



Original research article

Family planning knowledge, attitudes and practices among bariatric healthcare providers^{☆,☆☆,☆☆☆,☆☆☆☆}

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Abstract

Objective: This survey aimed to identify the family planning knowledge, attitudes and practices of bariatric providers in the perioperative period.

Study design: We developed a quantitative survey based on semistructured interviews with six bariatric providers. We mailed the survey to the American Society of Metabolic and Bariatric Surgery members with plans to use data from the first 275 responders to assess knowledge, attitudes and practices regarding family planning.

Results: Over 70% of 272 respondents recommended that women avoid pregnancy for 12–24 months after bariatric procedures. Most (73.0%) considered female reproductive health discussions very important, and most feel comfortable (70.4%) with these discussions. The majority considered the most effective contraceptive methods to be safe for women after gastric bypass; only a minority (35.3%) provided contraceptive services or referrals, and few (4.9%) have accurate knowledge of contraceptive effectiveness. Respondents most frequently preferred the patient's own gynecologist (80.9%) or bariatric surgeon (71.0%) discuss contraception. Discussing contraception was associated with provider age 40–49 years, training region in southeast or midwest and degrees of physician assistant or nurse practitioner with adjusted odds ratios exceeding 2.0.

Conclusion: Bariatric providers consider reproductive health very important, and while most are comfortable having these conversations, few have accurate knowledge of contraceptive safety and effectiveness. Most would prefer patients see their gynecologists to discuss contraception. These findings suggest an opportunity for gynecologists to educate themselves and bariatric colleagues about contraception recommendations after bariatric surgery and collaborate with bariatric centers in their area to meet the needs of these patients.

Implications: Gynecologists must become educated and involved in the care of female bariatric patients to discuss reproductive health concerns and to counsel effectively regarding contraception after bariatric surgery.

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Keywords: Family planning; Bariatric surgery; Contraception; Weight loss surgery

1. Introduction

While the US annual rate of bariatric surgery has increased [1,2] and the majority of patients are women within the reproductive years [2–4], data on postoperative pregnancy and

other reproductive health outcomes are limited. Pregnancies following bariatric procedures have been associated with lower rates of gestational diabetes, large for gestational age infants and macrosomia when compared with obese controls but may also be associated with increased rates of perinatal or intrauterine fetal death [5,6]. The initial weight loss may be associated with intrauterine growth restriction, anemia and neural tube defects from poor maternal nutritional status, though strong evidence is lacking [7,8]. Case reports document bariatric postoperative complications during pregnancy including gastrointestinal bleeding, internal intestinal herniation, intestinal obstruction and maternal death [9–11].

As obesity is often associated with anovulatory cycles and polycystic ovary syndrome (PCOS), the weight loss experienced after bariatric surgery may lead to an increase in fertility [9]. Improved fertility may create an unmet need for

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contraception when pregnancy is unfavorable. Recent guidelines cosponsored by the American Association of Clinical Endocrinologists, The Obesity Society and the American Society of Metabolic and Bariatric Surgery (ASMBS) provided Grade D recommendations — that is, based on limited or no evidence — that women avoid pregnancy preoperatively and 12 to 18 months after surgery, be counseled on contraception options after surgery, including nonoral methods if they have had malabsorptive procedures, discontinue combined (estrogen-containing) oral contraceptives (COCs) for one cycle prior to surgery and be advised that fertility may improve postoperatively with PCOS [12].

It is unclear whether bariatric providers are aware of their patients' reproductive needs and how contraceptive counseling and provision is accomplished. This study aimed to describe the reproductive knowledge, attitudes and practices of bariatric providers.

2. Materials and methods

We obtained approval at Emory University in Atlanta, GA. The principal investigator (T.C.J.) first conducted one-on-one semistructured confidential interviews with various provider types [six bariatric surgeons, one internist, one registered dietician (RD), one clinical nurse specialist/center coordinator, one registered nurse/surgical first assistant and one support group leader] in a bariatric clinic in Atlanta to qualitatively evaluate knowledge of, need for and use of family planning, as well as barriers to effective contraceptive use, and contraceptive prescribing or referral practices. Next, the research team utilized the findings from the qualitative interviews, along with previously validated reproductive health survey questions in order to generate a survey instrument that would quantitatively assess a convenience sample of providers from across the United States [13].

A researcher (S.C.) then administered the pilot survey to three additional Emory Healthcare providers to validate survey question terminology and to ensure subject understanding of the questions. From this experience, we added additional response options for two questions tailored to dieticians and support staff who may not be discussing future pregnancy with patients.

We used the mailing list of approximately 4200 members of the ASMBS. The ASMBS membership consists of various types of healthcare providers who directly interact with patients for bariatric surgery, including physicians [doctor of medicine (MD) or doctor of osteopathic medicine (DO)], registered nurses (RN), physician assistants (PAs), nurse practitioners (NPs), RDs, licensed practical nurses (LPNs) and social workers, all of whom were included. We first used an online random sequence generator (<https://www.random.org/sequences>) to sequence numbers 1–4200 and then selected the first 2000 numbers generated to identify a random sample from the alphabetized ASMBS membership list. We chose to mail out to 2000

members and only accept the first 275 responses in order to capture a convenience sample in a short defined period of time due to funding and timeline constraints. A research team member (S.C.) listed the contact information for study participants in a secure subject log and assigned each a study number. We then mailed numbered instructions for confidential self-administered online surveys to all corresponding providers. We obtained consent electronically prior to participation by having participants read the consent and instructed them to move to the next screen to begin the survey only if they consented to enrollment. Respondents then completed online surveys within FeedBack server (feedbackserver.com), a confidential survey tool. We compensated those who enrolled in the study with an Amazon gift card for US\$30 via email. Since 273 responses were reached after the initial mailing, we did not attempt to contact nonresponders. We made no further contact with study subjects, and no subjects withdrew consent at any time.

We transferred all data from numbered surveys in FeedBack Server software into SAS statistical software (Version 9.3, Cary, NC, USA) for analysis and reported significance levels at $p \leq .05$ using chi-square or Fisher's Exact procedures. The survey included questions regarding demographics (age, gender, training region, years in practice, degree) and practice information (setting, proportion of female patients of reproductive age, contraceptive services offered). From the ASMBS membership data we received, we were only able to assess provider degree but did not have access to other demographic or practice information. To assess providers' knowledge of contraceptive effectiveness, we asked questions regarding the typical use failure rate of condoms and asked providers to identify methods with typical use failure rates of less than 1% [14]. We considered providers answering both questions correctly to have accurate contraceptive effectiveness knowledge. We also assessed whether providers consider methods safe for women after gastric bypass and followed the US Medical Eligibility Criteria for Contraceptive Use 2010 recommendations for malabsorptive procedures; we categorized long-acting reversible contraceptive (LARC) methods [i.e., intrauterine devices (IUDs) and implants] as safe (Category 1) and categorized oral contraceptives (OCs) as unsafe (Category 3) [15]. To examine attitudes and practices around reproductive health and family planning, we included questions pertaining to counseling on pregnancy after surgery, reproductive health, contraception and abortion counseling and provider preferences for providing contraceptive counseling and services.

We further assessed several questions as outcome variables to determine factors associated with certain responses. First we examined discussing contraception as a dichotomous outcome to measure whether providers routinely discuss contraception (always/almost always) or not (sometimes/almost never/never). We examined associations between respondent characteristics with this outcome. The variables that were significant in univariate analysis for discussing contraception were included in the multivariate model. We then examined

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