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Original Research

Exploring Canadian Physicians' Experiences with Diabetes Care for Indigenous Patients

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ABSTRACT

Objectives: The perspectives of physicians caring for Indigenous patients with diabetes offer important insights into the provision of health-care services. The purpose of this study was to describe Canadian physicians' perspectives on diabetes care of Indigenous patients, a preliminary step in developing a continuing medical education intervention described elsewhere.

Methods: Through in-depth semistructured interviews, Canadian family physicians and specialists with sizeable proportions of Indigenous clientele shared their experiences of working with Indigenous patients who have type 2 diabetes. Recruitment involved a purposive and convenience sampling strategy, identifying participants through existing research and the professional relationships of team members in the provinces of British Columbia, Alberta and Ontario. Participants addressed their understanding of factors contributing to the disease, approaches to care and recommendations for medical education. The research team framed a thematic analysis through a collaborative, decolonizing lens.

Results: The participants (n=28) included 3 Indigenous physicians, 21 non-Indigenous physicians and 4 non-Indigenous diabetes specialists. They practised in urban, reserve and rural adjacent-to-reserve contexts in 5 Canadian provinces. The physicians constructed a socially framed understanding of the complex contexts influencing Indigenous patients with diabetes in tension with structural barriers to providing diabetes care. As a result, physicians adapted care focusing on social factors and conditions that take into account the multigenerational impacts of colonization and the current social contexts of Indigenous peoples in Canada.

Conclusions: Adaptations in diabetes care by physicians grounded in the historical, social and cultural contexts of their Indigenous patients offer opportunities for improving care quality, but policy and health system supports and structural competency are needed.

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R É S U M É

Objectifs : Le point de vue des médecins qui soignent les patients autochtones diabétiques offre de nombreuses pistes sur la prestation des services de santé. L'objectif de la présente étude était de présenter le point de vue des médecins du Canada sur les soins aux patients autochtones diabétiques, une étape préliminaire à l'élaboration d'interventions de formation médicale continue décrites autre part.

Mots clés :

formation médicale continue

politiques en matière de soins de santé

santé des Autochtones

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Méthodes : Grâce à des entrevues semi-structurées en profondeur, les médecins de famille et les spécialistes du Canada ayant une importante clientèle autochtone ont partagé leurs expériences de travail auprès des patients autochtones qui souffrent du diabète de type 2. Le recrutement impliquait une stratégie d'échantillonnage intentionnel et à l'aveuglette pour trouver les participants par le biais de la recherche actuelle et des relations professionnelles des membres de l'équipe dans les provinces de la Colombie-Britannique, de l'Alberta et de l'Ontario. Les participants ont pris en compte leur compréhension des facteurs qui contribuent à la maladie, les approches de traitement et les recommandations de formation médicale. L'équipe de recherche a structuré l'analyse thématique dans une optique de décolonisation axée sur la collaboration.

Résultats : Parmi les participants (n=28), il y avait 3 médecins autochtones, 21 médecins non autochtones et 4 spécialistes du diabète non autochtones. Ils pratiquaient en milieu urbain, dans une réserve ou en milieu rural à proximité d'une réserve de l'une des 5 provinces canadiennes. Les médecins ont développé une compréhension socialement structurée des contextes complexes influençant les patients autochtones diabétiques en opposition avec les obstacles structurels à la prestation des soins aux diabétiques. Par conséquent, les médecins ont adapté les soins axés sur les facteurs sociaux et les conditions qui tiennent compte des répercussions multigénérationnelles de la colonisation et du contexte social actuel des personnes autochtones du Canada.

Conclusions : Les adaptations réalisées par les médecins sur les soins aux diabétiques fondés sur les contextes historiques, sociaux et culturels de leurs patients autochtones offrent l'occasion d'améliorer la qualité des soins, mais exigent l'appui des politiques et du système de santé et des aptitudes structurelles.

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Introduction

In Canada, the prevalence of type 2 diabetes is 3 to 5 times higher in Indigenous populations than in the general population (1,2), and type 2 diabetes in youth is increasing in incidence (3,4). The lifetime risk of a young First Nations adult in the province of Alberta is 80%, compared to 50% among the non-First Nations population (5). Diabetes-related complications in Indigenous populations occur at higher rates (6,7), and health-care costs are higher than among comparable non-Indigenous populations (8–11). Such studies indicate that high-quality clinical care is one facet of a broad systemic approach needed to address the worrisome trend of increasing rates of diabetes and its complications in Indigenous populations (12,13). Unfortunately, gaps in the quality of diabetes care for Indigenous patients exist (14,15); approximately one-third of patients achieve targets for control of glycated hemoglobin (A1C) levels, and very few achieve control of lipids, blood sugars and blood pressure (16). This article describes experiences of diabetes care by physicians with significant numbers of Indigenous patients and pays particular attention to contextual factors to be learned from health professionals experienced in adapting care to address Indigenous health inequities.

Previous research identifies multiple factors important in the delivery of high-quality care for diverse patients at high risk for diabetes (17–19), though few explore physicians' experiences with Indigenous patients. The research that does exist provides a glimpse of the barriers perceived by health practitioners; the barriers arise at the levels of the patients, the providers and the wider system (20), including health practitioners' frustrations with negative health outcomes, staff shortages and turnover, inadequate training and the fragmentation of care, in addition to community isolation and poverty. Some note general similarities between Aboriginal patients and physician-perceived barriers around "access to transportation, education material, traditional care and medicine, and diagnostic services" (13). In one family resident-trainee sample, although a majority were willing to work in Indigenous contexts, the vast majority of them felt underprepared, even though community experience and exposure to Aboriginal issues increased the likelihood of intention to work in Indigenous settings (21). Such data lead some to call for access to cultural mentorship and increased knowledge of social and historical factors impacting healthcare delivery for Indigenous patients (22). A broader and deeper understanding of barriers and facilitators perceived by physicians is required to inform clinical practice. Focusing on the experiences and strategies of physicians who adapt their care to diverse Indigenous realities in Canada, this article provides more specific recommendations for practitioners,

service organizers and policy makers for ensuring high-quality care. A related article based on this same study describes Indigenous patients' experiences of diabetes care (23).

The study was implemented in Canada as part of a tri-national research collaboration, known as Educating for Equity (E4E), which has teams in New Zealand and Australia. The Canadian team focuses on health professionals' education in Indigenous contexts to reduce disparities in chronic disease care and improve outcomes for Indigenous populations.

Methods

Involving a collaborative partnership among University of Calgary, University of British Columbia, Queen's University and Laurentian University researchers (Appendix), ethics approval was secured from each. Grounded in qualitative research methods, the study drew on semistructured telephone interviews with family physicians and diabetes specialists. Qualitative interviews have been employed extensively in health and primary care research to gain insight into providers' perspectives on issues relevant to patient care in general and to diabetes care specifically (24–28).

Recruitment

One-hour telephone interviews were conducted between 2011 and 2012 with generalist primary care physicians who provide service to Indigenous communities and for whom diabetes care is one of the many aspects of their service, as well as with focused diabetes physicians who are specialist or primary care providers and whose service is specific to diabetes care. The research team considered the inclusion of a generalist physician population, given that it represented a target audience for findings and provided specific insights into diabetes care. Recruitment occurred via a purposive and convenience sampling strategy (29,30). Participants were identified through existing research and professional relationships of team members in the provinces of British Columbia, Alberta and Ontario, with fewer than 3 being previous research collaborators of team members. Posters and electronic notifications were sent to clinical service medical leads for distribution to physician staff and to the Indigenous Physicians Association of Canada. Eligibility for participation included having 3 or more years of experience in providing care to Indigenous peoples and a minimum of 10% of one's patients being Indigenous.

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