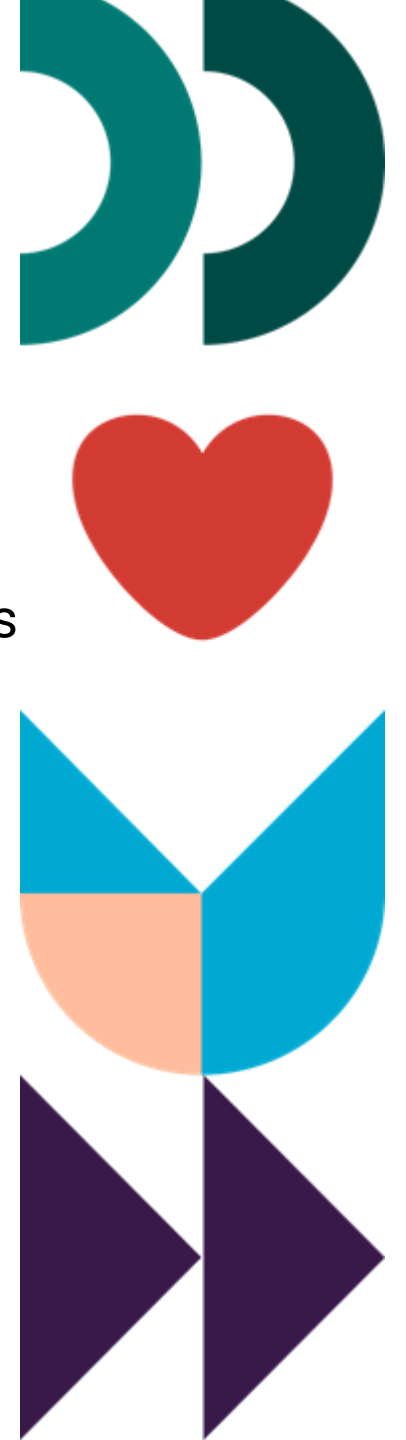
- Roux-en-Y Gastric Bypass (RYGB)
- Laparoscopic Adjustable Gastric Banding (LAGB)
- Laparoscopic Sleeve Gastrectomy (LSG)
- Duodenojejunal Bypass Liner (DJBL)
- Intra-Gastric Weight Loss Device (IGWLD)

## Outcomes:

- PROMs – HRQL, Anxiety, Depression
- Blood Pressure
- Insulin Resistance – Fasting Insulin, HOMA-IR
- Lipid profile
- ALT
- BMI, BMI z-score
- Weight
- Adverse Events

## Follow-up periods:

- short (<18 mths), intermediate (18-24 mths), long-term (>24 mths)



# Systematic Review: Bariatric surgery in childhood obesity

Pediatric  
**OBESITY**

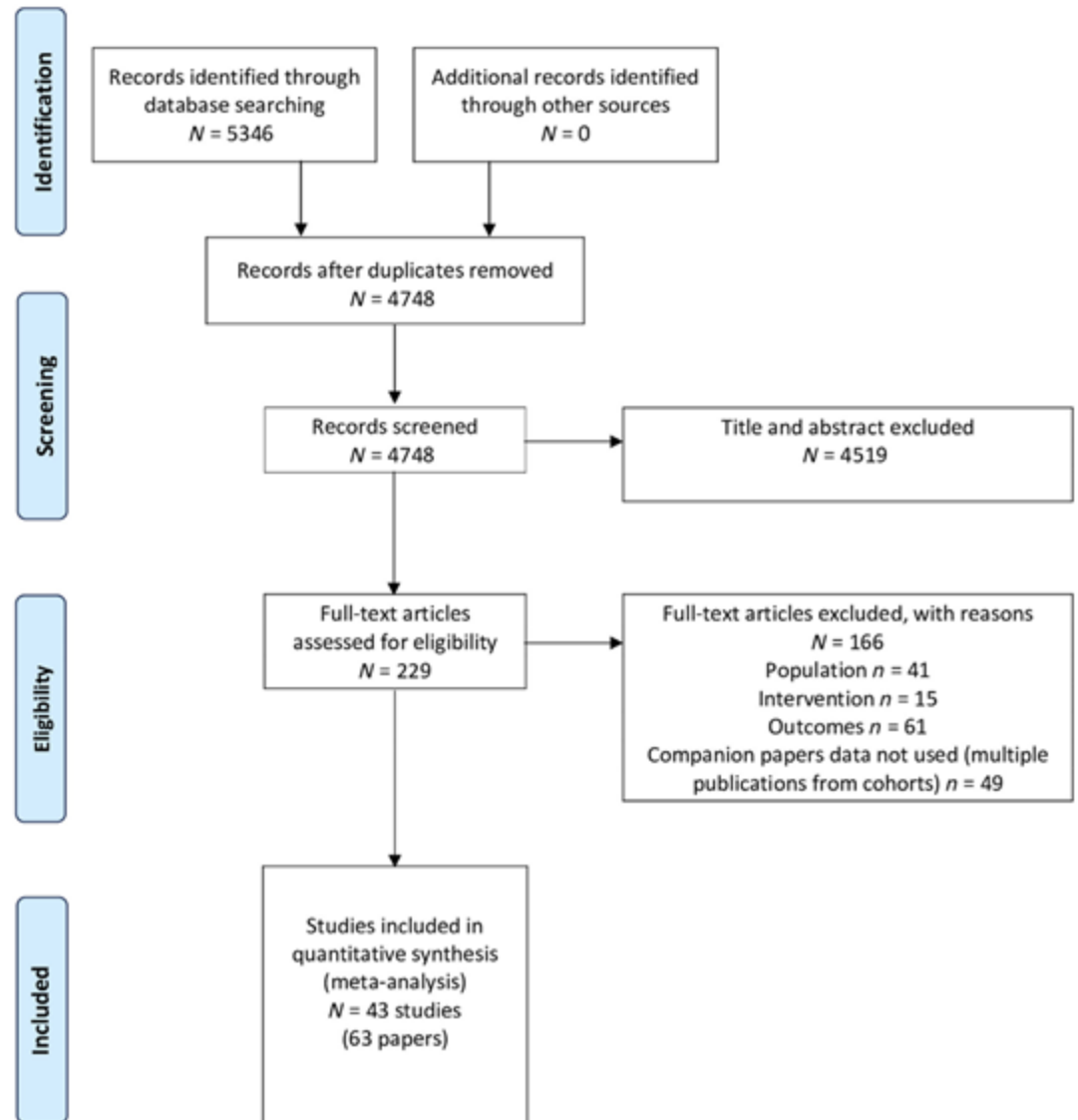
WORLD  
**OBESITY**

REVIEW ARTICLE |  Open Access |  

## Effectiveness of surgical interventions for managing obesity in children and adolescents: A systematic review and meta-analysis framed using minimal important difference estimates based on GRADE guidance to inform a clinical practice guideline

Krista Oei, Bradley C. Johnston, Geoff D. C. Ball, Donna Fitzpatrick-Lewis, Ali Usman, Diana Sherifali, Zahra Esmaeilnezhad, Roah Merdad, Elizabeth Dettmer, Julius Erdstein ... [See all authors](#) ▾

First published: 03 October 2024 | <https://doi.org/10.1111/ijpo.13119>



# Studies

- 63 publications (43 original studies)
- Studies included:
  - 1 RCT
  - 13 controlled observational studies
  - 49 uncontrolled single-arm observational studies
- Total number of participants = 6,128 (66% female)



# Recommendations

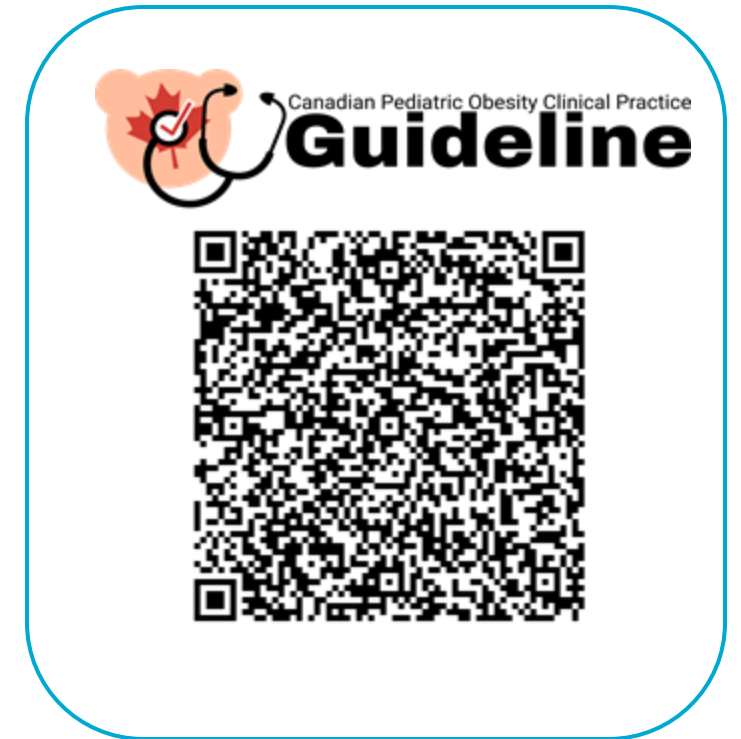
| Recommendations                         |                                                                                      | Strength of recommendations | Certainty of evidence |
|-----------------------------------------|--------------------------------------------------------------------------------------|-----------------------------|-----------------------|
| SURGICAL INTERVENTIONS                  |                                                                                      |                             |                       |
| Laparoscopic sleeve gastrectomy ( for ) |   | Conditional                 | low to moderate       |
| Roux-en-Y gastric bypass ( for )        |  | Conditional                 | low to moderate       |

Geoff D.C. Ball et al. CMAJ 2025;197:E776-E796



# Gaps and Limitations

- Lack of RCTs
- Limited number of studies with long-term follow up
- Poor characterization of long-term complications
- Limited data on pre-adolescent patient population



# Managing pediatric obesity:

## a clinical practice guideline



## Shared decision making

- A **collaborative process**; patients/families and clinicians work together to make healthcare choices.
- Patients/Families are **informed** about their **options**, understand the potential **benefits and harms**, and **actively participate** in decision making based on their values and preferences.
- Ensures health services align with the patient/family **needs** and **goals**.



# Canadian Adult Obesity Clinical Practice Guideline

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Assistant Professor, University of Toronto  
Adjunct Professor, McMaster University  
Adjunct Professor, York University

# Conflict of Interest: Dr. Sean Wharton

| Nature of relationship(s)                                                                                                                                                         | Name of organization(s)                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| Any direct financial payments including receipt of honoraria/speaker's fee                                                                                                        | Abbvie, Amgen, Astra Zeneca, Bausch Health Canada, Boehringer Ingelheim, Eli Lilly, i2o Therapeutics, Merck, NGX, Novo Nordisk, Regeneron |
| Membership on advisory boards or speakers' bureaus                                                                                                                                | Abbvie, Amgen, Astra Zeneca, Bausch Health Canada, Boehringer Ingelheim, Eli Lilly, i2o Therapeutics, Merck, NGX, Novo Nordisk, Regeneron |
| Funded grants or clinical trials                                                                                                                                                  | Amgen, Astra Zeneca, Bausch Health Canada, Boehringer Ingelheim, Eli Lilly, Merk, Novo Nordisk and Pfizer                                 |
| Patents on a drug, product, or device                                                                                                                                             | None                                                                                                                                      |
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My 2 babies

## **GUIDELINE** CPD

# **Obesity in adults: a clinical practice guideline**

Sean Wharton MD, David C.W. Lau MD PhD, Michael Vallis PhD RPsych, Arya M. Sharma MD PhD, Laurent Biertho MD, Denise Campbell-Scherer MD PhD, Kristi Adamo PhD, Angela Alberga PhD, Rhonda Bell PhD, Normand Boulé PhD, Elaine Boyling PhD, Jennifer Brown RD MSc, Betty Calam MD, Carol Clarke RD MHSc, Lindsay Crowshoe MD, Dennis Divalentino MD, Mary Forhan OT PhD, Yoni Freedhoff MD, Michel Gagner MD, Stephen Glazer MD, Cindy Grand MPH, Michael Green MD MPH, Margaret Hahn MD PhD, Raed Hawa MD MSc, Rita Henderson PhD, Dennis Hong MD, Pam Hung MScOT BSc, Ian Janssen PhD, Kristen Jacklin PhD, Carlene Johnson-Stoklossa RD MSc, Amy Kemp BKin BA, Sara Kirk PhD, Jennifer Kuk PhD, Marie-France Langlois MD, Scott Lear PhD, Ashley McInnes PhD, David Macklin MD, Leen Naji MD, Priya Manjoo MD, Marie-Philippe Morin MD, Kara Nerenberg MD MSc, Ian Patton PhD, Sue Pedersen MD, Leticia Pereira PhD, Helena Piccinini-Vallis MD PhD, Megha Poddar MD, Paul Poirier MD, Denis Prud'homme MD MSc, Ximena Ramos Salas PhD, Christian Rueda-Clausen MD PhD, Shelly Russell-Mayhew PhD RPsych, Judy Shiao MD, Diana Sherifali RN PhD, John Sievenpiper MD PhD, Sanjeev Sockalingam MD MHPE, Valerie Taylor MD PhD, Ellen Toth MD, Laurie Twells PhD, Richard Tytus MD, Shahebin Walji MD, Leah Walker BA RCT, Sonja Wicklum MD

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CMAJ Podcasts: author interview at <https://www.cmaj.ca/lookup/doi/10.1503/cmaj.191707/tab-related-content>

**O**besity is a complex chronic disease in which abnormal or excess body fat (adiposity) impairs health.

It increases the risk of long-term medical complications and reduces lifespan.<sup>1</sup> Epidemiologic studies define obesity as a body mass index (BMI; weight/height<sup>2</sup>), which can be used to assess health risks at the population level. Obesity is defined as a BMI exceeding 30 kg/m<sup>2</sup> and is subdivided into class 1 (30–34.9), class 2 (35–39.9) and class 3 (≥ 40). At the population level, health complications

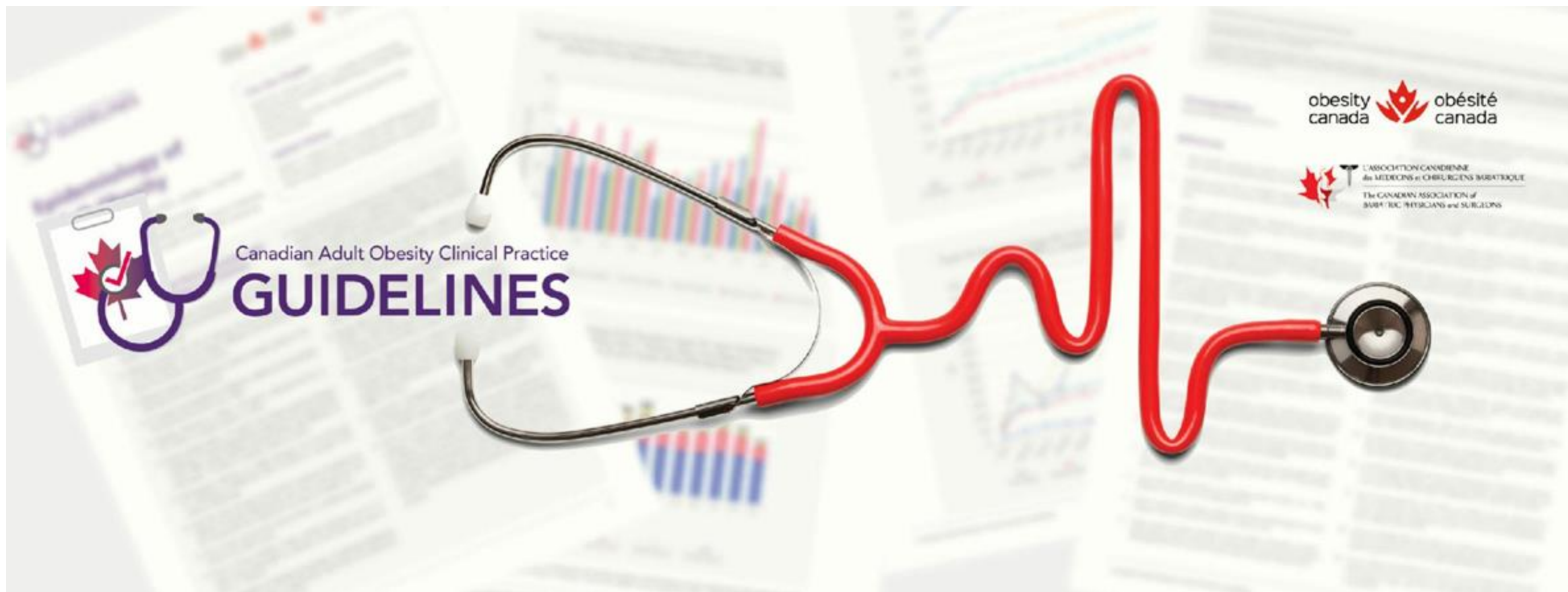
### **KEY POINTS**

- Obesity is a prevalent, complex, progressive and relapsing chronic disease, characterized by abnormal or excessive body fat (adiposity), that impairs health.
- People living with obesity face substantial bias and stigma, which contribute to increased morbidity and mortality independent of weight or body mass index.
- This guideline updates previous guidelines, reflects substantial advances in the pathophysiology, assessment, management and treatment of obesity, and shifts the focus of management toward improving patient-centred health outcomes rather than weight loss alone.
- Care should be based on evidence-based principles of disease management, must validate patients' lived experiences, move beyond simplistic approaches of "eat less, move more," and address the root drivers of obesity.
- People living with obesity should have access to evidence-informed interventions, including medical nutrition therapy, physical activity, psychological interventions, pharmacotherapy and surgery.

increased throughout the world,<sup>12</sup> and in Canada, it has increased threefold since 1985.<sup>13</sup> Importantly, severe obesity has increased more than fourfold and, in 2016, affected an estimated 1.9 million Canadian adults.<sup>14</sup>

Obesity has become a major public health issue that

Guidelines – Collaboration **between**  
OC (Obesity Canada) **and**  
CABPS (Canadian Association of Bariatric Physician and Surgeons)



# Timeline for the Canadian Guidelines 4 years (2016 – 2020)





# **Canadian Guideline Authors 2017**

# Canadian Adult Obesity Clinical Practice Guidelines Summary CMAJ 2020

Wharton, S. et al. Canadian Medical Association Journal 2020; 192: E875-891.

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**O**besity is a complex chronic disease in which abnormal or excess body fat (adiposity) impairs health, increases the risk of long-term medical complications and reduces lifespan.<sup>1</sup> Epidemiologic studies define obesity using the body mass index (BMI; weight/height<sup>2</sup>), which can stratify obesity-related health risks at the population level. Obesity is operationally defined as a BMI exceeding 30 kg/m<sup>2</sup> and is subclassified into class 1 (30–34.9), class 2 (35–39.9) and class 3 (≥ 40). At the population level, health complications from excess body fat increase as BMI increases.<sup>2</sup> At the individual level, complications occur because of excess adiposity, including environmental, genetic, biologic and socioeconomic factors (Box 1).<sup>1,3</sup>

Over the past 3 decades, the prevalence of obesity has steadily increased throughout the world,<sup>1,3</sup> and in Canada, it has increased threefold since 1985.<sup>1,3</sup> Importantly, severe obesity has increased more than fourfold and, in 2016, affected an estimated 1.9 million Canadian adults.<sup>1,3</sup>

Obesity has become a major public health problem that increases health care costs and reduces quality of life.

## **KEY POINTS**

- Obesity is a prevalent, complex, progressive and relapsing chronic disease, characterized by abnormal or excessive body fat (adiposity), that impairs health.
- People living with obesity face substantial bias and stigma, which contribute to increased morbidity and mortality independent of weight or body mass index.
- This guideline update reflects substantial advances in the epidemiology, determinants, pathophysiology, assessment, prevention and treatment of obesity, and shifts the focus of obesity management toward improving patient-centred health outcomes, rather than weight loss alone.
- Obesity care should be based on evidence-based principles of chronic disease management, must validate patients' lived experiences, move beyond simplistic approaches of "eat less, move more," and address the root drivers of obesity.
- People living with obesity should have access to evidence-based interventions, including medical, surgical and behavioural.



## Quick reference: Recommendations & key messages by chapter

Reducing Weight Bias in Obesity Management, Practice, & Policy

Epidemiology of Adult Obesity

The Science of Obesity

Prevention and Harm Reduction of Obesity (Clinical Prevention)

Enabling Participation in Activities of Daily Living for People Living with Obesity

Assessment of People Living with Obesity

The Role of Mental Health in Obesity Management

Medical Nutrition Therapy in Obesity Management [Updated 2022]

*Updated 2022*

Physical Activity in Obesity Management

Effective Psychological and Behavioural Interventions in Obesity Management

Pharmacotherapy in Obesity Management [Updated 2025]

*Updated 2022 & 2025*

Bariatric Surgery: Selection & Pre-Operative Work Up

Bariatric Surgery: Surgical Options & Outcomes

Bariatric Surgery: Postoperative Management

Primary Care & Primary Healthcare in Obesity Management

Commercial Products & Programs in Obesity Management

Emerging Technologies and Virtual Medicine in Obesity Management

Weight Management Over the Reproductive Years for Adult Women with Obesity

Obesity Management with Indigenous Peoples

# What about these Guidelines is new, different?



# Adult Obesity Clinical Practice Guidelines Launch



**#1**

read article in  
CMAJ for 2020



**60+**

expert Canadian  
authors



**500K+**

published peer-reviewed  
papers searched and assessed



**85M**

media hits during  
launch week



**3**

front page stories on  
launch day: National Post,  
Toronto Star, Globe & Mail



**1.2M**

social media impressions  
during launch week



**45K+**

health professionals  
reached via CPG  
webinars and  
presentations



**19**

detailed supplementary  
chapters on the Obesity  
Canada website



- 1 GUIDELINE  
Obesity in adults: a clinical practice guideline\*
- 2 RESEARCH  
Impact of climate and public health interventions on the COVID-19 pandemic: A prospective cohort study
- 3 RESEARCH  
Effect of moist heat reprocessing of N95 respirators on SARS-CoV-2 inactivation and respirator function
- 4 ANALYSIS  
Smartphones, social media use and youth mental health\*
- 5 REVIEW  
Safety considerations with chloroquine, hydroxychloroquine and azithromycin in the management of SARS-CoV-2 infection\*
- 6 RESEARCH  
Mathematical modelling of COVID-19 transmission and mitigation strategies in the population of Ontario, Canada

- 1 GUIDELINE  
[Hypertension Canada guideline for the diagnosis and treatment of hypertension in adults in primary care](#)
- 2 GUIDELINE  
[Managing obesity in children: a clinical practice guideline](#)
- 3 GUIDELINE  
[Pharmacotherapy for obesity management in adults: 2025 clinical practice guideline update](#)
- 4 REVIEW  
[Move more, age well: prescribing physical activity for older adults](#)
- 5 REVIEW  
[Diagnosis and management of iron deficiency in females](#)



Canadian Adult Obesity Clinical Practice  
**Guideline**

## Key take away #1

“We are biased against people living with obesity, but we can treat people better ”



# Chapter 1 - Obesity Bias, Stigma and Discrimination





**HOW WE TREAT PEOPLE  
CAN HELP TREAT THE DISEASE.**



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The CANADIAN ASSOCIATION of  
BARIATRIC PHYSICIANS and SURGEONS

## Key take away #2

**“Obesity is NOT solely defined by BMI, but by biology and disease process”**



# Obesity Redefined to Support the Evidence

Then...

Obesity is defined by a BMI of  $\geq 30 \text{ kg/m}^2$



Now...

“Obesity is a complex chronic disease in which abnormal or excess body fat (adiposity) impairs health, increases the risk of long-term medical complications and reduces lifespan.”



The new Canadian Adult Obesity Clinical Practice Guidelines call for a shift in the obesity treatment paradigm, **focusing on patient centric care**, moving away from “eat less and move more”, and advocating for HCPs to focus on a patient’s overall health and experience rather than solely on their weight, to determine the root causes of obesity.



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## Key take away #3

**“Start treatment with  
compassion – Ask”**



# 5As Framework for Obesity Management in Adults

Ask the patient  
permission



**ASK**  
Step – 1

Assessment of an  
individual living with  
obesity



**ASSESS**  
Step – 2

Discussion of the core  
treatment options



**ADVISE**  
Step – 3

Agreement regarding  
goals of therapy



**AGREE**  
Step – 4

continued follow-up  
and reassessments



**ASSIST**  
Step – 5

# 5As Framework for Obesity Management in Adults

**i** Obesity is a multifactorial, progressive, and relapsing chronic disease characterized by abnormal and/or excessive body fat (adiposity) that impairs health.

## 1 Ask

### Would it be alright if we discussed your weight?

Weight is a sensitive issue. Do not assume every patient with a larger body has obesity. Ask for permission to discuss body weight. Does the person feel their weight is impairing their medical, functional, or psychosocial health?

**i** If the person is not ready to discuss their weight offer resources about obesity as a chronic disease and an open opportunity to reassess.

## 2 Assess

Understanding an individual's story and life context is crucial in the management of obesity.

1. The value-based goal that matters to the patient e.g. *Being able to play at the park with my grandchildren*
2. Obesity classification (height, weight, BMI & waist circumference)
3. Adiposity related complications and 'root causes' of weight gain (**4M framework** - Mechanical, Metabolic, Mental and Social Milieu)
4. Disease severity e.g. Edmonton Obesity Staging System (EOSS)

**Primary care assessment**  
5as Toolkit  
[obesitycanada.ca/5as-team/](http://obesitycanada.ca/5as-team/)



## 3 Advise

### on obesity risks. Discuss the health benefits of obesity management.

### Medical Nutrition Therapy (MNT)

MNT is used in managing chronic diseases and focuses on nutrition assessment, diagnostics, therapy and counselling. MNT should:

1. be personalized and meet individual values, preferences and treatment goals to promote long term adherence
2. be administered by a registered dietitian to improve weight-related and health outcomes

### Physical Activity

30-60 mins of aerobic activity on most days of the week, at moderate to vigorous intensity, can result in:

1. small amount of weight and fat loss
2. improvements in cardiometabolic parameters
3. weight maintenance after weight loss

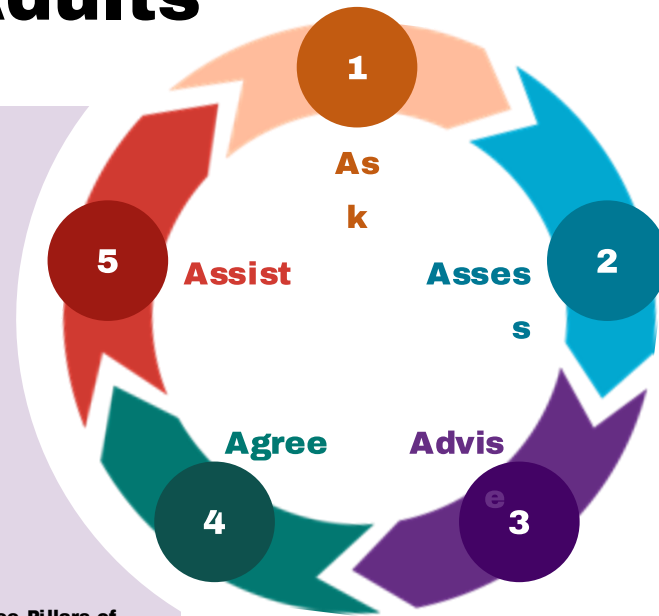
**The Three Pillars of Obesity Management**

## 4 Agree

Agree on realistic expectations, sustainable behavioural goals, and health outcomes. Agree on a personalized action plan that is practical and sustainable, and addresses the drivers of weight gain.

## 5 Assist

Assist in identifying and addressing drivers and barriers. Provide education and resources. Refer to appropriate providers or interdisciplinary teams (if available). Arrange for regular, timely follow-up.



**i** Remember nutrition and physical activity recommendations are important for all Canadians regardless of body size or composition.



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## Key take away #4

**“Diet and exercise are supported by obesity treatments”**



# Diet vs Medical Nutrition Therapy (MNT)



We recommend a non-dieting approach to improve:

- quality of life,
- psychological outcomes (general well-being, body image perceptions),
- cardiovascular outcomes,
- body weight,
- physical activity,
- cognitive restraint and
- eating behaviours.



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## Key take away #5

**“3 pillars of obesity treatment include psychological, along with pharmacological and surgery”**



## Medical Nutrition Therapy (MNT)

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- b. be administered by a registered dietitian to improve weight-related and health outcomes

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**i Remember nutrition and physical activity recommendations are important for all Canadians regardless of body size or composition.**

## The Three Pillars of Obesity Management that Support Nutrition and Activity



### Psychological Intervention

- a. Implement multicomponent behaviour modification
- b. Manage sleep, time, and stress
- c. Cognitive behavioural therapy and/ or acceptance and commitment therapy should be provided for patients if appropriate



### Pharmacological Therapy

- a. semaglutide
- b. liraglutide
- c. naltrexone/bupropion  
(in a combination tablet)
- d. orlistat
- e) Tirzepatide

criteria

**BMI  $\geq 30 \text{ kg/m}^2$  or**

**BMI  $\geq 27 \text{ kg/m}^2$  with obesity (adiposity) related complications**



### Bariatric Surgery

**i** Procedure should be decided by surgeon in discussion with the patient.

- a. Sleeve gastrectomy
- b. Roux-en-Y gastric bypass
- c. Biliopancreatic diversion with/without duodenal switch

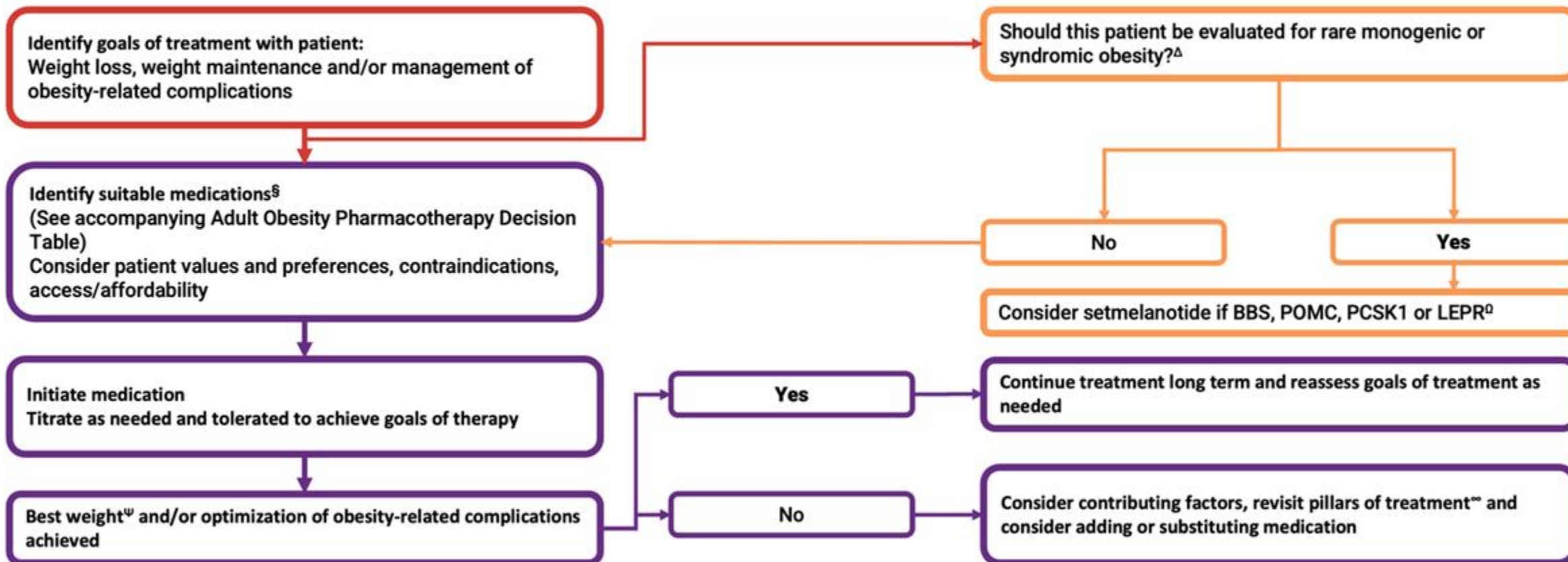
criteria

**BMI  $\geq 40 \text{ kg/m}^2$  or**

**BMI  $\geq 35 - 40 \text{ kg/m}^2$  with an obesity (adiposity) related complication or**

**BMI  $\geq 30 \text{ kg/m}^2$  with poorly controlled type 2 diabetes**

# Adult Obesity Pharmacotherapy Decision Tool



Δ Consider genetic testing if early onset obesity with hyperphagia, features of monogenic obesity (see text)

Ω BBS - Bardet-Biedl Syndrome ; POMC - pro-opiomelanocortin deficiency; PCSK1 - proprotein convertase subtilisin/kexin type 1 deficiency; LEPR - leptin receptor deficiency

§ Medications approved in Canada:  
Liraglutide 3 mg daily,  
Naltrexone/Bupropion 16/180 mg bid,  
Orlistat 120 mg tid, Semaglutide 2.4 mg weekly, tirzepatide 5/10/15 mg weekly.  
All are recommended in conjunction with health behavior changes.

Ψ The weight that a person can achieve and maintain while living their healthiest and happiest life

see <https://obesitycanada.ca/wp-content/uploads/2020/10/191707-guide-2-at.pdf>

# Adult Obesity Pharmacotherapy Decision Table

|                                              |                   | Liraglutide<br>3 mg daily | Naltrexone/ Bupropion<br>16/180 mg BID | Orlistat<br>120 mg TID | Semaglutide<br>2.4 mg weekly | Tirzepatide<br>5/10/15 mg weekly |
|----------------------------------------------|-------------------|---------------------------|----------------------------------------|------------------------|------------------------------|----------------------------------|
| Cardio-<br>Metabolic Complications           | Prediabetes       | ✓                         |                                        | ✓                      | ✓                            | ✓                                |
|                                              | T2D               | ✓                         | ✓                                      | ✓                      | ✓                            | ✓ **                             |
|                                              | MASH              | ✓                         |                                        | ∅                      | ✓                            | ✓                                |
|                                              | ASCVD             |                           | Q                                      |                        | ✓                            | Q                                |
|                                              | HFpEF             |                           |                                        |                        | ✓                            | ✓ *                              |
| Mechanical Complications                     | OSA               | ✓                         |                                        |                        |                              | ✓ **                             |
|                                              | OA                | ∅                         |                                        |                        | ✓                            | Q                                |
| Patient Reported Outcome Measures<br>(PROMS) | QoL               | +                         | +                                      |                        | +                            | +                                |
|                                              | Physical Function | +                         | +                                      |                        | +                            | +                                |
|                                              | Cravings          |                           | +                                      |                        | +                            |                                  |
| Average weight loss (placebo subtracted)     |                   | 5.4%                      | 4.8%                                   | 2.9%                   | 12.4%                        | 11.9/16.4/17.8%                  |

✓ Level 1a  
Very High Certainty

✓ Level 2a  
Moderate Certainty

✓ Level 3  
Low Certainty

∅ No Benefit

+ Benefit

Q In study as identified on  
[www.clinicaltrials.gov](http://www.clinicaltrials.gov)

\*15 mg, \*\*10 mg or 15 mg . T2D - type 2 diabetes, MASH - metabolic dysfunction-associated steatohepatitis; ASCVD - atherosclerotic cardiovascular disease; HFpEF - heart failure with preserved ejection fraction; OSA - obstructive sleep apnoea; OA - osteoarthritis; QoL - quality of life



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## Key take away #6

“Inclusion of patients living with obesity brings clarity to the guideline process, from rationale to implementation”



# Endorsement of the Canadian CPGs



date: 04/08/2020



date: 03/08/2020



date: 24/07/2020

date: 13/08/2021



date: 01/06/2023



date: 30/08/2023



date: 30/07/2020



date: 29/07/2020



date: 08/10/2020



date: 28/03/2022



date: 06/07/2023



date: 01/06/2023



date: 16/08/2021



Canadian Liver Foundation  
Fondation canadienne du foie



date: 12/06/2023



date: 25/07/2023





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Michael Vallis  
Denise Campbell-Scherer  
Laurent Biethro  
63 Canadian Authors

International Adaptation

120+ International Authors

# 2027 Canadian Adult Obesity Clinical Practice Guideline

**Help shape the future of obesity care in Canada**

## New Lead Author

**Dr. Roshan Abraham**



## Call for Authors

**Applications close  
September 29, 2026  
Apply Now!**





# **Awareness, Education, Implementation and Mobilization**

**Dr. Roshan Abraham MD, CCFP, MHSE**  
Associate Professor, University of Alberta

# Conflict of Interest: Dr. Roshan Abraham

| Nature of relationship(s)                                                                                                                                                         | Name of organization(s) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| Any direct financial payments including receipt of honoraria/speaker's fee                                                                                                        | Obesity Canada          |
| Membership on advisory boards or speakers' bureaus                                                                                                                                | none                    |
| Funded grants or clinical trials                                                                                                                                                  | none                    |
| Patents on a drug, product, or device                                                                                                                                             | none                    |
| Salaried or contract employee within the past 5 years                                                                                                                             | none                    |
| All other investments or relationships that could be seen by a reasonable, well-informed participant as having the potential to influence the content of the educational activity | none                    |

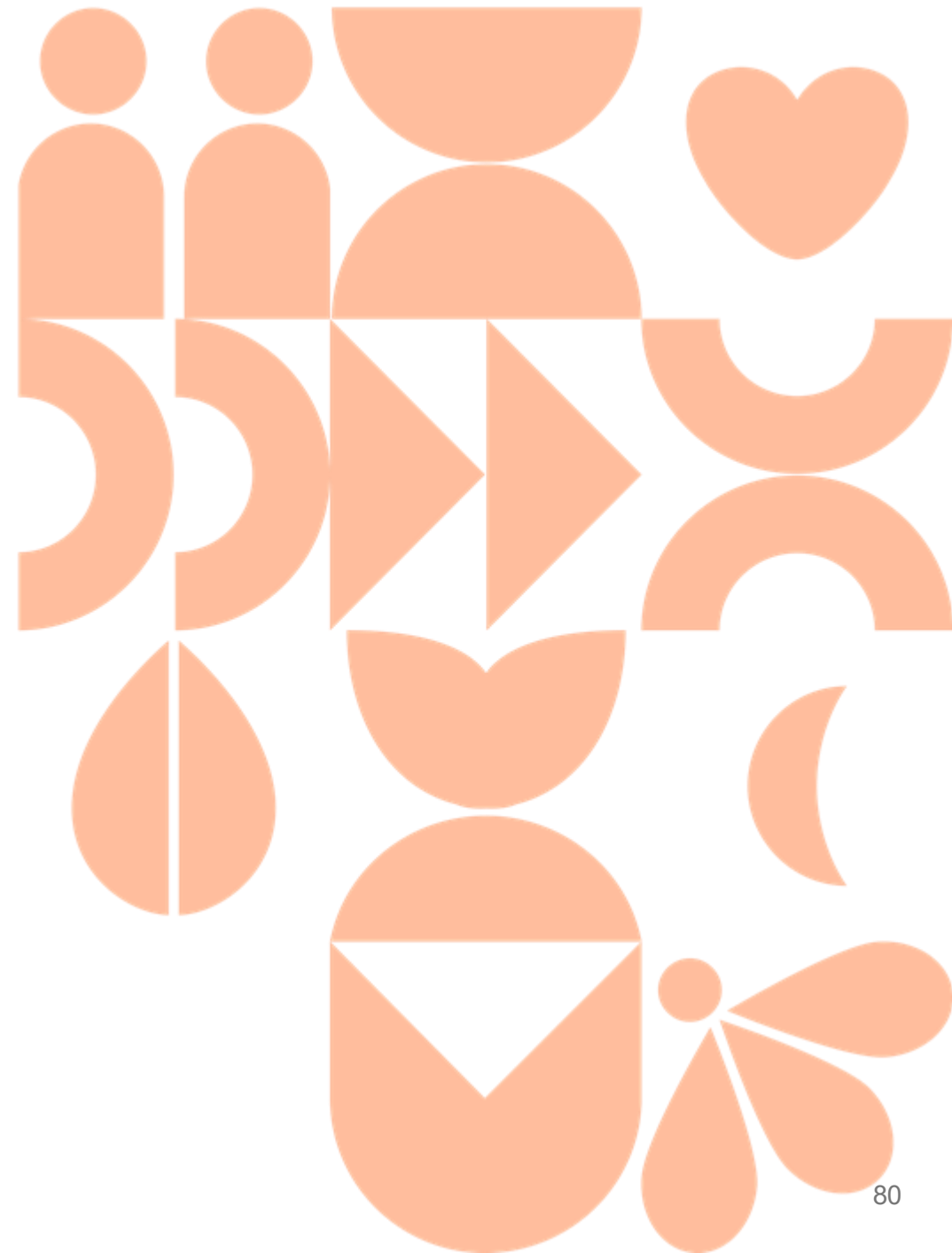




# **The Implementation Gap and Need for Science Mobilization**

# The Implementation Gap: 18 Years to Behaviour Change

- Historically, it takes an **average of 17 to 18 years** for scientific evidence to reach routine clinical practice.
- Even after nearly two decades, **only 1 in 5** (20%) evidence-based interventions make it into daily patient care.
- Disadvantaged and under-resourced populations face an even wider gap, **worsening health inequities.**



# Rethinking Science Mobilization and Competencies

- Passive dissemination (publishing papers, releasing guidelines) fails to change practitioner behavior fast enough.
- We must treat **implementation as a deliberate science**—incorporating system readiness, behavioral nudges, and practical execution.
- Bridging this gap requires **moving beyond knowledge acquisition** to core competencies and active mobilization.





# **Current State of Obesity Care Education in Canada**





# Moving from Guidelines to Competency-Based Medical Education

- Needs assessments and a review of the literature highlighted a **persistent lag between clinical guidelines and actual undergraduate medical curriculum in Canada**, leaving graduating learners underprepared to manage complex, chronic obesity.
- Conventional curricula failed to systematically identify or address implicit **weight bias** among practitioners, leading to suboptimal care and healthcare avoidance.

Passive dissemination of clinical practice guidelines proved insufficient to change clinical behavior without embedded educational milestones.

# The Solution?

## 2023 Canadian Obesity Education Competencies (COECs)

- **13 Key & 37 Enabling Competencies** developed by Obesity Canada's multi-professional Education Action Team to embed evidence-based care directly into training programs.
- Grounded in the universally adopted 2015 CanMEDS Framework to allow seamless adoption across Canadian medical schools.
- Explicitly prioritizes co-constructed treatment plans, root-cause assessments, and mitigation of weight bias in clinical and educational settings.





# Transforming the landscape of obesity education - The Canadian obesity education competencies

[Joseph Abraham Roshan](#)<sup>a</sup>, [Taniya S Nagpal](#)<sup>b</sup>, [Nicole Pearce](#)<sup>c,\*</sup>, [Khushmol K Dhaliwal](#)<sup>c</sup>, [Mohamed El-Hussein](#)<sup>d</sup>,  
[Mary Forhan](#)<sup>e</sup>, [Stasia Hadjiyanakis](#)<sup>f</sup>, [Raed Hawa](#)<sup>g</sup>, [Robert F Kushner](#)<sup>h</sup>, [Dayna Lee-Baggley](#)<sup>i</sup>, [Michelle McMillan](#)<sup>c</sup>,  
[Sarah Nutter](#)<sup>j</sup>, [Helena Piccinini-Vallis](#)<sup>i</sup>, [Michael Vallis](#)<sup>i</sup>, [Sean Wharton](#)<sup>k</sup>, [David Wiljer](#)<sup>l</sup>, [Sanjeev Sockalingam](#)<sup>l,m</sup>

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PMCID: PMC10728696 PMID: [38125661](#)

**Read the paper**



# Canadian Senior Clerk Assessment of Obesity Competencies

- Methodology (N=194, 78% Completion): Evaluated graduating Canadian medical clerks against the 2023 COEC framework to assess real-world clinical readiness.
- Trainees demonstrate strong mastery of basic science and pathophysiology but exhibit significant deficits in multi-modal care options and practical management.

Obesity care education in Canadian medical schools: A multi-site qualitative study

Kerri Z. Delaney<sup>a,b,c,\*</sup> , Lucy Shrestha<sup>a,b</sup>, Taniya S. Nagpal<sup>d</sup> , Hannah Geddie<sup>e</sup>,  
Christine Tenedero<sup>e</sup>, Sonja Wicklum<sup>f</sup> , Helena Piccinini-Vallis<sup>c</sup> , Nicole Pearce<sup>g</sup> ,  
Michelle McMillan<sup>g</sup>, Boris Zevin<sup>h</sup> , Michael Vallis<sup>c</sup> , Sanjeev Sockalingam<sup>g,i,j</sup>,  
Erin Cameron<sup>a,b</sup>, Roshan Abraham<sup>k</sup> 



# Emotional Preparedness & Clinical Exposure Deficits

- Widespread trainee reluctance surrounding weight bias, combined with a lack of practical tools to initiate non-judgmental conversations.
- Low hands-on engagement across core rotations highlights that traditional exam metrics fail to predict point-of-care clinical readiness.

**Read the paper**



# Influencing National Standards

- Successful effort by the Education Action team to update the Medical Council of Canada's (MCC) learning objective on Obesity in 2026
- This alignment bridges the gap between academic theory and clinical expectations for graduating clerks.

**Read the MCC  
learning objective  
for obesity**



## Obesity

Version: March 2026 Legacy ID: 118-1

[Download this objective \(PDF\)](#)

### Rationale

Obesity is a chronic multifactorial disease that is complex and progressive. It develops from social, behavioural, physiologic, and metabolic interactions. Characterized by dysfunctional or excess adipose tissue that impairs health, obesity is a risk factor for a wide range of serious illnesses.

### Causal Conditions

(list not exhaustive)

1. Social milieu (e.g., socioeconomic status, occupation, disability, lifestyle)
2. Neuroendocrine factors (e.g., hypothyroidism, Cushing syndrome, polycystic ovary syndrome)
  - a. Genetic (e.g., Prader-Willi syndrome)
  - b. Epigenetic
3. Substances and medications (e.g., smoking cessation, psychiatric medications, cancer treatment)
4. Life cycle changes
5. Mental health conditions

### Key Objectives

Given a patient with obesity, the candidate will assess the root causes and severity and collaborate on a care plan that is based on the patient's values.





# **Catalyzing Real-World Implementation**



# Mobilizing Knowledge into Clinical Practice

## Bridging the Gap

- Moving from passive guideline dissemination to active curricular integration.
- The MCC objective acts as a catalyst for systematic change in undergraduate medical education (UME).
- Ensures that evidence-informed, stigma-free care becomes an assessable competency rather than a theoretical concept.

## Scaling the Science

- Utilizing OC Education Hub resources for point-of-care support.
- Extending the COEC framework beyond medical students to allied health professions (Nursing, Pharmacy, Dietetics, etc.).
- Embedding decision-support tools into EMRs to reduce the "18-year gap" between research and practice.
- Moving from one-time curriculum updates to iterative, evidence-based education cycles.



# A Unified Approach to Obesity Care

- Education is not just about knowledge transfer; it is about behavior change.
- By integrating competencies, policy, and implementation science, we can build a sustainable infrastructure for obesity care.
- Call to action: Engage with our Education Hub and join the upcoming 2027 CPG revision to continue this momentum.





## **obesity canada education**

Obesity Canada is dedicated to advancing obesity education for many populations including:

**Patients**



**Healthcare  
Professionals**



**Public**



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