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Original Research – Qualitative

Postnatal gestational diabetes mellitus follow-up: Australian women's experiences

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ABSTRACT

Problem: Postnatal follow-up screening is recommended for all women diagnosed with gestational diabetes mellitus (GDM). However follow-up rates are poor and highly variable in Australia and internationally. The reasons that mothers are not completing recommended postnatal screening after GDM diagnosis are not well understood or studied. The quality of communication may be an important influence on the completion of postnatal GDM follow-up.
Aim: To explore and assess women's communication experiences of postnatal GDM follow-up.
Methods: Theoretical, purposeful sampling was used to identify women diagnosed with GDM. Convergent interviews explored participants' communication experiences with GDM and postnatal follow-up. Transcripts were provided to and updated by participants. Data was analysed with Leximancer® (V4, 2011) automated content analysis software.
Setting and participants: This research was conducted at a major tertiary referral hospital in Queensland, Australia, between December 2012 and July 2013. Women participating in maternity shared care and diagnosed with GDM were interviewed ($n = 13$).
Findings: Five themes, all concerned with obtaining information, were identified: diagnosis of GDM; seeking GDM information; accessing specialist services; need for postnatal GDM follow-up; and completing GDM follow-up. Results were interpreted using Communication Accommodation Theory (CAT) to explore whether and how the information needs of women were accommodated. Women's interpretations of communication events influenced their knowledge, perceptions and motivation to complete recommended postnatal follow-up.
Conclusion: Accommodation of the communication and information needs of women with GDM may be an effective strategy for clinicians to encourage completion of recommended postnatal GDM follow-up.

1. Background

1.1. Gestational diabetes mellitus

In Australia 8–10% of pregnancies are affected by Gestational Diabetes Mellitus (GDM).[1] GDM is defined as "any degree of glucose intolerance with onset or first recognition during pregnancy".[2,3] Risk factors for GDM in pregnancy include a history of elevated blood glucose levels in pregnancy, age ≥40 years, ethnicity (Asian, Indian subcontinent, Aboriginal, Torres Strait Islander, Pacific Islander, Maori, Middle Eastern, non-white African), family history of diabetes mellitus, pre-pregnancy body mass index (BMI) > 30 kg/m^2, previous baby >4500 g birth weight, a history of polycystic ovary syndrome.[4] GDM affects both maternal and foetal health during the pregnancy and beyond the pregnancy. For mothers, a diagnosis of GDM increases a woman's risk of developing type two diabetes mellitus (T2DM) after the birth. Half of all women diagnosed with GDM go on to develop T2DM.[5,6] Globally rates of T2DM are rising in every country and have been predicted to continue to cause personal cost and additional financial burden on already stretched health

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systems. Postnatal GDM screening aims to identify those women who are at most risk of progressing to T2DM. Subsequently, strategies to manage or mitigate the risk of progressing to T2DM can then be offered to women.[5,6]

Australian guidelines specify that all women diagnosed with GDM (unless clinically contraindicated) complete a 75 g 2-h Oral Glucose Tolerance Test (OGTT), between six and 12 weeks postpartum as well as continue regular ongoing surveillance for T2DM.[4] Annual surveillance is recommended for women contemplating another pregnancy, otherwise annual or biennial testing should be undertaken, based on women's clinical risk.

Both the need for and benefits of GDM follow-up are well established and corroborated by local and international guidelines.[4,7,8] Despite this consensus postnatal GDM follow-up completion rates remain low.[9,10]

1.2. The problem: gestational diabetes mellitus postnatal follow-up

The reasons that women do not complete postnatal GDM follow-up are not well understood.[11,12] Interventions to improve compliance, such as patient and clinician reminders, have met with limited success.[13] One well-established factor known to influence follow-up is communication between the patient and her health care[12,14] providers. Health communication research validates that high quality communication improves health outcomes and patient and clinician satisfaction.[15,16]

1.2.1. Australian Maternity Health Care

In Australia 66% of women choose public maternity care.[17] Maternity health care services are delivered by multidisciplinary health care professionals (medical, nursing, midwifery and allied health clinicians) in public and private sectors.[18] One central public sector model of care which is offered to women with low-risk pregnancies is maternity shared care. As the name implies, care is shared between general practitioners (GPs) in primary health care, and hospital-based maternity clinicians. Communicated between settings relies on the Pregnancy Health Record (PHR), which outlines the schedule of care up to the birth and includes routine screening for recognised complications including GDM.[19] When a women is diagnosed with GDM the risk status of the pregnancy increases and the woman is referred by the general practitioner for specialist management until the birth.[4] Multidisciplinary services are commonly linked to hospital maternity outpatient departments and include GDM management by specialist obstetricians, endocrinologists/physicians, diabetic educators (who provide individualised diabetes self-management and education) and dieticians.[20] Pregnancy management of GDM includes medical management including addressing lifestyle and behaviour interventions and pharmacological management, in collaboration with obstetric management to monitor foetal growth and determine the optimal timing and mode of delivery.[21] Benefits of GDM management include fewer cases of preeclampsia, shoulder dystocia and macrosomia.[22]

Hospitals are the principal place of birth in Australia and provide birth and early postnatal care for 97% of women. On average, well women and babies are discharged home from hospital after a two day stay.[17] Hospital maternity clinicians who provide care include medical, midwifery, nursing and allied health staff. As part of discharge planning, clinicians produce a discharge summary that details pregnancy, birth, postnatal care and plans for postnatal follow-up. In some cases women return to the hospital for GDM follow-up. Once women leave hospital later postnatal follow-up and ongoing primary health care is provided by their GP. Researchers have demonstrated the use of patient and clinician reminders to improve postnatal GDM screening rates, although the ongoing effect is unknown.[23]

1.2.2. Communication and Maternity Care

Hospitals (and health organisations) are intergroup environments comprising multiple health professionals who interact and negotiate to provide patient care.[24]

The quality of health care depends on effective communication between clinicians, and clinicians and their patients.[25] When health care is provided by different clinicians, sometimes in different locations, the risk of miscommunication increases.[26,27] Messages may not be understood as intended, which in turn impacts on proposed care.[25] Ineffective communication is known to occur when group differences are emphasised by people, instead of attempting to minimise differences in order to find common ground and meaning.[28] This often occurs where there is tension or conflict.[29] On the other hand, finding common ground and recognising an individual's needs enhances understanding and improves the quality of communication.[30] These aspects of communication are theorised by Communication Accommodation Theory (CAT). CAT explains both interpersonal and intergroup communication and their interaction, thus highlighting often-overlooked features of communication in health care settings and their influence on patient care.

CAT interprets communication as socially motivated and dynamic, and clarifies how an individual's group membership influences communication events; such as those that contributed to poor GDM follow-up.[30] Individuals perceive and assess communication events and interactions as either positive or negative in nature; accommodation characterises positive interactions. When accommodation occurs, a speaker considers and adjusts his or her communicative stance to establish a mutual common ground and shared understanding; fundamental features of effective communication.[30,31] In cases of non-accommodation (including under-accommodation) there is a lack of response or insufficient response to meet individual needs. People may not understand or may misinterpret what is being communicated and the timing may be inappropriate; this results in intergroup distance, lack of understanding, and negative perceptions of the interaction.[30,31] CAT explains these processes and results, and so provides health researchers with a theory that identifies the impact of communicative influences on the quality of health care.[32–34]

The communication strategies used between women with GDM and their health professionals are not currently known; nor are women's perceptions of these interactions. The objective of this research is to explore and assess the communication experiences of women as they manage their GDM in the postnatal period, and to interpret these findings with CAT. Understanding women's knowledge, values, beliefs and perceptions of the quality of communication about GDM has the potential to address the problem of poor GDM follow-up in the postnatal period.

2. Methods

2.1. Design

Participants were selected using theoretical sampling. Relying on both hospital records and staff advice, it was confirmed that women had been diagnosed with GDM prior to being invited to participate in the research. Qualitative in-depth interviews were conducted to explore women's communication experiences about GDM postnatal follow-up. Interviews were timed between twelve and sixteen weeks following the birth. Recorded interviews were transcribed, then content checked and validated by participants, then de-identified prior to analysis. The strategy of confirmation of interview transcripts or member checking prior to data analysis is a recognised method for quality assurance in qualitative research.[35,36] Ethics (and ethics protocol) was approved by the