

# Pregnancy and cultural competencies



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People with diabetes spend less than 150 minutes per year interacting with any health professional, which equates to only 0.03% of their time (Schatz, 2016), leaving them to spend 99.97% of the year coping with a complex condition alone. Therefore, it is incredibly important that we provide people who have diabetes with support and self-management resources. Readers who attended the National PCDS Conference in November will have heard Anthony and Ian Whittington and their father Geoff, who are featured in the “Fixing Dad” TV documentary (which can be viewed at [www.fixingdad.com](http://www.fixingdad.com)), share their motivational journey into self-management of Geoff’s diabetes. The PCDS will continue to work closely with the Whittington family to raise awareness of the importance of diabetes self-management and behaviour change in improving outcomes in type 2 diabetes.

## National Pregnancy in Diabetes audit

Following on from the PCDS audit on pre-conception counselling for women with diabetes (Seidu and Diggle, 2016) in the previous issue of the Journal, the publication of the National Pregnancy in Diabetes (NPID) audit report (NHS Digital, 2016) in October provides us with an opportunity to compare our own practice’s pre-conception care with that achieved by colleagues. The audit, part of the National Diabetes Audit commissioned by the Healthcare Quality Improvement Partnership (HQIP), reported on quality of care and outcomes for 3044 pregnancies in women with pre-existing diabetes cared for in 155 joint diabetes/antenatal services in England, Wales and the Isle of Man during 2015.

The NPID audit benchmarks care against the NICE (2015) diabetes in pregnancy guideline (NG3) and seeks to address three questions:

- Were women adequately prepared for pregnancy (i.e. taking folic acid 5 mg, having an HbA<sub>1c</sub> <48 mmol/mol [6.5%], substituting glucose-lowering medication other than metformin and stopping statins, angiotensin-converting enzyme [ACE] inhibitors and angiotensin receptor blockers [ARBs])?

- Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother (i.e. early contact with joint diabetes/antenatal service, retinal screening, management of hypoglycaemia and monitoring HbA<sub>1c</sub> to assess pregnancy risk)?
- Did any adverse outcomes occur, such as stillbirths or congenital malformations?

Whether women are appropriately prepared for pregnancy is influenced by the primary care that we provide, so this will be the focus here. As we have discussed previously, almost half of all pregnancies in woman with diabetes now occur in those with type 2 diabetes (46% overall, with over 70% in some ethnic groups), a significant change from the previous type 1 diabetes predominance. These women with type 2 diabetes are likely to receive most, if not all, of their pre-conception advice from primary care teams.

Sadly, the NDIP audit reported that only 16% of women with type 1 and 38% with type 2 achieved the recommended HbA<sub>1c</sub> target of <48 mmol/mol (6.5%) at any point in the first trimester, and there were wide variations between services (NHS Digital, 2016). Nearly 10% of women with type 1 diabetes and 8% with type 2 had an HbA<sub>1c</sub> ≥86 mmol/mol (10%), the level at which pregnancy would not be recommended due to increased risk to mother and baby (NICE, 2015).

Diabetes increases the risk of neural tube defects, but many pregnancies are unplanned and the need for the higher, prescribed, folic acid dose has not yet reached all women or clinicians. Only 46% of women with type 1 and 23% of women with type 2 diabetes were taking 5 mg folic acid prior to pregnancy with a further 6% (type 1) and 11% (type 2) taking 400 µg folic acid (NHS Digital, 2016). There was a clear correlation with deprivation: women with type 2 diabetes in the most deprived quintiles were least likely to have taken folic acid; twice as many (75%) of those with type 1 diabetes in the least deprived areas were taking folic acid compared to the most deprived areas.

Women with type 1 diabetes receive insulin and only a tiny proportion of those in the audit were receiving other glucose-lowering drugs, whereas 8% of women with type 2 were on oral hypoglycaemic drugs that should be stopped prior to pregnancy. In total, 8.6% of women with type 2 were receiving a statin, ACE inhibitor or ARB at conception (with wide variations between services and levels of more than 10% in around 40 services), compared with less than 3% of those with type 1. This is likely to reflect improved pre-conception planning for women with type 1 diabetes.

NICE (2015) recommends that women with diabetes should be offered immediate contact with a joint diabetes/antenatal clinic when they become pregnant, yet the NDIP demonstrated that only just over half of women with type 1 diabetes and 36% of those with type 2 diabetes had their first clinic visit prior to 8 weeks' gestation. Specialist clinics provide access to expert help in achieving tight glycaemic control and in the management of comorbidities with drugs that are safe during pregnancy. Many women with type 2 diabetes will require insulin during pregnancy and the initiation and intensification needs to be achieved as promptly as possible after withdrawal of oral medications unsuitable during pregnancy. In my own area recently, with a very motivated specialist team delivering high-quality joint diabetes/antenatal care, it still took nearly 2 hours, nine phone calls and all my persuasive skills to overcome logistical barriers and arrange an early pregnancy assessment for insulin initiation in a lady with type 2 diabetes, so we need to be proactive.

So what are the take-home messages for us in primary care? Simplifying the messages for clinicians and women with diabetes (*Box 1*) may improve care when we are short of time and resources. Raising awareness among all members of our teams, discussing pregnancy planning in contraception consultations, having prompts within our primary care clinical systems, prescribing patient information prescriptions and using templates, such as the one in our pre-conception audit (Seidu and Diggle, 2016), should all help ensure we consistently discuss all aspects of pre-conception care with all women with diabetes of child-bearing potential.

Since the publication of the NICE (2015) diabetes in pregnancy guideline, there is growing

awareness that primary care teams are the only people providing pre-conception care to many women with type 2 diabetes. The next NDIP audit report, looking at data from 2016, will for the first time provide comparative data, and it is hoped that this will reflect an improvement in the preparation for pregnancy among all women. The next issue of the Journal includes an updated CPD module dealing with pregnancy complicated by diabetes. It provides an in-depth look at the impact and practical management of diabetes in pregnancy.

### Cultural competency and the ageing population

The UK ageing population is expanding, including rapid expansion in some non-White ethnic groups, leading to concerns about increased inequalities in diabetes care. A recent review by Wilkinson et al (2016) outlined the paucity of studies exploring care for older people from South Asian and other ethnic minority backgrounds. Ethnic minorities comprise half of the population in some areas of the UK. By 2051, it is estimated that there will be 2.7 million non-White people over the age of 65 and 1.9 million aged 70 and over in the UK. Challenges identified and discussed by Wilkinson et al (2016), which focused particularly on South Asian populations, are, therefore, very relevant to our delivery of diabetes care both now and in the future.

Earlier studies identified that people of South Asian ethnicity have a prevalence of type 2 diabetes four times greater than White Europeans (Burden et al, 1992), develop diabetes approximately 10 years earlier and have more rapid progression of complications (Earle et al, 2001). Their risk of diabetic nephropathy is 13 times as high as in White Europeans (Burden et al, 1992), and there are increasing proportions of South Asian people requiring renal replacement therapy and end-of-life care. The increased risk of depression and vascular dementia in all groups raises questions about whether our commonly used diagnostic tools will accurately identify dementias in people of South Asian and other non-White ethnicities (Lloyd et al, 2012).

Feedback from South Asian people with diabetes referred to renal services in one study highlights a lack of awareness of complications and feelings that there had been missed opportunities for information provision and support for self-

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#### Box 1. Crucial messages for clinicians and women with diabetes.

- Plan pregnancy.
- Glycaemic target <48 mmol/mol (6.5%).
- Avoid pregnancy if  $\geq 86$  mmol/mol (10%).
- Folic acid dose 5 mg.
- Stop statins, ACE inhibitors/ARB and glucose-lowering drugs other than insulin or metformin.
- Urgent referral when pregnancy confirmed.

***“In my opinion, offering to have some discussions through the medium of Language Line, when appropriate, can facilitate more sensitive discussion, leading to useful, individualised, discussion of diabetes management.”***

management (Wilkinson et al, 2011). Throughout, the authors identified how to address these inequalities. They highlighted that not only do clinicians need culturally valid tools to diagnose and assess complications and comorbidities, but also that we need an understanding of the person's culture and beliefs to reach a mutual agreement with a patient on individualised targets and self-management options. For those of us working with culturally diverse populations with type 2 diabetes, developing “cultural competence” for more than one or two ethnic groups will be challenging but rewarding. It requires knowledge, sensitivity and a willingness to have open discussions with people about their culture and beliefs. Offering to have some discussions through the medium of Language Line, in my opinion, can be hugely beneficial, allowing people to express themselves and their needs and wants in their own language with the knowledge that these will be expertly translated so that their clinician can understand them better. From my experience, this can facilitate more sensitive discussion leading to a better understanding of the person's perceived barriers and confidence gaps in self-managing their diabetes, and useful, individualised, discussion of dietary and lifestyle messages.

The thought-provoking review by Wilkinson et al (2011) raised other areas for future exploration and research, such as the possible benefits of clinicians who share the same ethnicity as their patients, peer support interventions and cultural intelligence and cultural competency. Two of these themes are explored in more detail in this issue of the Journal. Noura Abouammoh and colleagues share their findings from qualitative research of the experiences of people with diabetes and the perceptions of non-local clinicians of the cross-cultural barriers to discussing lifestyle (page 283), and Lynne Bromley and Harnovdeep Singh Bharaj outline their model for diabetes and cardiovascular screening in people of South Asian ethnicity in Bolton, which won last year's PCDS poster award (page 279).

Also in this issue, Bill Taylor and Joanna Bircher provide details of the Royal College of General Practitioners' *Quality Improvement Toolkit for Diabetes Care* and how to access the resources online (page 264) and our Around the Nations series focuses on Wales, with Dai Williams from Diabetes UK Cymru sharing recently launched educational initiatives

(many of which are also available in other parts of the UK; page 261). Mark Baker and Tonya Gillis from NICE answer questions posed by the PCDS Committee on page 267, and Sam Seidu shares the last in the current series of audits looking at accuracy in coding of those with type 2 diabetes and non-diabetic dysglycaemia (page 271). Molly Courtenay and colleagues share one way to improve barriers to insulin adherence (page 274). In the CPD module in this issue, David Edwards shares practical guidance on sexual dysfunction in diabetes on page 288 and the corresponding CPD questions can be found on [www.diabetesonthenet.com/cpd](http://www.diabetesonthenet.com/cpd).

Following my last editorial, experts continue to argue over the benefits and harms from statins, (e.g. Horton, 2016; Krumholz, 2016). We need to understand the controversy, remain open-minded and continue to give clear advice to people with diabetes.

### Thanks

As we reach the end of 2016, I want to say a huge thank you to everyone involved in *Diabetes & Primary Care* this year, including our authors and Editorial Board who help steer the content, credibility and culture of the Journal. My special thanks go to Jane Diggles, the Associate Editor-in-Chief, who has worked tirelessly this year, giving generously of her time and energy, always willing to share her in-depth diabetes knowledge and skills and to provide ideas and support. Our thanks to Dr Sam Seidu for helping to demystify audits and for challenging us to take a careful look at some important aspects of our care. Look out for examples of audit results from our readers in 2017. Thanks also to our in-house editorial team who keep us organised and help us deliver practical, readable content. As always, if you are involved in innovative work or feel strongly about something and want to share your views with our readers, then please contact [dpc@omniamed.com](mailto:dpc@omniamed.com) to discuss contributing to the Journal.

In the meantime, in the words of Stephen Covey in *7 Habits of Highly Successful People*, I hope we all have the opportunity to “sharpen the saw”, to relax and reinvigorate our own health and well-being over the holidays, and to return with renewed enthusiasm to deliver quality and culturally competent diabetes care in 2017. ■

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