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From Weight Loss Outcomes to Comprehensive Health Outcomes: the Paradigm Shift for the Health & Fitness Sector

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ABSTRACT

Obesity is a complex, chronic disease requiring individualized, long-term management that can integrate behavioral/lifestyle, pharmacologic, procedural, and surgical approaches according to the individual's health status, complications, goals, preferences, and treatment response [1]. While advances in obesity management medications (OMMs) and metabolic/bariatric surgery have expanded treatment options, long-term success remains dependent on sustained lifestyle change behaviors that preservefunctional capacity, improve cardiometabolic health and enhance quality of life.

This perspective proposes that the health and fitness sector reposition itself from an exercise-centric, weight-focused model toward a Person-First Adaptive Approach (PFAA) to Obesity Management, one that begins with understanding the person rather than fitting the person into a predetermined program. We introduce the Activity Starting-Point Spectrum (ASPS), which identifies where an individual is currently starting from (inactive, under-active, or active) rather than assigning a fixed label, and the Person's Adaptive Training Zone (PATZ), a proposed conceptual framework in which the training dose (frequency, intensity, duration, modality, volume, mechanical load, and programmed recovery) is selected, monitored, and adjusted relative to the individual's current capacity. Psychological readiness, weight stigma, medical status, and environment are treated as factors that modulate an individual's tolerance, response to, and recovery from that dose, not as components of the dose itself. We further propose that Emotional Intelligence and Motivational Interviewing are relational competencies through which fitness professionals understand the person receiving the training dose. We argue that the appropriate physiological stress is person-specific, context-specific, and time-dependent, and that community-based fitness professionals are positioned as partners, not substitutes, within an interdisciplinary Patient Care Team.

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Introduction

Based on our professional observations and feedback from customers and respected professionals within and outside the Health & Fitness Sector, it is our perspective that, as recently as Q3 2026, a substantial part of our Sector continues to struggle with understanding the nature of obesity-care management. The Health & Fitness Sector often struggle with obesity-management programming because the traditional fitness-club model was built primarily around exercise delivery, while successful obesity management requires a much broader, person-centered support system.

Key Reasons Include:

- An exercise-first mindset: Programs may begin with workouts instead of first understanding the individual, their goals, readiness, experiences, barriers, and preferred pathway.
- Limited obesity-specific education: Many fitness professionals have strong exercise knowledge but limited formal education in obesity as a complex, chronic, multifactorial disease involving biological, behavioral, environmental, psychological, and social factors.
- Weight-loss thinking instead of obesity-management thinking: Success is still frequently defined primarily by pounds lost rather than improvements in strength, mobility, metabolic health, cardiovascular fitness, function, quality of life, and sustainable behaviors.
- Failure to meet people where they are: Traditional programs may expect individuals to adapt to the fitness center rather than designing programming around their current abilities, needs, preferences, confidence, and readiness.
- One-size-fits-all programming: Individuals managing obesity represent a highly diverse population. The same exercise prescription, onboarding process, or coaching strategy will not work for everyone.
- Programming that begins with a physiological stress dose that is excessive relative to the individual's current capacity may create disproportionate soreness, fatigue, discomfort, pain, or discouragement and undermine participation, while chronically insufficient stimulus may eventually limit adaptation [2,3,4].
- Insufficient attention to psychological safety and weight bias/stigma. This has been associated with reduced physical activity and self-exclusion from some exercise settings, making the quality of the environment itself part of the implementation problem [5].

- From the lens of the Health & Fitness Sector, we seek to evolve our understanding of obesity management care from being an exercise-centric, weight-focused model towards a person-first, whole-person, adaptive approach to health and well-being. Our recommendation is that effective obesity management care begins with understanding the person, not fitting the person into a predetermined program. But more importantly, our Sector must develop a more comprehensive understanding of obesity.



Figure 1: Defining an Obesity-Management Strategy: A Cross-Functional Fitness Team Aligning Person-First Experience, Training Standards, Accountability, and Health Outcomes

Person-First Adaptive Approach to Obesity Management

The Person-First Adaptive Approach (PFAA) to Obesity Management is an individualized, multidisciplinary, and adaptive framework for the management of obesity that recognizes obesity as a complex, chronic, heterogeneous, and multifactorial disease influenced by interacting biological, physiological, psychological, behavioral, social, and environmental factors.

This approach places the person, not body weight, the diagnosis, or a standardized intervention, at the center of care. Clinical and lifestyle-management strategies are developed through comprehensive person-first assessments and shared decision-making, then continuously evaluated and adapted according to the individual's clinical status, functional capacity, treatment response, preferences, goals, lived experience, and changing circumstances.

Rather than applying a predetermined or one-size-fits-all intervention, the framework uses an adaptive process that includes

Assess → Individualize → Implement → Monitor → Evaluate → Adapt → Progress

Depending on the individual's needs, wants, and goals, obesity care may integrate medical management, nutrition, physical activity and structured exercise, behavioral and psychological support, and physical therapy or rehabilitation. When indicated, care may also include sleep and stress management, health coaching, and social and community support, with the composition and intensity of services individualized to the needs of the person.

We are proposing in our Abstract that the Health & Fitness Sector consider repositioning ourselves as Obesity Care Advocates so that we can successfully provide better customer-centric solutions and outcomes that go beyond weight loss that go beyond weight loss while staying within the scope of our practice.



Figure 2: Person-First Adaptive Approach (PFAA) to Obesity Management: Assess, Individualize, Implement, Monitor, Evaluate, Adapt, and Progress with the Person at the Center

Our Person-First Adaptive Approach to Obesity Management is therefore built around an interdisciplinary Patient Care Team. We propose the following as a recommended minimum framework that can be adapted to the scope, capabilities, referral relationships, and operational realities of individual facilities:

- Physicians & Obesity Medicine Specialists
- Registered Dietitians
- Physical Therapists
- Qualified Movement/Exercise Professionals
- Behavioral Health Professionals
- Health Coaches & Support Professionals

The Health & Fitness Sector, when ready, can potentially become an active partner on Patient Care Teams.



Figure 3: Patient Care Team Collaboration: Coordinated Support Across Medical, Nutrition, Rehabilitation, Behavioral-Health, Exercise, and Coaching Roles

Four Potential, Patient-Specific Obesity Management Pathways

Because of the complex nature of obesity, the following four potential, patient-specific obesity management pathways are being referenced in this article. These pathways should not be seen in any way as competitive approaches. The appropriate pathway should emerge from comprehensive assessments, shared decision-making, clinical indications, contraindications, treatment responses, patient preferences, and changing patient needs over time. Importantly, lifestyle and behavioral support can accompany pharmacologic and surgical treatment rather than functioning only as a separate alternative.

Obesity Management Medications

Obesity management medications are evidence-based pharmacologic therapies used as part of comprehensive treatment for eligible

individuals with obesity or overweight with associated health risks. Depending on the medication, these therapies act through specific physiological pathways involved in appetite regulation, satiety, energy intake, and/or metabolic function. Current clinical guidance supports pharmacologic treatment alongside lifestyle modification and emphasizes shared decision-making that weighs benefits, harms, access, comorbidities, preferences, goals, contraindications, and treatment response [6].

Medication selection should be individualized according to clinical indications, obesity-related complications, medical history, contraindications, potential adverse effects and drug interactions, patient preferences, treatment goals, accessibility, and response to therapy. Within a Person-First Adaptive Approach, pharmacotherapy is not a substitute for comprehensive care.

Clinical Objective: Improve Obesity-Related Health and Reduce Disease Burden Through Individualized, Evidence-Based Pharmacologic Treatment while Supporting Long-Term Health, Function, and Well-Being.

Metabolic and Bariatric Surgery

Metabolic and bariatric surgery encompasses evidence-based surgical procedures that modify gastrointestinal anatomy and physiology to produce clinically meaningful changes in weight regulation and metabolic health.

Updated ASMBS/IFSO guidance broadened surgical indications and emphasizes long-term multidisciplinary follow-up care [7].

Surgical treatment should be considered within a comprehensive multidisciplinary pathway that includes appropriate preoperative assessment, informed shared decision-making, perioperative management, nutritional surveillance, and long-term follow-up.

Clinical Objective: Achieve Clinically Significant and Durable Improvements in Obesity-Related Health Through Metabolic and Anatomical Intervention While Supporting Long-Term Nutritional Status, Physical Function, Psychological Well-Being, and Quality of Life.

Metabolic/Bariatric Surgery + Obesity Management Medication: Hybrid Treatment Pathway

This is a Hybrid Treatment Pathway that integrates metabolic/bariatric surgery with obesity management medications when clinically appropriate as part of individualized, long-term obesity care. Rather than viewing surgery and medication as competing treatment options, this approach recognizes that obesity, being such a complex, chronic, and heterogeneous disease, may require adaptable treatment strategies. Medication may be considered before or after surgery based on clinical needs, treatment response, weight recurrence, obesity-related complications, and individual goals. Ongoing medical monitoring, nutrition support, physical activity, structured exercise, behavioral support, and lifestyle management remain important components of comprehensive care. Through shared decision-making, the care team continually evaluates outcomes and adapts treatment to support comprehensive health, physical function, quality of life, and long-term well-being.

Clinical Objective: Optimize Long-Term Clinical Outcomes by Strategically Integrating Surgical and Pharmacologic Therapies According to the Individual's Disease Severity, Treatment History, Physiological Response, Health Risks, and Evolving Clinical Needs.

Intensive Behavioral Therapy (IBT) Pathway

As a point of clarification, we want to make it clear that this pathway is a structured treatment rather than generic lifestyle advice. Intensive Behavioral Therapy is an established CMS/Medicare classification for structured behavioral obesity treatment. Under current Medicare coverage, the benefit follows a defined visit schedule that may include up to 22 face-to-face visits over 12 months, subject to eligibility and reassessment criteria, and the covered service must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting [8]. The treatment is grounded in individualized, evidence-informed behavioral interventions and can address physical activity, nutrition-related behaviors, behavioral skills, social support, and other modifiable determinants of health. Community-based fitness professionals should therefore be viewed as complementary partners who can support physical activity, structured exercise, behavior change, and referral coordination within their professional scope, not as independent Medicare IBT providers or billers. This pathway nevertheless represents an important opportunity for the Health & Fitness Sector to align with structured, longitudinal behavioral obesity care and help extend person-first support across settings. The objective extends beyond increasing caloric expenditure or producing weight loss. Programming should provide an appropriate physiological and psychological stimulus based on the person's medical status, physical and functional capacity, activity history, preferences, readiness, environment, and response to intervention.

Movement strategies may include walking, aquatic training, resistance training, cardiorespiratory exercise, mobility and balance training, recreational activity, and hybrid approaches, with modality, intensity, volume, and progression adapted to the individual. Outcomes should likewise extend beyond body weight to include cardiorespiratory fitness, muscular strength and preservation of lean mass, metabolic health, mobility, balance, functional capacity, psychological well-being, self-efficacy, health behaviors, quality of life, and sustained participation in physical activity.

Clinical Objective: Improve Health, Function, Behavioral Capacity, and Quality of Life Through Individualized and Progressively Adapted Lifestyle Interventions that can Function Independently when Appropriate or Complement Pharmacologic and Surgical Treatment.

Under the Person-First Clinical Principle, these four pathways are not being presented as a hierarchy. The question is not, "Which obesity program should this patient fit into?" The question is, "Which combination of evidence-based interventions is appropriate for this person, at this point in their obesity-management journey?"



Figure 4: Four Potential Patient-Specific Obesity-Management Pathways: Obesity-Management Medications, Bariatric Surgery, Combined Surgery Plus Medications, and Intensive Behavioral Therapy

A Biological Systems Perspective

Activity, movement, and exercise initiate complex signaling pathways that influence gene expression, mitochondrial biogenesis, muscle remodeling, vascular function, immune regulation, and metabolic flexibility. A 2024 systematic review of randomized controlled trials found that exercise interventions can alter specific and global DNA-methylation patterns, while emphasizing considerable heterogeneity across populations, tissues, exercise characteristics, and measurement methods [9]. Epigenetics is treated here as an emerging mechanism within a broader biological-systems perspective, not as a deterministic explanation for obesity or exercise response.

For Individuals Managing Obesity, these Adaptations May Include:

- Improved insulin sensitivity [10,11]
- Improved muscular strength and physical fitness [12]
- Reduced chronic low-grade inflammation [13]
- Improved endothelial function, particularly with aerobic training [14]
- Better balance and mobility [15]
- Increased functional independence
- Improved psychological well-being and self-efficacy
- Greater capacity for activities of daily living

These outcomes reinforce an important clinical principle: improvements in health often precede measurable changes in body weight.

The Comprehensive Programming Option Concept: Activity Starting-Point Spectrum

Designing comprehensive programming solutions for individuals managing obesity requires a fundamental shift from standardized exercise prescriptions to a Person-First Adaptive Approach (PFAA) to Obesity Management.

Under PFAA, we have created what we call the Activity Starting-Point Spectrum (ASPS). Inactive, Under-Active, and Active are activity starting points for each individual, not fixed identities.

Activity Starting Point: Inactive Adults: Establish Movement

These are individuals who currently engage in little or no regular physical activity and may spend substantial amounts of time sedentary. The initial objective is not to immediately achieve conventional exercise targets. It is to safely establish movement, build tolerance, and create positive movement experiences.

Person-First priority: Initiate → Build Tolerance → Build Confidence → Establish Consistency

Activity Starting Point: Under-Active Adults: Build Capacity

These are individuals who participate in some physical activity but at a frequency, duration, intensity, or variety that may be insufficient to achieve their individual health, fitness, or functional objectives.

Person-First priority: Assess → Build on Current Activity → Expand Capacity → Progress Appropriately

Activity Starting Point: Active Adults: Optimize s Individualize

Individuals who regularly participate in physical activity and/or structured exercise at levels generally capable of producing meaningful health or fitness adaptations. Being active does not mean the current program is necessarily optimal for obesity management.

Person-First priority: Evaluate → Optimize → Individualize → Adapt → Progress

The individual programming strategy may include Land-Based Training, Aquatic-Based Training, or Hybrid-Based Training (Land & Aquatics), driven by each person's current activity exposure, functional capacity, clinical considerations, preferences, and readiness.

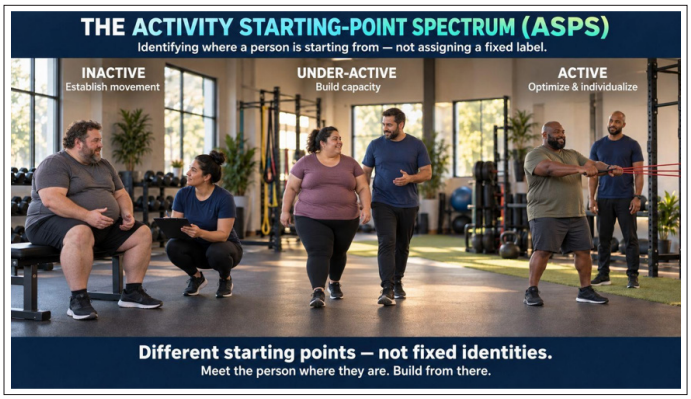


Figure 5: Activity Starting-Point Spectrum (ASPS): Inactive, Under-Active, and Active are Starting Points Rather Than Fixed Identities

The Person's Adaptive Training Zone (PATZ)

Where the Activity Starting-Point Spectrum answers the question of where a person is starting, a second question remains: what training dose is appropriate for this person right now? We propose the Person's Adaptive Training Zone (PATZ) as a conceptual framework for answering that question.

Exercise is fundamentally a physiological stressor. Acute exercise disrupts homeostasis and initiates molecular, metabolic, cardiovascular, neuromuscular, and immune responses that contribute to subsequent adaptation [4,16]. Effective training requires sufficient overload to stimulate adaptation, but a mismatch between load and recovery can produce maladaptation [2,3]. The same training dose does not necessarily produce the same response in every person [17,18,19].

We initially considered describing this concept using the terms "high-inflammation training" and "low-inflammation training." We now believe this framing is scientifically imprecise and have replaced it with Higher and Lower Physiological Stress Training. A 2025 systematic review and network meta-analysis of 123 randomized controlled trials found that different exercise modalities and intensities produced different effects on inflammatory biomarkers, and that higher-intensity exercise was not uniformly associated with worse inflammatory outcomes [13].

We wish to be precise about what is being proposed. Higher and Lower Physiological Stress Training is not an established clinical classification; it is a conceptual framework grounded in established exercise-physiology, training-load, recovery, and individualized-prescription literature.

Body size should not be used as a proxy for exercise capacity. This principle is consistent with the American Heart Association's scientific statement connecting physical activity directly to obesity treatment and cardiometabolic health [20].



Figure 6: Person's Adaptive Training Zone (PATZ): The Appropriate Physiological Stress is Person-Specific, Context-Specific, and Time-Dependent

Assess → Select the Appropriate Training Dose → Monitor Response → Evaluate Recovery s Adaptation → Adjust → Progress

The training dose itself is defined here as the interaction of frequency, intensity, duration, modality, volume, mechanical load, and programmed recovery, the elements being prescribed. That dose interacts with, and is modulated by, the person's medical status, functional capacity, training history, nutrition, sleep, psychological stress, medications or treatment, environment, and recovery capacity. These modifiers are not themselves components of the prescribed dose; they shape how the dose is tolerated, experienced, and recovered from.

The central proposition is not that low stress is inherently good or high stress is inherently bad. It is that the appropriate physiological stress is person-specific, context-specific, and time-dependent. The Adaptive Training Zone moves as the person changes.



Figure 7: Recovery and Adaptation: Tissue Repair, Nervous-System Recovery, Muscle Remodeling, Immune Function, and Protein Synthesis Support Adaptation After Exercise

The Value of Aquatics Programming

Based on the 45+ years that Ann Gilbert has used aquatics-based programming with her students and clients, we want to formally introduce Aquatics Programming into our discussion.

Aquatic Programming represents an underutilized therapeutic modality within obesity management. Water immersion reduces joint loading through buoyancy while providing multidirectional resistance that supports muscular strength, aerobic conditioning, balance, and flexibility. One recent clinical review reports reduction in load-bearing stress of approximately 50 to 70% in aquatic settings [21]. primary biomechanical studies support the general unloading principle while showing its magnitude is context-dependent; instrumented hip and knee implants demonstrated substantially lower joint forces during matched activities in chest-high water than on land, while faster movement and added resistance could increase forces, and water-treadmill research shows deeper immersion changes impact-loading and physiological response [22,23].

A systematic review and meta-analysis found aquatic exercise significantly improved VO_2max (mean difference $+3.70\ mL \cdot kg^{-1} \cdot min^{-1}$, 95% CI 2.49 to 4.90, $p < 0.001$) along with reductions in resting heart rate, blood pressure, triglycerides, and fasting glucose; no significant pooled changes were observed for BMI, body fat percentage, or cholesterol, with certainty ranging from low to very low [24-25]. found moderate-certainty reductions in body weight and waist circumference from water-aerobics interventions specifically [26]. found modest improvements in pain and physical function in adults with overweight/obesity and lower-limb osteoarthritis, with low overall certainty.

This uncertainty is important: aquatic programming should not be oversold as a superior obesity treatment, nor dismissed as an inferior form of exercise simply because it occurs in a pool. For individuals experiencing osteoarthritis, musculoskeletal pain, reduced mobility, or exercise apprehension, aquatic environments may lower barriers to participation while promoting adherence, and frequently provide an emotionally supportive setting in which individuals can engage in movement with reduced fear of discomfort, embarrassment, or injury.



Figure 8: Aquatics Programming: Buoyancy, Immersion Depth, Movement Speed, and Resistance can be Adjusted to Shape Loading, Physiological Demand, and Participation Experience

Psychological Readiness, Weight Stigma, and Adherence

The psychological experience of exercise is part of the individual's response to a training dose, not the dose itself. A systematic review found that weight teasing, discrimination, and internalized weight stigma were often associated with reduced physical activity [5]. Fear-related barriers can include fear of pain, movement, judgment, embarrassment, or injury [27]. Person-centered, nonjudgmental language, inclusive facilities, and attention to weight bias are supported by obesity-care consensus recommendations [28]. Recent adherence reviews suggest that supervised and group-based exercise interventions can improve exercise adherence among adults with overweight or obesity, although study quality remains variable [29,30].

Being transparent, we acknowledge that weight bias and weight stigma remain significant problems within the Health & Fitness Sector, and that our Sector has contributed to their perpetuation.

The question for our Sector to address is: How do we collectively reduce and mitigate weight bias and weight stigma within our Sector?
Our recommendation: we become Obesity Care Advocates.

Obesity Care Advocacy: Reducing Weight Biass Weight Stigma
An Obesity Care Advocate who embraces a Person-First approach can help reduce weight bias and weight stigma by changing how the Health & Fitness Sector sees, speaks about, engages with, and supports individuals managing obesity. Person-First thinking recognizes obesity as a complex, chronic, heterogeneous disease, not simply the result of personal choices, motivation, or willpower. It encourages fitness professionals to replace assumptions and judgment with curiosity, empathy, respect, and individualized support.

This means listening to each person's lived experience, using respectful language, creating psychologically safe environments, and designing programming around individual needs, abilities, preferences, goals, and responses. By challenging stereotypes and advocating for inclusive practices, Obesity Care Advocates can help shift the sector from weight-centered judgment toward whole-person support, creating environments where people feel welcomed, valued, understood, respected, and empowered to pursue sustainable health and well-being.

Emotional Intelligence (also known as EQ) training and Motivational Interviewing (MI) skills can be powerful tools for reducing weight bias and weight stigma in the Health C Fitness Sector because both approaches require fitness professionals to shift from judging, assuming, and directing toward listening, understanding, collaborating, and individualizing.

Emotional Intelligence → Changes How We See and Respond to the Person Motivational Interviewing → Changes How We Communicate with the Person

Motivational Interviewing complements EQ by providing fitness professionals with practical communication skills for having collaborative rather than prescriptive conversations.
We further address the EQ and MI concepts below.

Expanding the Role of Community-Based Fitness Professionals
As obesity care continues to be increasingly interdisciplinary, appropriately trained health and fitness professionals can contribute meaningfully within our professional scope of practice. This role is complementary, not competitive, with medical care.

"Appropriately Trained" is best understood as a set of observable competencies rather than a jobtrait alone, Including:

- Ongoing obesity-specific education and person-first language training;
- Weight-bias awareness and respectful communication skills;
- Ability to conduct functional assessments and apply exercise progressions and regressions within scope of practice;
- An understanding of land, aquatic, and hybrid movement options;
- The ability to distinguish external workload from the individual's internal response to that workload;
- The ability to monitor and manage tolerance, adherence, recovery, and functional changes;
- The ability to recognize response signs that require a pause, referral, or clinical communication;
- The ability to communicate respectfully across disciplines and maintain respect for all members of the Patient Care Team.

Emotional Intelligence and Motivational Interviewing
In order to make this expanded Fitness Professional role come to life, we want to introduce Emotional Intelligence Training & Motivational Interviewing Skills into the "Appropriately Trained" discussion.

EQ and MI skills can be especially valuable within a Person-First Adaptive Approach to Obesity Management because they help fitness professionals move beyond simply prescribing exercise toward understanding the person who will experience the program [31,32].

The additional upside with EQ and MI is this: Before asking, "What exercise does this person need?" The Ask Is, "What do I need to understand about this person to help create an exercise experience they can engage with, respond to, and sustain?"

Emotional Intelligence: Improves the Fitness Professional's Ability to Understand the Person
EQ training can develop the Fitness Professional's ability to recognize, understand, and appropriately respond to our own emotions and those expressed by others [31,33]. In obesity management, this is particularly relevant because individuals may enter fitness environments with very different previous experiences, expectations, confidence levels, concerns, and perceptions of exercise.

Motivational Interviewing (MI): Helps the Professional Understand What Matters to the Person
MI complements EQ by providing a structured, collaborative communication approach for exploring a person's own motivations, values, goals, concerns, and ambivalence about behavior change [32]. Rather than telling someone, "You need to exercise more," the Fitness Professional Might ASK: "What would becoming more physically active allow you to do that matters to you?" That difference is fundamental.

Through open-ended questions, affirmations, reflective listening, and summaries, MI can help uncover information that a conventional fitness assessment may never reveal. A person might disclose that they want enough stamina to travel or play with their grandchildren; dislike traditional gyms but enjoy walking outdoors; previously experienced embarrassment in a group exercise environment; are concerned that exercise will worsen joint discomfort; enjoy aquatic exercise but assumed it "doesn't count"; or understand the health benefits of exercise but are uncertain how to fit it into their life. Those insights can fundamentally change program design.

EQ + MI → Person-First Programming
EQ helps the professional better perceive and understand the person. MI helps the professional create conversations through which the person can articulate what matters to them. Person-First Adaptive Programming uses that information to help individualize the exercise experience.

An Important Scope-of-Practice Boundary
For Fitness Professionals, EQ and MI should be viewed as communication and behavior-support competencies, not psychotherapy. When conversations reveal concerns requiring clinical psychological, medical, nutritional, or other specialized intervention, the appropriate response is referral and collaboration with the person's broader Patient Care Team.

Ultimately, EQ and MI Transform our role as the Fitness Professional from: "I prescribe. You comply." to: "I listen. We

understand. We collaborate. The program adapts." That may be one of the most important behavioral dimensions of the Person-First Adaptive Approach to Obesity Management because the appropriate physiological stimulus should not be considered independently from the psychological experience of the person receiving it.

Motivational Interviewing has Relatively Direct Evidence: A 2024 BMJ systematic review of 97 randomized trials (27,811 adults) found MI-containing behavioral interventions produced short-term improvements in physical activity, though certainty was generally low to very low and the independent effect of MI alone was not always clearly isolated [32]. Emotional Intelligence evidence is more indirect for this paper: EQ training shows generally favorable effects in healthcare-workforce and nursing populations, but direct evidence that EQ training improves obesity-management outcomes when delivered to community fitness professionals remains limited [31,33].

From Weight-Loss Outcomes to Comprehensive Health Outcomes

Body weight can remain a clinically relevant measure, but it should not be the sole measure of exercise value or program success. The 2026 AHA scientific statement emphasizes that physical activity provides important cardiometabolic benefits and is a component of comprehensive obesity treatment even when weight loss is modest [20]. A person-first outcome framework should examine multiple domains:

- Physiological and clinical: cardiorespiratory fitness, glycemic measures, blood pressure, lipid profile.
- Functional: mobility, strength, balance, activities of daily living, exercise tolerance.
- Behavioral: attendance, adherence, physical-activity frequency, persistence, dropout.
- Psychological: self-efficacy, confidence, exercise apprehension, mood, perceived competence.
- Social and experiential: belonging, perceived support, satisfaction, quality of the member experience.
- Person-reported: quality of life, perceived function, pain where relevant, perceived value.



Figure 9: The Person-First Difference: Comprehensive-Health Outcomes Broaden Success Beyond Body-Weight Change Alone.

An Illustrative Case: The Adaptive Training Zone in Practice

Phase 1: Weight-Management History

At a highest weight of approximately 700 lb, one member of our team began his weight-management journey independently, researching and practicing fasting on his own. He lost approximately his first 100 lb through fasting alone before determining that fasting was not sustainable as a primary long-term strategy. This phase belongs to his broader weight-management history rather than to the exercise-dose framework described above.

Phase 2: Entry Into Structured Movement

As his mobility improved, he decided to join a gym and completed an initial fitness consultation. His starting point on the Activity Starting-Point Spectrum was inactive, confirmed directly by him, including limited exercise experience and low confidence at that stage. Conventional land-based exercise proved too physically demanding to sustain. He independently gravitated toward aquatic exercise after observing that substantial training could be performed in water.

Phase 3: Capacity Expansion

Aquatic exercise became his primary structured training environment for approximately the next year and a half. As his strength and movement tolerance built progressively, his Adaptive Training Zone shifted, and additional land-based activity became possible: Tai Chi entered his program roughly a year and a half after he began aquatic training, and physical therapy has since become an additional component. As of this writing, his weight is approximately 424 lb, and the overall process continues.

Confidence remains an area of ongoing work for him, not a resolved past-tense state. In this framework, psychological readiness and self-efficacy are treated as dynamic modifiers of engagement, tolerance, response, and recovery rather than as components of the prescribed training dose; physiological capacity and psychological response can evolve together without changing at identical rates.

The relevant point for this framework is not the specific pounds lost through any one phase, but that his movement strategy evolved as his capacity evolved: an initial land-based dose that did not fit was replaced with an environment that did, and expanded options followed as capacity increased.

Research Priorities

- Does explicit use of an Activity Starting-Point Spectrum improve early adherence in community fitness settings for individuals managing obesity?
- Does a PATZ-based approach improve function or adherence compared with standardized progression?
- Which measures of internal response and recovery are practical and valid in community health-club settings?
- Do land-based, aquatic, and hybrid pathways differ in adherence, confidence, pain, function, or retention when assigned through a person-first assessment process?
- Does obesity-specific communication and weight-bias training for fitness staff improve belonging, satisfaction, and retention?
- Does training community-based movement/exercise professionals in Motivational Interviewing and emotional-intelligence-based communication improve engagement, self-efficacy, adherence, retention, or other person-reported outcomes among adults managing obesity?

Clinical Implications

A systems-oriented approach suggests that successful obesity management should evaluate outcomes beyond weight loss alone. Functional capacity, mobility, strength, cardiometabolic health, physical activity adherence, quality of life, and psychological well-being are clinically meaningful indicators of success.

A Call to Action for the Health & Fitness Sector

From Weight Loss to Comprehensive Health: Put the Person First. The Health & Fitness Sector has an opportunity to redefine its role in obesity management.

For too long, success has often been framed through a narrow question: "How much weight did they lose?" A Person-First Adaptive Approach challenges us to ask a much bigger question: "How has this person's comprehensive health, physical capacity, confidence, function, well-being, and quality of life improved?" That shift requires us to move beyond weight-loss-only thinking and recognize obesity as a complex, chronic, heterogeneous disease. Individuals managing obesity do not arrive at our facilities with the same medical histories, fitness levels, treatment pathways, movement experiences, psychological readiness, preferences, barriers, or goals. Why would we expect one standardized exercise solution to work for everyone?
The future is person-first, adaptive, and response-informed.

It means understanding the person's medical diagnosis and treatment pathway before designing the exercise strategy. It means using comprehensive fitness assessments to understand physiological and psychological profiles. It means recognizing whether someone is currently Inactive, Under-Active, or Active and meeting them at that activity starting point, not where we think they should be.

It means developing Emotional Intelligence and Motivational Interviewing skills so fitness professionals can listen before prescribing, understand before assuming, and collaborate rather than dictate.

It means understanding exercise as a biological stimulus, not simply a calorie-burning tool. Higher and lower physiological stress training become options, not judgments, with the goal of finding the Adaptive Training Zone that provides the appropriate challenge, manageable stress, adequate recovery, and positive adaptation for this person, at this time.

And it means expanding our programming toolbox. Walking, resistance training, mobility, traditional cardiovascular exercise, recreational movement, and aquatics programming can all have a place. Instead of forcing individuals into the movement environments, we have traditionally prioritized, we can create environments in which more people can succeed.

The Pivot

- FROM: Weight loss as the primary measure of success → TO: Comprehensive health outcomes
- FROM: One-size-fits-all exercise → TO: Individualized, adaptive programming
- FROM: "Exercise harder" → TO: Apply the appropriate physiological stimulus
- FROM: Prescribe and expect compliance → TO: Listen, collaborate, monitor, and adapt
- FROM: Designing people around programs → TO: Designing programs around people
- FROM: Pounds lost → TO: Health gained

Our outcomes can therefore become broader and more meaningful: cardiorespiratory fitness, muscular strength, mobility, metabolic health, functional capacity, confidence, self-efficacy, psychological well-being, sustainable physical activity, social connection, quality of life, and weight-related outcomes when clinically appropriate.



Our Call to Action

The Health & Fitness Sector doesn't need to abandon weight management. We need to stop allowing weight change to define the entire value of what we do.

Let's expand our skillsets. Let's expand our programming options. Let's strengthen our connections with Patient Care Teams. Let's assess the person before creating the program. Let's meet people where they are, and adapt as they change.

Most importantly: See the Person. Honor the Journey. Support the Pathway. Change Lives.
Because the future of obesity management isn't simply about helping people lose more weight. It's about helping people gain more health.

PERSON-FIRST. ADAPTIVE. RESPONSE-INFORMED.
COMPREHENSIVE-HEALTH FOCUSED.



Figure 11: Call to Action for the Health & Fitness Sector: See the Person, Honor the Journey, Support the Pathway, and Change Lives

Declarations

Use of Artificial Intelligence and AI-Assisted Technologies

OpenAI ChatGPT and Anthropic Claude were used during manuscript preparation for language editing, structural organization, iterative review, and manuscript refinement. ChatGPT was also used to assist with literature searching, citation and reference consistency checks, and the development and refinement of illustrative conceptual figures. OpenAI image-generation tools were used to assist in producing the manuscript figures. The figures are conceptual illustrations and do not depict actual patients or clinical encounters. AI tools were not listed as authors and did not independently determine the scientific claims, interpretations, or conclusions. All AI-assisted text, source citations, references, and figures were reviewed by the human authors and contributor, who accept responsibility for the accuracy, integrity, originality,

and final content of the manuscript.

Conflicts of Interest
The authors report no conflicts of interest.

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Consent for Publication
The individual described in the illustrative case is a contributor to this manuscript and approved inclusion of the account.

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