MULTIMORBIDITY AND PATIENT COMPLEXITY: OPPORTUNITIES FOR OBESITY MANAGEMENT WITH INDIGENOUS PEOPLE

Obesity Clinical Practice Guidelines

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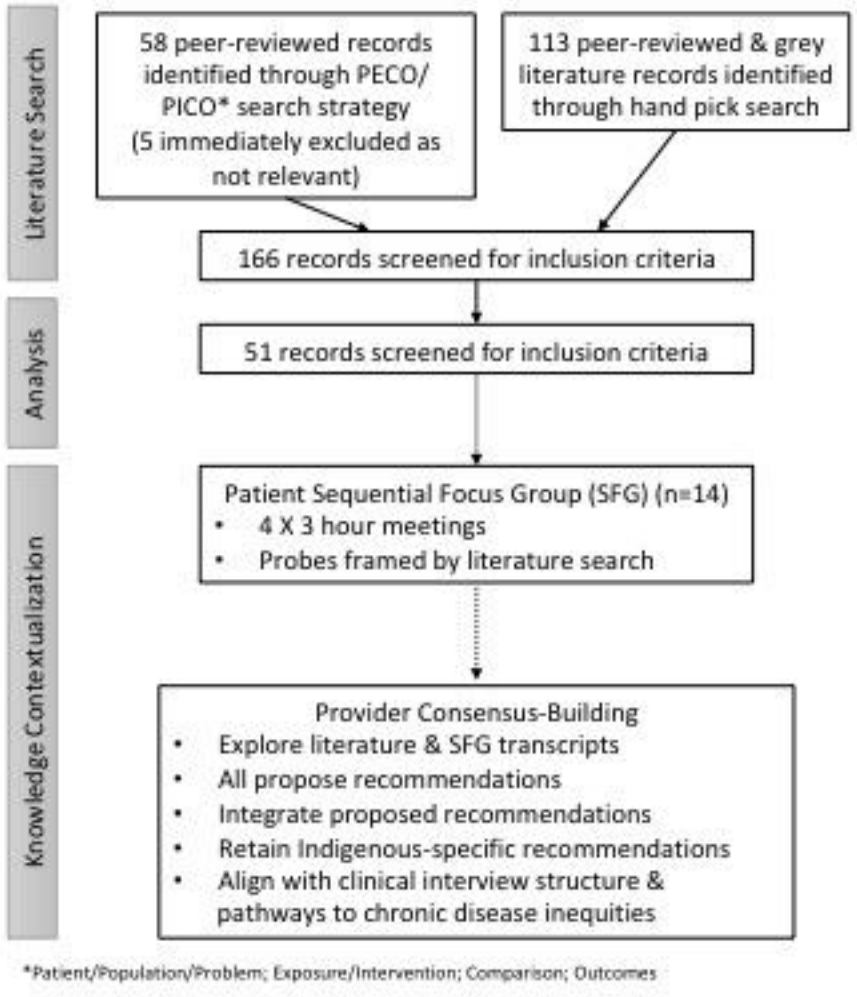
Process for Knowledge Contextualization



Centers a review of relevant scholarship within:

- Community experiences
- Insights from providers who work closely with Indigenous patients

Recommendations

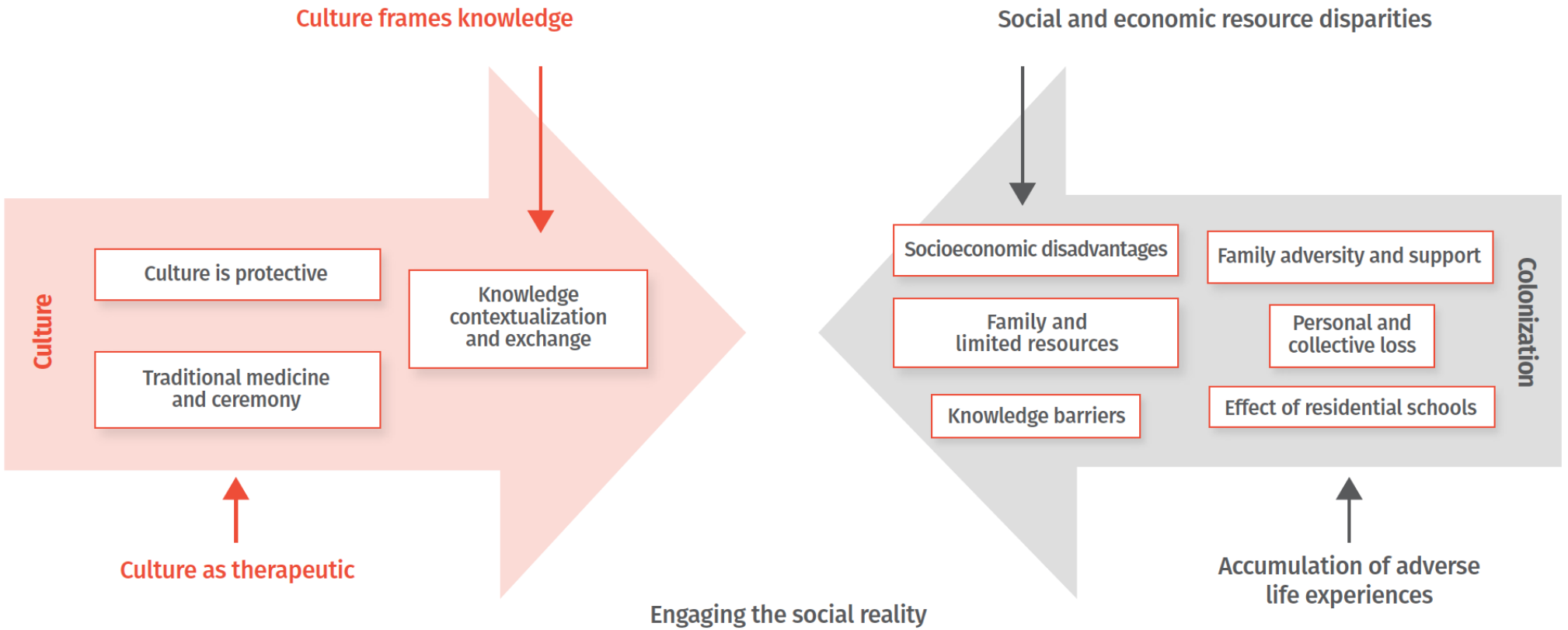
1. Engage with patient social realities

- Validate the patient's experiences of stress and systemic disadvantage
- Advocate for access to obesity management resources
- Help patients recognize that good health is attainable
- Negotiate small, attainable steps

2. Address resistance, seeming apathy & paralysis in patients & providers

- Self-reflect on anti-Indigenous sentiment common within healthcare systems
- Expect patient mistrust in health systems and reposition yourself as a helper to the patient instead of as an expert
- When resistance, seeming apathy and paralysis are encountered, explore patient needs

Engage with Patient Social Realities



Recommendations

3. Build complex knowledge by healing relationships

- Build patient knowledge and capacity for obesity self-management and strive for relationships that incorporate healing from multi-generational trauma
- Build your own knowledge regarding the health legacy of colonization
- Ensure knowledge provided is congruent with the patient's perspectives

4. Connect to Behaviour, the Body, and Indigenous Ways of Knowing, Doing & Being

- Elicit and incorporate the patient's individual and community-based concepts of health and healthy behaviours
- Deeply engage in learning of common values and principles around communication and knowledge-sharing in Indigenous contexts

Evidence Synthesis

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*

Respecting diversity of perspectives and experiences, **CULTURE** *is a facilitator of the clinical relationship and patient capacity*

1. Materialist Pathways to Health Inequity: Engage with Patient Social Realities

"[A doctor should understand] the context of what happened to us…you need a doctor that actually cares, that thinks that you've got to make changes" **(Male-Ojibwe-47 years)**

2. Psycho-Social Pathways to Health Inequity: Addressing Resistance, Seeming Apathy, & Paralysis in Patients & Providers

"Addictions and obesity are fused together because of years of abuse… some people supress those memories with eating" **(Male-Cree-32 years)**

3. Political/Economic Pathway to Health Inequities: Build Complex Knowledge by Healing Relationships

"I can do all the research myself, but at the same time just trying to understand and figure out this syndrome or whatever it is that I have…I find healthcare providers don't really have the - well, it's not that they don't have the time, it's that they don't really take the time." **(Female-Cree-35 years)**

4. Culture as Protective: Connect to Behaviour, the Body, & Indigenous Ways of Knowing, Doing & Being

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"[It helps when doctors are] really actually focused on you, have deep discussions with you, look eye to eye. Not just listening to what you say, you really connect with that kind of doctor…My family doctor, I can really connect with" **(Male-Cree-32 years)**

Conclusion

- Colonization: Stress is a significant effect of systemic disadvantage, leading to health inequities through multiple pathways
- Personalized obesity assessment: Grounding relationships in compassion and listening aligns with emerging scholarship in primary care (Luig, Anderson, Sharma, Campbell-Scherer, 2018)