

Educating for Equity Care Framework

Addressing social barriers of Indigenous patients with type 2 diabetes

Lynden (Lindsay) Crowshoe MD CCFP Rita Henderson MA PhD Kristen Jacklin MA PhD
Betty Calam MD CCFP MCISC FCFP Leah Walker Michael E. Green MD CCFP MPH

Abstract

Objective To present a clinical framework for addressing critical social elements for Indigenous patients with type 2 diabetes.

Sources of information The Educating for Equity (E4E) Care Framework was developed through a rigorous analysis of qualitative research that included the perspectives of Indigenous patients (n=32), physicians (n=28), and Indigenous health curriculum developers (n=5) across Canada. A national advisory group of Indigenous health experts, educators, leaders, physicians, and community members provided feedback on integrating analysis from primary research into recommendations for physicians. Systematic literature reviews were conducted and a nominal group technique process helped forge research team consensus around the framework's themes and recommendations.

Main message For Indigenous patients with type 2 diabetes, social factors arising from the legacy of colonization are often barriers to improved diabetes outcomes, while culture is often not recognized as a facilitator in diabetes management. Structural competency in balance with cultural safety should be central to the clinical process when negotiating diabetes management with Indigenous patients. The E4E Care Framework presented in this article provides recommendations to navigate this terrain.

Conclusion A focus on social and cultural elements is fundamental to effective diabetes care among Indigenous patients. The E4E Care Framework is a resource that can help clinicians improve Indigenous patients' capacity for change in a way that acknowledges the social factors that affect the increasing diabetes rates, while using a cultural lens to facilitate improved outcomes.

Case description

Geraldine is a 55-year-old First Nations woman with type 2 diabetes that was diagnosed 5 years ago; she also has hypertension, high cholesterol, and chronic shoulder, hip, and knee pain. She has been in your practice for 3 years, and her glucose control has been marginal. Review of her hemoglobin A_{1c} levels shows that they have ranged from 8% to 8.8% despite your management attempts involving medications (ie, basal insulin therapy and maximum dose of metformin) and health behaviour teaching. What more can you do?

The prevalence of type 2 diabetes among Indigenous people in Canada is 2 to 3 times the national average, depending on whether on-reserve or off-reserve populations are counted, with increasingly younger ages at diagnosis, greater severity at diagnosis, and higher complications rates.^{1,2} The Canadian Diabetes Association has noted that "Aboriginal peoples living in Canada are among the highest risk populations for diabetes and related complications."³ The reasons

Editor's key points

► From a health care perspective, reconciliation involves providing care that addresses the specific cultural and social needs of Indigenous people. The insidious effects of colonization on health and health care are multifaceted and persistent within the lives of many Indigenous people. Owing to ongoing social exclusion, many Indigenous peoples' lives are burdened by poverty, persistent psychosocial discord within family and community, and daily racism. This is the context in which many Indigenous people experience type 2 diabetes.

► The Educating for Equity Care Framework presented in this article is a resource for deeper clinician engagement with Indigenous patients with type 2 diabetes. At its core, the framework provides 2 directives for clinicians: re-centring the clinical relationship (strategies include reflecting on your own biases and using narrative approaches) and engaging the social realities of Indigenous patients (strategies include screening for resource limitations that influence diabetes management and building patients' knowledge about diabetes care). Each directive is grounded in Indigenous cultural concepts for addressing critical social variables that influence patient health and clinical interactions.

► Viewing Indigenous people's experiences of health and illness through a cultural lens can help improve diabetes care and help practitioners to understand patients' preferences, connections, and barriers to accessing cultural resources.

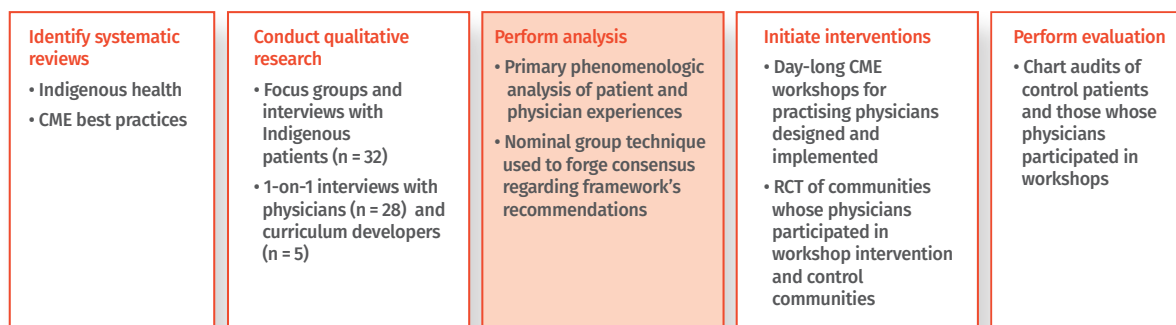
for this disparity are more complex than a biologic explanation allows and they include the effects of social environments arising from colonization^{4,5} and exclusion from Canadian society.⁶ The 2015 *Truth and Reconciliation Commission of Canada: Calls to Action* report lists 94 calls to action that highlight the health legacy of the country's residential school system.⁷ One of the calls to action⁷ directs health services to effectively address the health outcomes that have arisen from the multi-generational effects of what the Truth and Reconciliation Commission has termed "cultural genocide."⁸ The existing evidence base provides limited direction to clinicians around the interplay between colonization, health, and health care.³

Educating for Equity (E4E) is a research collaboration (2010-2016) among stakeholders from Australia, Canada, and New Zealand that explores how health professional education can reduce disparities in chronic disease care and improve outcomes for Indigenous populations. Noting the knowledge gap in clinical approaches for effective, culturally safe⁹ diabetes care for Indigenous patients, the Canadian E4E team set out to develop an evidence-based tool for educational contexts. The Canadian team completed and analyzed in-depth interviews with Indigenous patients, Indigenous and non-Indigenous physicians, and curriculum developers. Qualitative insights into health care relationships then informed the development of the E4E Care Framework (Figure 1), as well as a 1-day continuing medical education workshop that was implemented and evaluated in partnership with community service providers.

Sources of information

The E4E team aimed to identify evidence distinctly addressing Indigenous patients and to frame a clinical approach. The team began in 2011 with a series of scoping reviews of scientific literature on the following: health professional education on Indigenous health equity; best practices for treating type 2 diabetes; and biologic manifestations of social inequities affecting Indigenous patients with diabetes internationally. Little was found to establish best practices for health professional education in Indigenous health, while one 2011 review addressed the quality of intervention research on Indigenous populations with type 2 diabetes.¹⁰ A rich literature outlined the effects of social inequities on biology and disease causes. This included research on chronic psychosocial stress and its activation of the hypothalamic-pituitary-adrenal axis and cortisol pathways,¹¹ gene-environment interactions,¹² epigenetic mechanisms including during fetal and neonatal growth,^{13,14} metabolic consequences of childhood stress,¹⁵ effects of social change (eg, in the process of food procurement or sharing), inequities framing poor health behaviour (eg, diet, exercise),¹⁶ and historical trauma produced by colonization.¹⁷ The team's literature review of studies on the lived experiences of Indigenous populations with type 2 diabetes generated important insights on how social inequities and biologic processes overlap in daily life.^{18,19} Additionally, the team scanned existing Indigenous curricula in 5 Canadian medical schools and online continuing medical education

Figure 1. Steps to building and implementing the E4E Care Framework



CME—continuing medical education, E4E—Educating for Equity, RCT—randomized controlled trial.

summaries addressing any health disparities or disease entities among Indigenous populations.

Patient sequential focus groups and interviews (n=32) were then conducted in 5 Indigenous communities located in 3 Canadian provinces,²⁰ and 1-on-1 telephone interviews were conducted with physicians (n=28) and curriculum developers (n=5) from across Canada. The feedback of a national advisory group of Indigenous health experts, educators, leaders, physicians, and Indigenous community members helped to transform research findings into care recommendations. Building on primary phenomenologic thematic analysis,²¹ the research team leads conducted a secondary analysis to develop the care framework, employing a nominal group technique^{22,23} process to populate and structure the multi-component resource. The resulting E4E Care Framework provides strategies for enhancing clinical approaches to diabetes management within Indigenous communities by integrating social and cultural lenses. It promotes structural competency²⁴ in balance with cultural safety²⁵⁻²⁸ as critical components of a patient-centred care model.²⁹⁻³¹ These concepts are reinforced through health-promoting primary care strategies, including motivational interviewing^{32,33} and trauma-informed care.³⁴⁻³⁶ All patient and physician perspectives in this article derive from E4E focus groups and interviews.

Main message

Colonization and diabetes. Colonization is the predominant determinant of health for Indigenous people.^{37,38} Both patients and physicians recognized colonization as a distal determinant that undermines individual resilience and leads to negative health outcomes through pervasive poverty, adverse life experiences, and ongoing racism.^{18,19} These unfavourable conditions underlie and exacerbate Indigenous people's experiences of diabetes, as the structural barriers and psychosocial effects of poverty have consequences for health.^{39,40} Research participants emphasized that historical discrimination against Indigenous people persists, resulting in their relatively low social status. Additionally, participants attributed the disruption of social cohesion or the development of dysfunctional relationships to the insidious effects of colonization. Thus, diabetes can be contextualized as a manifestation of social suffering originating from colonization and enacted through structural violence and inequity.⁴¹⁻⁴³

It is therefore important for clinicians to recognize that, far from being a distant historical event, colonization is indeed a *process* that has enduring effects. Moreover, it is essential to situate health care within a legacy of colonization. Using a postcolonial theoretical lens⁴⁴ to examine the experiences of Indigenous people with type 2 diabetes, the E4E initiative identified a great need for understanding the relationship between Canada's colonial history and how Indigenous people experience both diabetes and the health care system.

Health care can contribute to ill health when it is culturally unsafe⁴⁵ or complicit in the processes of colonization. This tension plays out within spaces structured by the unresolved legacy of colonization, from health care policies that provide differential access to health benefits⁴⁶ to discriminatory emergency department triage practices.⁴⁷ Care is thereby shaped through systemic and individual levels of racism⁴⁸ that might stir physician biases, trigger patient resistance, and sustain systemic barriers.

Framing diabetes care for Indigenous patients. The guiding principles of the E4E Care Framework orient the clinician toward social factors that affect Indigenous patients with type 2 diabetes (**Figure 2**). Motivated by patient stories of harmful care,¹⁹ as well as by patient and physician descriptions of positive health care relationships,⁹ these principles highlight the dynamic nature of cultural humility and culturally safe care.⁴⁹ A clinical approach attuned to the Indigenous patient's social and cultural realities facilitates congruent management strategies. Clinicians are reminded that the cultural experiences of Indigenous people are diverse. Engagement that considers cultural diversity is not about treating all patients alike, but rather it is about supporting and leveraging the necessary tools for each patient to build capacity and resilience. Providing effective care for Indigenous patients necessitates health care equity, where resources are discrimination free, are developed for the specific needs of Indigenous patients, and fill existing gaps.

In addressing social factors that adversely influence the health care outcomes of Indigenous patients with diabetes, physicians are called upon to comprehend complex social domains within an already-complex biomedical explanatory model. The notion of stress-induced disturbances of the hypothalamic-pituitary-adrenal axis as a mechanism for diabetes outcomes⁵⁰⁻⁵²

Figure 2. Principles of the E4E Care Framework

Colonization is the predominant cause of health inequity for Indigenous people

Health care equity is providing appropriate resources according to need and addressing differential treatment arising from system and individual factors

Empowerment is building capacity with patients to address social determinants influencing health outcomes

Culture, by respecting its diverse perspectives and experiences, is a facilitator of the clinical relationship and patient capacity

E4E—Educating for Equity.

provides a rationale for clinicians to explore patients' stress. Population health studies that link inequity and chronic disease through material, psychosocial, and political pathways⁵³⁻⁵⁵ lend a useful framework. Within the Indigenous context, the political pathway plays out as the ongoing influence of colonization, while material and psychosocial pathways represent complex social effects on health, such as poverty and multi-generational trauma.

Described here is a call for clinicians to identify and address the systemic causes of disease within the patient's environment. Metzl and Hansen²⁴ describe this approach in terms of structural competency, where clinicians are encouraged to move beyond an "individual choice" paradigm toward recognizing how social and economic status shape health resource access, health behaviour, and ultimately health outcomes.

To facilitate practice implementation, the E4E team developed a framework (Figure 3) best understood in terms of the interplay of structural competency and cultural safety within a patient-centred care approach. At its core, the E4E Care Framework provides 2 directives for clinicians: re-centring the clinical relationship and engaging the social realities of Indigenous patients to find opportunities for change. Each directive is grounded in Indigenous cultural concepts for addressing critical social variables, arising from the legacy of colonization, that influence patient health and clinical interactions. While the directives act synergistically, the framework intentionally describes the relational directive first, as developing a relationship is fundamental to effective care.¹⁹ Respectful inquiry can also engender a therapeutic relationship. The following sections describe the interplay of social and cultural concepts related to each directive.

Re-centring the relationship. Implicit physician bias results in health care inequities directly through

misinformed physician decision making and indirectly through destabilizing the clinical relationship.⁵⁶ Patients reported being routinely discriminated against, stereotyped, and marginalized. The damaging and uneven historical relationships between Indigenous people and non-Indigenous Canadians means that many Indigenous patients have apprehensions about the Western medical system,¹⁹ which for many remains a living symbol of continuing oppression, mistreatment, and neglect. As a result, patients remain highly vigilant for any threat of stereotype.⁵⁷ Resistance, hesitation, withdrawal, and acquiescence are all potential patient responses to approaches that establish physician authority and power imbalance.

Re-centring clinical relationships involves attending to colonization and inequity within health care (Table 1). The E4E Care Framework directs clinicians to address dynamics related to "unequal treatment" and imbalance of "power and authority." Clinicians must become aware of their potential complicity in perpetuating these concepts. Critical self-reflection is the first step in identifying one's stereotypes, assumptions, and biases. Using the notion of power distance,⁵⁸ an agreeable power balance is achieved by direct inquiry, refraining from language rooted in oppression and racism, and using nonverbal communication cues⁵⁹ that mirror the patient's communication approach. The framework recommends that clinicians examine any remaining moments of discord for underlying historical tensions.

The E4E Care Framework suggests what the concepts of cultural competency and cultural safety⁹ might look like for Indigenous patients, and how they might foster patient-physician concordance for management plans. We advocate refocusing on relational aspects of care by using a cultural lens that is attuned to Indigenous perspectives on sharing, time, and connectedness¹⁹ (Figure 4). Strategies in this area involve critical self-reflection on one's own concepts of health and diabetes care, as well as assumptions about Indigenous perspectives, including preferences around professional distance or objectivity. Tools include strengthening skills in intercultural communication,⁶⁰ such as using narrative and indirect approaches more common in Indigenous contexts.^{61,62} It could also involve increased community engagement.

Geraldine's social environment: Key to Geraldine's social context is a history of trauma originating from her first husband, with whom she has adult children and who was physically abusive until she escaped by leaving her reserve community years ago. This trauma is compounded by the adversity of growing up in poverty and her residential school experiences. You notice that Geraldine's summer visits to the reserve with her children appear to trigger annual retraumatization that correlates with worsening of her diabetes control. She also has an unstable current home environment, where her second husband is a heavy

Figure 3. Conceptual model of the E4E Care Framework

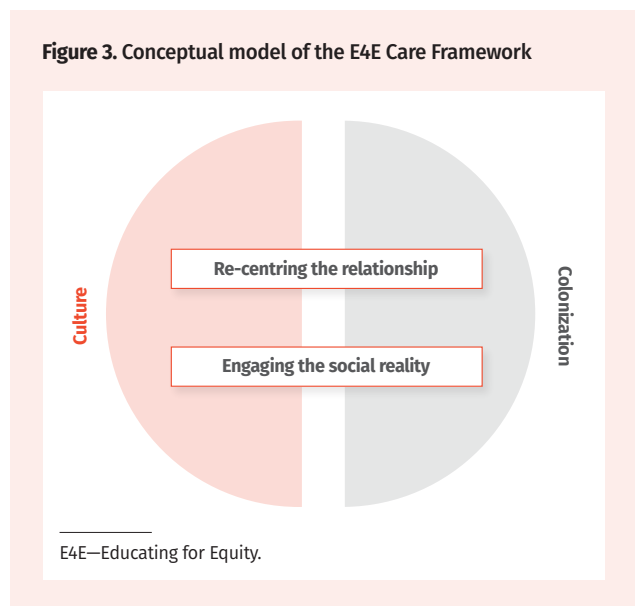


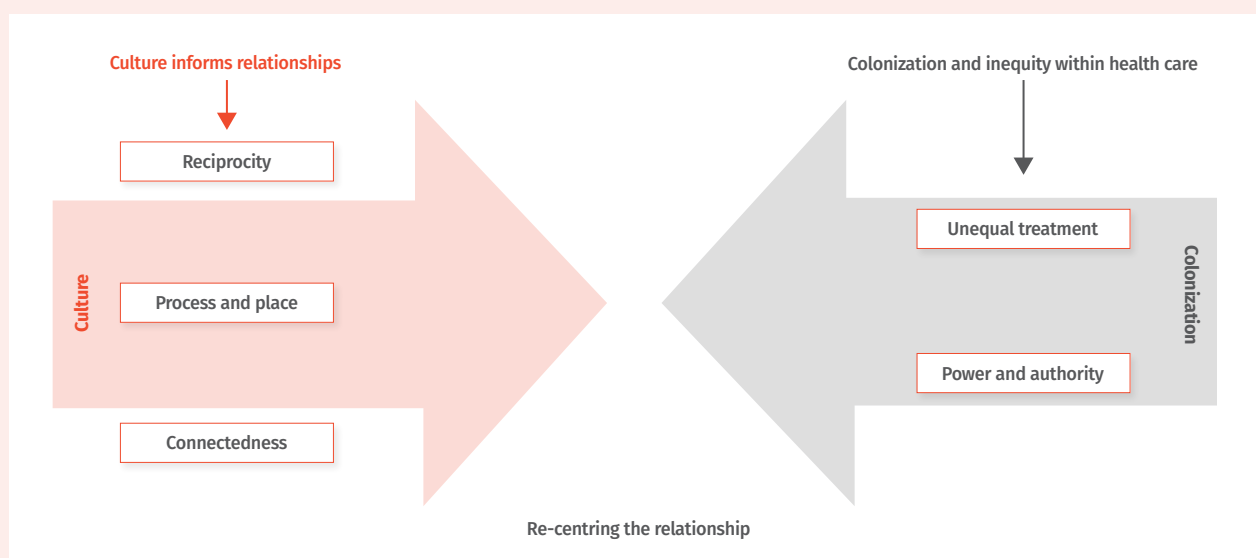
Table 1. The E4E Care Framework for re-centring the relationship

| KEY CONCEPTS OF RE-CENTRING THE RELATIONSHIP | RECOMMENDATIONS |
|--|--|
| Colonization* and inequity within health care Unequal treatment <ul style="list-style-type: none"> • The health system, as a social and cultural construction of Canadian society, is perceived (and experienced) by patients as an institution that supports and facilitates ongoing colonization and control over Indigenous people through racist, oppressive, and exclusionary practices Power and authority <ul style="list-style-type: none"> • Indigenous patients' heightened awareness of and reaction to the power and authority mismatch within the doctor-patient relationship arises from historical injustices that undermined individual autonomy and from negative experiences of authority from residential schooling | Addressing colonization and inequity within health care: <ul style="list-style-type: none"> • Identify and critically reflect on your own stereotypes, assumptions, and biases • Negotiate an agreeable power balance • Identify and explore moments of discord, paying particular attention to patient resistance, hesitation, and withdrawal • Refrain from an authoritarian approach that relies on language rooted in oppression and racism |
| Culture informs relationships† Reciprocity <ul style="list-style-type: none"> • Creating an authentic relationship involves sharing key social contexts in order to build rapport and trust Process and pace <ul style="list-style-type: none"> • Providing appropriate care requires attention to issues of process and pace to allow for exploration of and reflection on the patient's experiences Connectedness <ul style="list-style-type: none"> • Patient experience of diabetes and diabetes care is embedded in relationships, family dynamics, and community supports and structures | Reflecting on how culture informs relationships: <ul style="list-style-type: none"> • Critically reflect on your own concepts of health and diabetes care and potential assumptions about Indigenous perspectives • Reflect on professional distance and objectivity, and in the spirit of reciprocity, consider sharing aspects about yourself to build trust • Adjust your pace when exploring the patient's world • Connect and work to foster positive relationships at the individual, family, and community levels |

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*Colonization is a traumatic historical episode and an ongoing process resulting in uneven power relations between Indigenous people and Canadian society. It is the mechanism by which inequality shapes diabetes and health care outcomes for Indigenous people. Participants attributed racism and societal exclusion of Indigenous people to ongoing processes of colonization. Approaches that establish physician authority, expertise, status, and professional distance can negatively affect clinical relationships in the context of these historical relationships, social exclusion, and trauma.

†Cultural perspectives inform how patients experience diabetes and engage with health care, as well as how physicians approach care. Patient resistance might reflect incongruence and the need for physician reflection.

Figure 4. Conceptual model of re-centring the relationship

drinker and is emotionally abusive. Grown children and grandchildren also live in her home to help supplement the rent, as she has trouble making ends meet.

You notice that her diabetes seems to improve when she is able to work regularly as a house cleaner. However, over the years, she has shared with you that she drinks to cope with her stressors. During those times, she is often not eating well and cuts back on her medications. She also works less at these times, often overwhelmed with spousal conflict and caring for her grandchildren. It seems that stressors and chronic joint pain influence her ability to work. How do you start to support Geraldine in order to improve her diabetes outcomes?

Engaging the social reality. Effective health care for Indigenous patients is shaped by a deep understanding of the causal relationships between social factors specific to Indigenous people and health. These social factors form constant stressors that accumulate and operate concurrently to maintain chaotic and overwhelming living conditions, which lead to diabetes while undermining an individual's capacity to cope with it. For instance, family networks can be a source of support, but within contexts of socioeconomic disadvantage family members can diminish capacity for self-care by pressuring a patient to divert limited resources elsewhere. For clinicians, engaging with social contexts of diabetes in Indigenous settings involves recognizing distinct barriers that hinder patients in achieving improved outcomes, developing strategies for achieving management and therapeutic goals, and identifying tools for fostering self-efficacy and positive health behaviour among patients (Table 2).

The E4E Care Framework recommends that clinicians consider the broader environment through screening for resource limitations and adverse life experiences, and then acknowledging these as playing a role in diabetes onset and management. This approach is concordant with traditional Indigenous perspectives of relational, indirect, and nonconfrontational approaches.⁶¹ The screening question, "Do you ever have difficulty making ends meet at the end of the month?," is aligned with recommended Indigenous approaches.⁶³ Screening is best framed by asking about "hardship" beyond poverty that is related to discord within the family, community, and broader society. At this point, clinicians could indicate that they have some understanding of the outcomes of colonization on health and then explore those experiences.

A strategy for incorporating social factors within care is to speak with patients about population health evidence that demonstrates material and psychosocial pathways to chronic disease. For example, the concept of effort-reward imbalance⁶⁴ on health outcomes was a strong theme within our research. Additional key themes arising from the legacy of colonization include lateral violence,⁶⁵ intergenerational trauma, attachment,⁶⁶ and

the need for social support.⁶⁷⁻⁶⁹ Clinicians are advised to be aware of the principles of trauma-informed care when exploring adverse life experiences.³⁶ Even though behaviour change remains important in the path to wellness, this contextual approach is intended to facilitate patient empowerment in addressing social factors that operate as barriers to health. In concordance with the concept of structural competency, the framework invites clinicians to engage as advocates at the system level in order to sustain individual patient change.

Helping Geraldine cope with adverse social contexts: One element of the E4E Care Framework encourages you to help patients cope with social barriers to well-being by acknowledging connections between adverse life experiences and patients' capacity to manage diabetes. In Geraldine's case, this includes helping her to address family stressors and to maintain employment in order to avoid poverty. Heavy drinking appears to be a marker of not coping well with her retraumatization and ongoing adversities, while it undermines her diabetes management through inconsistent eating and reduced medications. Given that Geraldine's heavy drinking is episodic and driven by the same social stressors as her diabetes, you use her alcohol consumption patterns to gauge where she is at in terms of being overwhelmed. Alcohol is therefore a point of entry into addressing the social contexts influencing her diabetes, helping you to reinforce the interconnection of social stressors with her health outcomes.

While the E4E Care Framework speaks to how a context of acculturation worsens diabetes outcomes and how accessing cultural resources might be a means for improving health outcomes through traditional knowledge and social support networks, Geraldine's past traumas make her hesitant to reconnect with Indigenous cultural practices. In this case, as in all, care follows the patient's priorities and contexts.

Culture as therapeutic: Culture is a key facilitator for approaching diabetes management, and we must understand that cultural beliefs, values, and practices might play a role for patients in acquiring health knowledge and resilience (Table 2). Culture was viewed as a protective factor and a facilitator for improving health and managing diabetes. Resilience through reaffirming cultural identity and continuity is nurtured by accessing cultural knowledge and cultural supports, which can be accomplished by engaging in ceremonies and having relationships with community knowledge keepers, for example.⁷⁰⁻⁷² This should not imply that all patients are equally connected to traditional Indigenous practices, but that culture serves a role in positioning a person within wider networks of community and support. Of note, patients often perceived the same social barriers to health as influencing their health literacy and

Table 2. The E4E Care Framework for engaging the social reality

| KEY CONCEPTS OF ENGAGING THE SOCIAL REALITY | RECOMMENDATIONS |
|---|---|
| Social and economic resource disparities* Socioeconomic disadvantages <ul style="list-style-type: none"> • Socioeconomic disadvantage is a normalized state for many patients, limiting choices while increasing stress and diminishing capacity for self-care and healthy behaviour patterns Family and limited resources <ul style="list-style-type: none"> • These are contexts in which self-care might occur. Food and financial sharing within large families results in diversion of resources, becoming another stressor Knowledge barriers <ul style="list-style-type: none"> • Health knowledge is affected through structural access barriers to learning, ongoing adverse life experiences, and discord within the health care relationship | Considering Indigenous patients' social and economic realities: <ul style="list-style-type: none"> • Screen for and explore resource limitations that influence diabetes onset and management • Acknowledge with the patient the effect of resource limitations on diabetes onset and management • Support access to key proximal health determinants • Assess diabetes knowledge and health literacy |
| Accumulation of adverse life experiences† Family adversity and support <ul style="list-style-type: none"> • Family and community are viewed as supportive but also potentially stressful in the context of pervasive social dysfunction arising from the outcomes of historical trauma, poverty, and underlying inequities from colonization Personal and collective loss <ul style="list-style-type: none"> • The nature and extent of multiple forms of loss (eg, personal, cultural, historical) are key features of adversity affecting individuals, families, and communities Effect of residential schools <ul style="list-style-type: none"> • The residential school experience traumatized individuals, disrupted communities, and continues to adversely influence health and health behaviour | Considering patients' adverse life experiences: <ul style="list-style-type: none"> • Acknowledge with the patient the connections between adverse life experiences and capacity for diabetes management • Explore patients' perspectives on personal adverse experiences in the context of diabetes in order to address their priorities |
| Culture frames knowledge‡ Knowledge contextualization and exchange <ul style="list-style-type: none"> • Knowledge contextualization and exchange rather than just information delivery was identified as an effective means to facilitate patient education | Helping build Indigenous patients' knowledge about diabetes care: <ul style="list-style-type: none"> • Build a shared understanding of diabetes that integrates and contextualizes biomedical, social, political, and cultural explanatory frameworks • Use language appropriate for the patient's educational and cultural background; consider metaphors within a narrative approach |
| Culture as therapeutic§ Culture is protective <ul style="list-style-type: none"> • Health is positively correlated with a sense of security in cultural identity and access to cultural knowledge and traditions Traditional medicine and ceremony <ul style="list-style-type: none"> • Traditional medicine and ceremony are desired modalities to access and reconnect with, in conjunction with Western medicine | Recognizing culture as therapeutic: <ul style="list-style-type: none"> • Strive for cultural congruency of management recommendations • Explore patients' preferences and support choices for accessing cultural resources • Engage with the community to learn about local beliefs and practices, as well as healing resources |

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*Relationships between resource limitations, socioeconomic status, and the social environment directly affect health and diabetes through material deprivation, as well as indirectly through psychosocial pathways such as stress, depression, anxiety, and loss of control. The ongoing process of colonization is conceptualized to be the apparatus responsible for these barriers affecting Indigenous people's health and their experiences with diabetes.

†Persistent and recurring throughout the life course of Indigenous individuals and communities, adverse experiences accumulate and pervasively influence wellness and health by undermining health behaviour patterns and diminishing resilience and capacity to cope with disease.

‡Placing diabetes care knowledge within the cultural, social, and political landscape of Indigenous people can facilitate patient engagement and learning. In addition, culture is fundamental to effective communication for achieving knowledge exchange and patient education.

§Recognizing culture as a protective factor in promoting health ensures that efforts toward improved diabetes care include using a cultural lens to view Indigenous peoples' experiences of health and illness, as well as understanding patients' own preferences and connections, and barriers to cultural resources.

access to cultural resources. Clinicians are advised to nonjudgmentally ascertain patient knowledge and access to resources of both biomedical and Indigenous contexts (**Figure 5**). By exploring patients' cultural perspectives and preferences for health, while sharing biomedical perspectives, clinicians and patients might build a shared understanding. In this way, clinicians can attain congruency of diabetes management with the social and cultural reality of the patient. The intent of the framework's knowledge contextualization and exchange recommendation is to build patient capacity through health literacy using an acceptable rapport-building strategy. Notably, culture influences health literacy in important ways, in turn shaping capacity for chronic disease management.^{73,74} Physicians are encouraged to engage with their local traditional community to learn more about cultural healing practices and resources.

Conclusion

According to one of the calls to action in the 2015 *Truth and Reconciliation Commission of Canada* report, health is the direct result of distal determinants arising from historical and ongoing colonizing policies.⁷ From a health care perspective, reconciliation involves achieving health care equity by providing care that can address the specific cultural and social needs of Indigenous people. The insidious effects of colonization on health and health care are multifaceted and persistent within the lives of many Indigenous people, who are often overwhelmed by a host of social factors that diminish capacity to cope and that affect their overall well-being. Owing to ongoing social exclusion, many Indigenous peoples' lives are burdened by poverty, persistent psychosocial discord within family and community, and daily racism. This is

the context in which many Indigenous people experience type 2 diabetes.

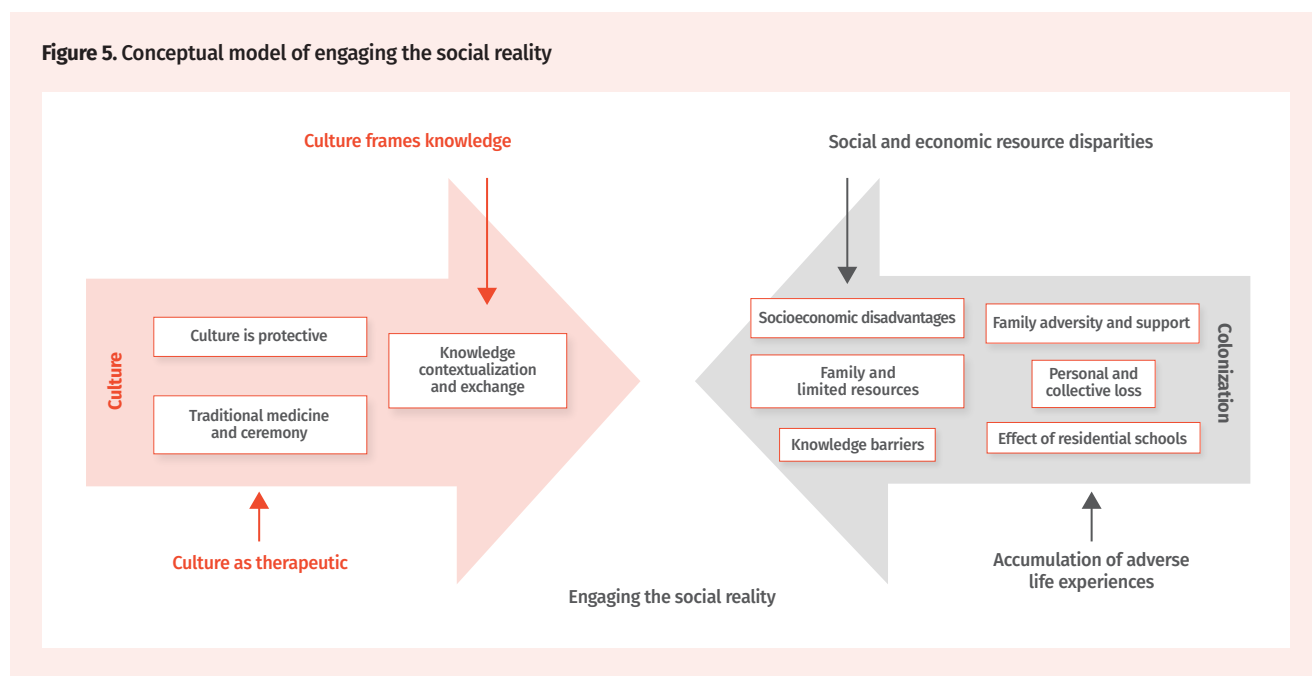
Clinicians require critical awareness and skills for addressing complex social factors that undermine health outcomes. The E4E Care Framework provides a resource for deeper clinician engagement with Indigenous patients with type 2 diabetes. This resource provides a lens to understand, identify, and apply opportunities for enhancing Indigenous patient capacity for change in a way that acknowledges the social factors driving high rates of diabetes, while using a cultural lens to facilitate improved outcomes. It presents recommendations for improved care within clinical contexts, wider communities, and the realm of social advocacy in which physicians can support patients in obtaining needed resources. It offers an applied map of integrated concepts including cultural safety, cultural competency, and structural competency. It also offers recommendations that inherently endorse and expand a patient-centred care approach. The framework can contribute to informing health care policies and services more broadly, offering an educational resource to build patient health literacy about the effects of colonization on their health, health behaviour, and health care interactions. 🍁

Dr Crowshoe is Associate Professor in the Department of Family Medicine at the University of Calgary in Alberta. **Dr Henderson** is Assistant Professor and Models of Care Scientist in the Department of Family Medicine at the University of Calgary. **Dr Jacklin** is Professor of Medical Anthropology in the Department of Family Medicine and Biobehavioral Health at the University of Minnesota Medical School in Duluth. **Dr Calam** is Associate Professor in the Department of Family Practice at the University of British Columbia in Vancouver. **Ms Walker** is Associate Director for Education at the Centre for Excellence in Indigenous Health at the University of British Columbia. **Dr Green** is Professor in and the Brian Hennen Chair and Head of the Department of Family Medicine, as well as Professor in the Department of Public Health Sciences, at Queen's University in Kingston, Ont.

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Figure 5. Conceptual model of engaging the social reality



Contributors

All authors contributed to building and implementing the Educating for Equity Care Framework, and to preparing the manuscript for submission.

Competing interests

None declared

Correspondence

Dr Lynden (Lindsay) Crowshoe; e-mail crowshoe@ucalgary.ca

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