

Childhood obesity: overcoming the fear of having healthier weight conversations with families

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Key points

Childhood obesity is increasing as a result of the COVID-19 pandemic and childhood obesity is linked with dental decay.

Clinicians struggle to have the 'healthier weight' conversation with children and their carers out of fear of causing offence.

Further training and advice on how to sensitively broach the conversation regarding childhood obesity with carers may be necessary so that children and carers can receive support when needed.

Abstract

Introduction Clinicians may find raising the issue of weight with patients or carers and having healthier lifestyle conversations uncomfortable, out of fear or experience of causing offence. A two-cycle audit was completed in a specialist paediatric dental service to ascertain whether healthier weight conversations were being had with patients and their carers.

Materials and methods The inclusion criteria for the audit were paediatric patients who were having a general anaesthetic assessment for dental extractions as a result of dental caries. A gold standard was set that all patients having a general anaesthetic assessment should have their body mass index (BMI) calculated and healthier weight conversations should be had with patients and carers and families signposted for further support when necessary.

Results Results for the first cycle found that only 7% of patients had their BMI recorded and there was no record of healthier weight conversations for any patient. After the results of the first cycle were shared and ways in which to have a helpful healthy weight conversation discussed, a second cycle was carried out. A significant improvement was made, with clinicians calculating the BMI for 65% of the patients and a healthier weight conversation being had when necessary.

Discussion Many of the clinicians voiced that as calculating a BMI and having healthier weight conversations is not something that they had previously routinely done, they often forget to do this. Others stated that they felt uncomfortable bringing up the topic in a way that wouldn't offend the patient or parent, so avoided doing so.

Conclusions As a result of the audit, it was strongly encouraged that all clinicians continue to calculate BMI as it was found to be a useful tool for introducing healthier weight conversations when necessary. The subject of healthier weight needs to be acknowledged in the dental setting and discussed with families in a non-judgemental and sensitive way. This paper aims to guide clinicians in how to sensitively broach this subject with children and carers and when and where to signpost if extra support is needed.

Introduction

The effect of COVID-19 on childhood obesity

Obesity is a common, multi-factorial condition that can put individuals at risk of other serious chronic diseases, such as type II diabetes, muscular-skeletal problems and cardiovascular

disease. Childhood obesity has been linked to increased risk of being overweight in adulthood, as well as risk of ill-health and premature mortality in adult life.¹

Childhood obesity is on the rise and the likely impact of COVID-19 lockdowns on childhood obesity needs to be acknowledged. The most recent UK National Child Measurement Programme showed that 21% of children aged 10–11 are obese and this is likely to have worsened as a result of COVID-19 lockdowns; weight gain was correlated with time spent out of school during closures as a result of reduced physical activity and with families more likely to be buying cheaper and more calorific foods.^{2,3,4}

There is a wide body of evidence highlighting the relationship between obesity and dental caries, with some studies showing a relationship

while others do not.^{5,6} A 2020 systematic review and meta-analyses aimed to examine whether children aged six years and younger who were overweight and/or obese had a higher dental caries experience. Six out of nine of the included studies reported a significantly higher caries experience among children with overweight and/or obesity.⁷ Analyses by Public Health England found that children who are underweight, overweight and very overweight are more likely to experience dental caries in comparison to children of a healthy weight.⁸ A position statement published by the British Society of Paediatric Dentistry stated that on average, children are currently consuming three times the recommended daily amount of sugar, increasing their risk of developing type II diabetes, cardiovascular disease, cancer and mental health problems. It also suggested there

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was a strong link between childhood obesity, caries and deprivation.⁹

As a result of the reduction in routine dental appointments during COVID-19 and a rise in childhood obesity in the UK, it is likely that the incidence of teeth with dental caries requiring extraction will increase. Children who are underweight, overweight or obese are more likely to develop dental caries and with dental extractions under general anaesthetic being the number one reason for children's hospital admission in the UK, being overweight carries additional risks.¹⁰ As part of diagnosis and treatment planning and prevention, it is the clinician's (those in the dental team who are trained to provide oral health and diet advice) responsibility to help and signpost patients and carers if there are concerns with weight.

Are clinicians comfortable having healthier weight conversations?

The ability to communicate information accurately, clearly and sensitively is an important skill, and as clinicians, good communication is essential in our everyday practice. The General Dental Council's *Standards for the dental team* sets out standards of conduct and performance for dental professionals and what patients can expect from the dental team.¹¹ Standard one states that a dental professional should treat patients with dignity and respect, be honest, and take a holistic approach to patient care. This includes being aware of how you speak to patients and treating patients with kindness and compassion while taking account of a patient's overall health. This also includes consideration about healthier weight conversations when appropriate when giving dietary advice for oral health.

Healthy weight conversations have been common practice in paediatrics, school nursing and health visiting for a number of years, with children being weighed and heights measured and plotted on growth charts as part of child health surveillance. In this environment, practitioners have been expected to and will be more comfortable having healthy weight conversations. In dental settings, this is less likely to take place unless a child is being weighed as part of a general anaesthetic assessment.

The idea of having a conversation about weight with a patient or carer may seem daunting and clinicians may choose to avoid having the conversation all together. As a result, the patient could miss out on potential helpful information and resources that could benefit both their general and oral health. As

a health professional, the importance of good communication is reinforced from as early as first year of undergraduate training, so why is the idea of having a healthier weight conversation uncomfortable? Is this due to lack of training specifically focused on this subject, or due to the general embarrassment of discussing sensitive subjects such as weight? The importance of having healthier weight conversations is important now more than ever due to the rise in childhood obesity as a result of the COVID-19 pandemic but what is just as important is ensuring the subject is broached sensitively so that both the clinician and patient aren't put in an uncomfortable position. Not only do words communicate information, they also hold the power to help, heal and harm if not used carefully.

Materials and methods

Healthier weight conversations audit

A two-cycle audit was completed between January and June 2021 in a specialist paediatric community dental service to ascertain whether healthier weight conversations were being had with patients and carers when appropriate. This community dental clinic is based in one of the 20% most deprived districts/unitary authorities in England and about 27.4% (14,430) of children live in low-income families. Life expectancy for both men and women is lower than the England average.¹² The water in the area is also not fluoridated.

Audit registration

The audit project was registered with and approved by the organisation's Quality and Integrated Governance Team and the final report was submitted to the team for their records. All members of the dental team were informed about the audit via the daily team briefings which are documented on a *pro forma* and stored. Ethical approval was not required as this study is an audit.

Aims and methodology

The aim of the audit was to ascertain if body mass index (BMI) was being calculated and recorded during general anaesthetic assessments and if 'healthier weight' conversations were being had with carers whose children had a non-healthy BMI. The inclusion criteria for the audit were paediatric patients who were having a general anaesthetic assessment for dental extractions as a result of dental caries. The

ages of patients included in the final results of the audit ranged from 1–16 years. A gold standard was set that all patients having a general anaesthetic assessment should have their BMI calculated and a record made of whether they were classed as underweight, healthy weight, overweight or obese. It was expected that healthier weight conversations should be had with patients and carers and families signposted for further support when necessary.¹³ Clinicians were asked to calculate a BMI for each patient and note healthier weight conversations in their clinical notes. The clinicians included in the audit included a paediatric dentistry consultant, a paediatric dentistry specialist registrar, dental core trainees and community dental officers. Clinical notes were reviewed for data collection.

Results

A total of 29 sets of records were analysed in the first cycle for patients seen for assessment between January and March 2021. Results for the first cycle found that although height and weight were calculated for all patients, only 7% of patients had their BMI recorded and there was no record of healthier weight conversations for any patient. While collecting the data, BMI was calculated for each patient to ascertain how many of the patients would have benefited from a healthier weight conversation. It was found that 39% of patients were either underweight, overweight or obese and would have benefited from a healthier weight conversation.

The results of the first audit cycle were discussed in a staff meeting and also shared with staff by email. Many of the clinicians voiced that as calculating a BMI and having healthier weight conversations is not something that they had previously routinely done, they often forget to do this. Others stated that they felt uncomfortable bringing up the topic in a way that wouldn't offend the patient/carer or parent, so avoided doing so. One colleague mentioned a past experience where when they addressed the subject to a patient who was overweight, the parent became very defensive and since then, the clinician has been reluctant to broach the topic again. Other reasons mentioned included time restraints during assessment appointments and not knowing where to signpost patients for help.

After the results of the first cycle were shared and ways in which to have a helpful healthy

weight conversation discussed, a second cycle was carried out. A total of 105 records were reviewed between April and June 2021. A significant improvement was made with clinicians calculating the BMI for 65% of the patients and a healthier weight conversation being had when necessary. A further discussion was had with participating clinicians. There were felt to be several reasons to explain the improved results. It was felt that calculating the BMI in the surgery with the patient present helped introduce the topic in an objective manner that would have been difficult to initiate otherwise. Furthermore, by calculating the BMI during the assessment appointment, it meant that the correct referral pathway for care could be made for patients that were in a category other than healthy and this also allowed an introduction to the conversation. As a result of the audit, it was strongly encouraged that all clinicians continue to calculate BMI as it was found to be a useful tool for introducing healthier weight conversations when necessary, allowing tailored diet and lifestyle advice to be given to patients and carers. Furthermore, since completing the audit, we have engaged with our local weight management services to update information about availability of services locally and to collect any other useful tips and information that we can use when having these healthier weight conversations (Fig. 1).

Discussion

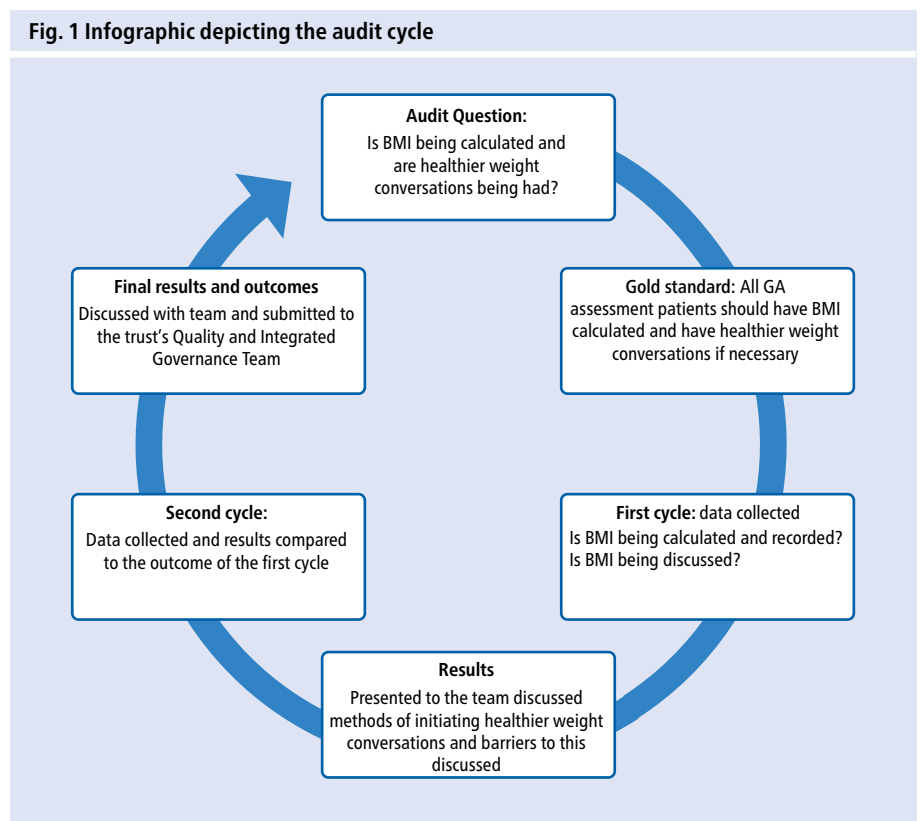
How to have a healthier weight conversation

As health care professionals, we are in an ideal position to talk to patients and carers about weight, adopting a healthier lifestyle and signposting to useful services. The Public Health England *Let's talk about weight* document states that health professions can identify children above a healthy weight, have sensitive discussions with families and where necessary, refer to Tier 2 and 3 weight management services.

The following tips and resources may help address this sensitive topic and the conversations needed to be had with patients who fall above or below healthier weight calculations.

Be objective

The NHS BMI healthy weight calculator is a good tool that can be used to objectively show patients or carers if they or their child



falls outside the category of healthy weight.¹⁴ Although it is not a diagnostic tool, it is a good screening tool that can be shown on a surgery desktop computer so that a parent or patient knows you are not making visual judgements regarding their or their child's weight. To calculate BMI, you simply need the patient's height and weight, date of birth and gender. This information can be collected when taking routine medical histories or when assessing a child before referring for general anaesthetic. It is important that if this information is collected and a BMI calculation made, that the result is shared with the patient/carer just like any other investigation undertaken.

Language and environment

Much of the diet advice that we discuss regarding caries prevention is relevant when it comes to making healthier diet and lifestyle choices and is therefore the perfect opportunity to naturally broach a healthier weight conversation.¹⁵ Children can be engaged in conversation about exercise in a non-confrontational manner by asking them what their favourite sport is and what activities they take part in at school and at weekends to gauge how much physical activity is incorporated into their lifestyle. As part of this conversation, a child can be asked about drinks and snacks taken while exercising and

at other times, so that specific advice can be given which would benefit caries control, as well as weight. By discussing diet in terms of helping with caries prevention and healthier weight means that any suggestions for change can be straightforward and more achievable for the family. By engaging the child in the conversation it can make the advice more personal to them and therefore more likely to be followed. It is, however, important to stress that the advice can be used by the whole family to improve healthier eating and lifestyle.

While offering support and information about weight, it is important to understand the relationship between weight and mental health. The links between obesity and mental health are complex and there are several theories about how the two are linked. Some researchers suggest that obesity can lead to common mental health disorders, while others have found that people with such disorders are more prone to obesity. This further reinforces as to why this topic should be managed sensitively and empathetically.¹⁶ It is important to be sensitive about where these conversations are being held and who could potentially be listening. Make sure the room is private and there isn't the risk of other people walking in and out and that doors are closed when possible. This will make both the clinician and carer/patient more comfortable and less

embarrassed about having any healthier weight conversations.

Resources and guidelines

The European Association for the Study of Obesity's *Obesity language matters guide*¹⁵ highlights how badly people living with obesity are spoken to and treated. It sets out principles for good practice for interactions between healthcare professionals and people living with obesity. The guide discusses using language free from judgements and negative connotations, including tone and non-verbal gestures. It is important to ensure that when discussing weight, speech is person-centred and there is avoidance of labelling a patient as their condition; for example, talking about 'a patient with obesity' as opposed to an 'obese patient'. It suggests that it is also helpful if your tone is positive and empathetic, to positively acknowledge existing healthy lifestyle habits and to try not to scare the patient and carers by using potential health threats that obesity may cause.^{17,18}

The British Dietetic Association have also published simple guidelines to aid in sensitively addressing and communicating with those living with obesity.¹⁹ In 2018, an All-Party Parliamentary Group on Obesity report indicated that only '26% of people with obesity reported being treated with dignity and respect by healthcare professionals when seeking advice or treatment for their obesity' and '42% of people with obesity did not feel comfortable talking to their general practitioner about their obesity'.¹⁹ The British Dietetic Association is working to tackle and end weight stigma.

The NHS approves an effective and evidence-based approach called Make Every Contact Count (MECC).²⁰ MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale within organisations. Drawing on behaviour change evidence, MECC enhances opportunities within routine health and care interactions for a brief or very brief discussion on health or wellbeing factors to take place. The MECC website links many useful resources that could be of use during healthier weight conversations, including the National Institute for Care and Excellence's *Behaviour change: general approaches guidance*.²¹

The Obesity Health Alliance is a coalition of over 40 organisations working together to reduce obesity by influencing government

policy. The goal of the Obesity Health Alliance is to prevent obesity-related ill-health by supporting evidence-based population level policies to help address the wider environmental factors that lead to excess bodyweight. They achieve this by developing and advocating evidence-based policy recommendations, as well as sharing insight and expertise among members.²²

Signposting

Once a conversation about weight has been raised, it is important to ask carers if they would be happy for you to offer further guidance and signposting to expert services. Good practice may be to have leaflets with details of services available so carers can do their own research after the appointment.

Patients can be signposted to:

- NHS services – Tier 2 and 3 weight management services where available
- Local community services, including community paediatrics and school nursing
- Healthy weight online resources.²³

Clinical nutrition and dietetic services are valuable and experienced members of the healthcare service that should be utilised when signposting patients. They can be found in hospital and community settings but often require formal referral via locally commissioned services which will vary from area to area. It is important to familiarise yourself with your available local services. Similarly, it is important to familiarise yourself with local mental health services – as mentioned previously, there is often a relationship between mental health and eating habits.

Recent news reports have announced that a pilot of 15 clinics are being set up within the NHS which aim to provide more than 1,000 children a year with specialist treatment to support weight loss. At these clinics, it is intended that group sessions will be provided with support of a full clinical team, including dietitians, psychologists, specialist nurses and paediatricians. The aim will be to identify the factors causing obesity in children alongside considering their mental and physical health.²⁴

It is also important to be aware that the devolved nations may have different services available for weight management. For example, in England, the government is aiming to launch an anti-obesity scheme in the coming year, in which rewards such as vouchers for discounted theme park tickets, in return for

eating healthy and exercising, will be offered to children and carers.²⁵ In Wales, there is a '10 Steps To A Healthy Weight' initiative which is available to help both carers and professionals in establishing healthy habits in children.²⁶

Conclusion

Childhood obesity and the link with dental caries has been established in the literature. The subject of healthier weight needs to be acknowledged in the dental setting and discussed with families in a non-judgemental and sensitive way.

The tools and resources for having healthier weight conversations with patients and carers are essential to ensure everyone is comfortable and help is being provided when necessary. Published guidelines by Public Health England¹ and resources within the NHS are available to help with raising the subject of childhood obesity but in some regions, these tools are limited and in the future, there may be more need for resources within the community to signpost children and carers to available services. Given the link between dental caries, deprivation and obesity, the dental setting is an ideal venue to begin a healthier weight conversation.

Author contributions

Sohaila Elyoussfi conducted the audit and analysed and reported on the results under the supervision of Elizabeth O'Sullivan. The original concept for the paper was devised by Elizabeth O'Sullivan and was developed jointly in discussion by both authors, with Sohaila Elyoussfi preparing the original manuscript and Elizabeth O'Sullivan revising successive drafts. Both authors contributed equally to the final approval of the version to be published.

Ethics declaration

The authors declare no conflicts of interest.

Ethical approval was not required as this study is an audit.

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