Vital Link
The professional journal of the Canadian Association of Naturopathic Doctors

Minority and Underserved Populations: Culture and Clinical Decision-Making for NDs

Volume 18, Issue 3
Fall 2011

Feature Articles

Canadian Association of Naturopathic Doctors
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Lactobacillus helveticus R0052	9 billion
Lactobacillus plantarum R1012	9 billion
Lactobacillus rhamnosus R0011	9 billion
Bifidobacterium bifidum R0071	1 billion
Bifidobacterium breve R0070	1 billion
Bifidobacterium infantis R0033	1 billion
Lactob. delbrueckii ssp. bulgaricus R9001	1 billion
Streptococcus thermophilus R0083	1 billion
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INDICATION

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FEATURES

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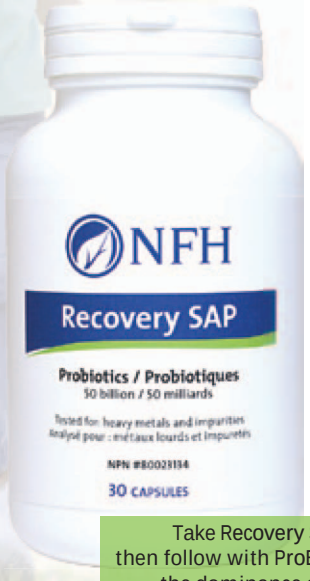

ACTIVE INGREDIENTS

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Lactobacillus casei R0215	440 million
Bifidobacterium longum R0175	330 million
Bifidobacterium infantis R0033	330 million
Bifidobacterium breve R0070	330 million
Streptococcus thermophilus R0083	220 million
Lactob. delbrueckii ssp. bulgaricus R9001	55 million
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INDICATION

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FEATURES

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Vital Link

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The Vital Link is the professional journal of the Canadian Association of Naturopathic Doctors (CAND). It is published primarily for CAND members and features detailed reviews of specific causal factors: philosophical and research-based papers, clinical practice articles and case reviews, as well as international updates on the profession. The Vital Link has an outreach to other health care professions and promotes qualified naturopathic doctors to corporations, insurance companies and the Canadian government.

Forthcoming Themes

Winter-Spring 2012 Lead Exposure

Summer 2012 Assessment and Diagnosis: A New Era

Fall 2012 Emerging Therapies

Submissions
When writing for the Vital Link, keep in mind its broad readership and out-reach to other professions. Your contribution to the Vital Link will benefit the naturopathic profession as a whole and provide you with personal professional exposure. Previously unpublished material is preferred. Please contact the managing editor for submission guidelines.

Circulation
The Vital Link is published three times per year and is distributed to over 2000 qualified Canadian NDs and students of CNME-accredited naturopathic programs in Canada and the U.S. The Vital Link is also distributed to the CAND's corporate members and in our media kit. The journal is available electronically to members only.

Advertising
Professional vendors providing NHPD-compliant products or other services to NDs are encouraged to advertise in the Vital Link. The CAND's advertising partners enjoy unequalled exposure to qualified Canadian naturopathic doctors.

Naturopathic Notes

Dr. Iva Lloyd, BScH, RPE, ND

The articles featured in this edition of the Vital Link highlight the importance of treating the individual, of truly listening and caring to learn about a person's history, their story, their challenges and their life. This edition is about the true human side of healthcare.

It is not disease or condition-based, but looks at how the uniqueness of the individual impacts not only their state of health but their willingness to make changes and to access the services that they require.

e reality is that people generally associate with those who are similar to them. ere is comfort in familiarity. e question that I encourage you to ponder is about the judgements that we may apply to individuals who are di erent than we are, whether that di erence relates to culture, religion, sexual preference or socioeconomic status. To what degree do you associate "di erent" with good or bad? As naturopathic doctors we often spend hours researching and studying about medical conditions and treatments, but how much time do we invest in understanding the strengths and challenges of others and how those factors can impact a person's health and healthcare?

Each distinct group typically shares a unique language, common terms and acronyms, acceptable traditions and behaviours, as well as common health challenges or disease conditions. Spending time learning these nuances, the accepted terminology and their importance is a beginning step to being able to assist an individual in their journey to health.

For this edition, we have chosen to explore the challenges of cultural diversity by providing articles that delve into Aboriginal history in Canada. A detailed article written by Dr. Johanne McCarthy, ND and an interview of naturopathic doctor and native healer Dr. Jeanne Paul explore the importance of ritual, culture and understanding a group's history. Some of the traditional Aboriginal forms of healing are also reviewed.

e obstacles facing lesbian and bisexual women who choose to navigate the process of family creation is provided in an in-depth article by Dr. Urszula May, ND. For this group there are many more decisions to be made, often without a lot of guidance from knowledgeable health practitioners. e process of conception is more complicated for this group and this group often faces discrimination, lack of understanding and unfairness in the healthcare system.

e ability to truly treat the body, mind and spiritual aspects of transgender people is critical and often hard to come by for this population. e article by Dr. Que Areste, ND succinctly provides a better understanding of terminology and some of the challenges and obstacles faced by transgender people and how naturopathic doctors can embrace this population with compassion and professionalism.

Socioeconomic status has the greatest impact not only on health, but often on naturopathic services. e opportunities and challenges of community health care centres are explored, as well as questions that can help to uncover the degree to which socioeconomic challenges are impacting health or the ability to access adequate healthcare. ere is often a stigma associated with poverty, which can have an impact on the ability of those who need care to reach out. Dr. Jennifer Hillier, ND very nicely articulates the sensitivity and knowledge that practitioners require with respect to socioeconomic challenges.

e naturopathic profession is diverse, with practitioners from many di erent ethnic, cultural, religious, sexual preference and socioeconomic backgrounds. However, the wealth of information within our profession is often underutilized. I encourage you to explore your own beliefs about and level of comfort with di erent groups, to question any judgements or prejudices that you might have and to consider the therapeutic value of learning more about people versus diseases. Building a strong referral network within the naturopathic profession is an important goal that will strengthen not only the profession, but the treatment options for our patients.

As always, we welcome your feedback on this edition of the *Vital Link* and any ideas that you have for future editions. Enjoy.

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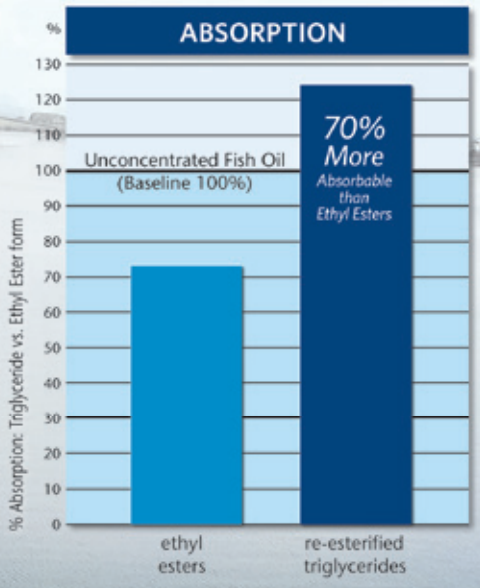

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—Tori Hudson, ND

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1. Dyerberg J, *et al.* Bioavailability of marine n-3 fatty acid formulations. *Prostaglandins Leukot Essent Fatty Acids* 2010 Sep;83(3):137—141.

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Four Corners: Updates on the Profession

Canadian Association of Naturopathic Doctors (CAND) www.cand.ca

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Every two years the CAND hits the road and brings Health Fusion to a di erent Canadian City. We selected Calgary as our 2011 conference venue and welcomed delegates from June 24 to 26 to the beautiful Hyatt in the heart of downtown. Our biennial congress has earned a reputation for connecting naturopathic doctors from across North America and presenting an unsurpassed and well-organized program and speaker line-up. is year we introduced two new elements into the mix: first, a well-attended public event with Dr. Rick Smith, PhD, scientist and executive director of Environmental Defence. Rick's session delivered in a most good-natured and humourous fashion a checklist of important ecological considerations for the everyday. Health Fusion also featured an afternoon business course that featured four diverse sessions o ering an array of practical advice about expanding and sustaining the growth of a healthy and highly functional naturopathic practice. Over 50 exhibitors greeted our eager delegates during the extended trade show hours and the CAND was pleased to welcome both longtime and new corporate supporters to the naturopathic marketplace. From the scientific and energetic exchange, highly-praised food, early mornings and unforgettable gala dinner, the CAND is honoured to have had the opportunity to host our delegates, exhibitors and speakers.

In advance of Health Fusion, the Canadian Naturopathic Coordinating Council (CNCC) met in Calgary to share news of recent events and review current issues facing the Profession. As so many of the provinces and territories are engaged with government on creating or updating regulatory legislation, the meeting provided an opportunity for all parties to share strategies, information on drafting appropriate bills, bylaws and regulations and communicating e ectively with government. Forward momentum is taking the profession ever closer to regulation in all jurisdictions. Watch for updates in the monthly e-Link e-newsletter.

e CAND's work at the federal level continues with ongoing participation on the Program Advisory Committee for the NHPD, submission to NAPRA supporting removal of all natural health products from the National Drugs Schedules, and dialogue on access to substances and the definition of practitioner with the Legislative Modernization Directorate, Bureau of Controlled Drugs and Substances and the O ce of Policy Development. Given the government's focus on the economy it is not yet clear whether we will see a return to the House of a bill proposing amendments to the Food and Drugs Act.

Interest in the new public-facing CNF website ExploreYourHealth.ca continues to grow. Linking it to your clinic website can assist in drawing new patients to your clinic and further educating Canadians on the value of naturopathic medicine. Our public outreach campaign is multi-pronged and includes social media with both the CAND and CNF on Facebook and Twitter (@naturopathicdrs and @XplorYourHealth), drawing increasing attention to naturopathic medicine across Canada.

Our busy fall season includes our having joined Canadian and American colleagues in Milwaukee for meetings of the CNME, NCC and AANMC and held our Annual General Meeting during which we outlined our goals for the future and shared our successes and financial stability during the past year.

American Association of Naturopathic Physicians (AANP) www.naturopathic.org

@aanp • facebook.com/theAANP

e American Association of Naturopathic Physicians is a mission-driven organization. Inspired by our members' desires, the Board of Directors defines its priorities from which a sta created work plan is designed. Our work is focused in three areas; expanding consumer awareness of naturopathic medicine, expanding state and federal recognition of naturopathic medicine and providing the tools our members need to be successful in their practices. For us, success in each of these arenas requires we aspire to the highest standards of naturopathic medicine. To that end, we are holding our members accountable for maintaining a valid license to practice naturopathic medicine from licensed states and provinces, even if you practice in an unlicensed U.S. jurisdiction.

Why is this so very important? Holding a valid license to practice accomplishes the following:

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While there remains the rare exception (if you are a member of a state association that does not require holding a license for full membership) if you choose to join the AANP you will not be listed on Find an ND. For the AANP, it's about public safety and accountability.

NDs and students also lobbied for equity in education, seeking access to loans, scholarships and a new primary care residency program created in the Patient Protection and A ordable Care Act. Currently, the federal government funds all residency programs for MDs and DOs. is program is unique in that it is funded through the Public Health Service Act and is specifically designed to increase the number of primary care providers, not specialists.

e law currently allows only MDs, DOs and PAs to access the program.

Council on Naturopathic Medical Education (CNME) *www.cnme.org*

e Council on Naturopathic Medical Education accredits naturopathic doctoral (ND) programs in Canada and the U.S., and graduation from a CNME-accredited or pre-accredited ND program is a requirement for taking the NPLEX exam and becoming licensed or regulated as a practitioner.

ere are two key aspects of the accreditation process:

- Each CNME-recognized ND program must submit an in-depth report (called a "self-study report") describing its approach to naturopathic medical education and how it meets CNME's accreditation standards and requirements; and
- Following submission of the self-study report, the CNME sends a four-person team to the ND program's campus to conduct an "evaluation visit" and report back to the Council on the ND program's compliance with standards.

is rigorous process is designed to promote high quality naturopathic education that produces well qualified practitioners who can e ectively serve their patients; more broadly, it also helps to establish the credibility of natural approaches to health and wellness in the eyes of the public. e Council is in the process of reviewing the requirements for the self-study report and the procedures governing the evaluation visit in order to improve the thoroughness and consistency of our accreditation process.

Currently, the CNME accredits two programs in Canada and four in the U.S., and also pre-accredits one program in the U.S. We invite practitioners who are potentially interested in becoming involved with the Council's important work to contact the Council.

Association of Accredited Naturopathic Medical Colleges (AANMC) *www.aanmc.org* *@AANMC*

AANMC took an historical step in September, launching a new central application system, Naturopathic Doctor Centralized Application Service (NDCAS), for prospective students. Furthering its mission to make naturopathic medical education accessible to an increasing number of qualified students, AANMC is now accepting applications online for fall 2012 programs at the following four of the seven accredited schools.

- Boucher Institute of Naturopathic Medicine, Vancouver, British Columbia
- Canadian College of Naturopathic Medicine, Toronto, Ontario
- Southwest College of Naturopathic Medicine & Health Sciences, Phoenix, Arizona
- University of Bridgeport College of Naturopathic Medicine, Bridgeport, Connecticut

Naturopathic medicine joins virtually every health profession requiring a graduate degree in enabling prospective students to manage their application process online. NDCAS will streamline and simplify the process for students applying to multiple schools, and enable them (and their academic advisors) to monitor the progress of their process online. ose who apply through NDCAS submit only one set of transcripts, essays and reference letters.

e application may be completed all at once or over multiple sittings, and the single application fee is payable via e-commerce transaction. Students will continue to apply directly to Bastyr, NCNM and NUHS.

We know that our best ND-candidates are encouraged to apply to naturopathic medical school by practicing NDs. Visit the website (https://portal.ndcas.org) today and share it with your friends, family and patients. Be a part of our collective e ort to grow the naturopathic profession.

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What Will it Take? The Effects of Cultural and Socioeconomic Status on Health

Dr. Denis Marier, MA, ND

The Canadian healthcare system is based on the premise of equal and respectful healthcare for every Canadian citizen, regardless of socioeconomic status, race, religion, gender-identification, sexual orientation, age, or disability. Then why are so many of our marginalized populations struggling to get even their basic health needs met, while professional sports teams jump the queue at the first sign of a pandemic requiring a flu shot that is purported to protect the elderly, immunocompromised, and infants?

Why are rates of HIV infection, tuberculosis, and diabetes doubling at a faster rate on our First Nations reserves than in major cities? Why are gay and lesbian couples wishing to artificially conceive facing longer wait times and increasing costs?

e history of marginalization of distinct populations within Canada's cultural milieu is a shame we can no longer perpetuate. In 2008, Prime Minister Steven Harper's apology on behalf of the government of Canada to all former students of Indian Residential Schools in Canada was a good start to correcting degrading of our First Nations people, but fell far short in addressing the pervasive health and socioeconomic crises a ecting this population. is same Prime Minister also strived to rescind the rights of LGBTQ couples to legally marry in Canada after those rights were granted in 2004. With such lack of discernment at the level of national leadership, it becomes imperative that socially and publically established professions, such as ours, strive for equal rights and access to healthcare for all Canadian citizens. Canada's role in providing global assistance to impoverished nations is exemplary, but improvement in caring for our own citizens – whether elders or the next seven generations – has primacy that is ethically imperative.

Naturopathic doctors are philosophically governed to treat the whole person: body, mind, and spirit. In no other modern healthcare profession is this more abundantly emphasized. In going back to the origins of healthcare, it was Hippocrates who urged his students to visit patients in their home, to get a feel for the conditions in which they live, and which may be a ecting their health. In my practice as a consultant to the Hospice of Windsor and Essex County, I am often asked to make home visits for initial consultations. Not only does this a ord me a wealth of information regarding the emotional climate of the home, the physical conditions, and opportunities to witness my patients' support network, it also provides an opportunity to ask to look inside their refrigerators and pantries, to get a firsthand look at the staples of their diet. In home visits, patients tend to be more at ease and open with their thoughts and feelings, including the stressors that are impacting their health in a negative way. rough a grant from the Green Shield of Canada Foundation, I was able to initiate a two-year pilot project in providing initial and follow-up consultations to patients of Hospice which was accessed by a large number of clients. Yet, at the completion of the pilot project, this valuable service, like so many in other areas, was not continued due to lack of coverage.

While the idea of sliding scales, reduced rates, barter systems, energy exchange systems, or pro bono work seem like an option, they are unsustainable in the long run for the community-minded naturopathic doctor, and are mostly not permitted by regional and federal governing bodies. How can we, as primary healthcare providers, lobby the national healthcare system to help subsidize naturopathic medicine? What will it take? ere are many resources to access in every community for pilot projects, such as the Green Shield project, and I encourage every ND to approach their local charitable foundations; and don't forget about the big businesses. Every major bank in Canada has a civic mandate to fund local community improvement projects.

Working within the community as primary health-care providers, naturopathic doctors are in a position of trust and a position of power. is is a relationship that cannot, under any circumstances, be underestimated, taken for granted, nor transgressed. We have the honour of confidentiality and the expectation of respect to treat every patient that crosses our thresholds with esteem and reverence for the simple fact that they are looking to us to bring balance and wellness into their lives. When sharing their personal stories of angst, illness, conundrum, or physical infirmity, our patients look to us for non-judgmental guidance on bringing their physical wellness into alignment with their emotional and spiritual welfare. It is our imperative to treat every heartbeat we encounter with unconditional acceptance, respect and love. is is the role we have to take; it's the right role to take.

e "Out and Aging Project" in Windsor, Ontario (a satellite program of the 519 Community Centre in Toronto, Ontario) holds workshops for agencies dealing with aging

populations on care and consideration for aging members of the LGBTQ community. Compassionate healthcare workers participating in this program acknowledge the practitioner's need for sensitivity with this population. In contrast, however, it is saddening to know that there are patients who feel unable to access grief services after the death of their same-sex partner "because it just isn't safe." What will it take?

As a CCNM intern at Anishnawbe Health Toronto, I was invited to participate in ceremonies with my patients, and encouraged to explore my own First Nations ancestry. A whole new world of healing was opened up to me which gave meaning and purpose to my training as a naturopathic doctor. I participated in sweetgrass harvest ceremonies and smudged before the start of each clinic with my peers and my supervisor, Dr. Al Denov, ND. And then I listened to stories of drug addiction, sexual abuse, alienation and soul-loss, and wondered, "What will it take?" Everybody and every demographically distinct population has so much to teach us, if only we take the time to listen and learn.

Last night I made a home visit to the home of a quadriplegic patient on disability assistance while his home-care nurse changed the dressing in a festering peri-anal fistula tunneling 5 cm into his pelvic cavity which started as a simple pressure sore four years ago. With naturopathic care, the wound has now begun to show signs of healing, and I was grateful that we have a health-care system that allows for daily home-care for this patient. But weakened by a consistent onslaught of antibiotics, and without adequate timely guidance by a provincially-funded primary health care provider, I left saddened and wondering, "What will it take?"

As naturopathic doctors, we take our cues and harvest our cures from the natural world. Whether observing a wounded stag standing in a cold mountain stream, or diluting poisons used in treating syphilis, our naturopathic ancestors opened the portal to a system of healing that encompasses all the various wonders of human existence, sickness, healing, birth, and death. In nature, a leaf grows from its edges, not its centre. As naturopathic doctors, working with the populations that are marginalized – those people living on the edges – we are growing into the paradigm shift necessary in current medical philosophy; to treat the whole person, regardless of socioeconomic status, disability, gender-identification, sexual orientation, race, age, and religion. It is in these transitional zones, such as where the continental shelf meets the deep ocean, that life is most abundant and emerging – from where our ancestors first crawled onto land. And it is this concept of "emergence" – the unpredictability of outcome – which will guide us into a future of healing a broken society on all levels – body, mind, and spirit.

e Canadian healthcare system has many positive qualities, and is the envy of many nations in our global community. But it cannot grow without acknowledging its shortcomings, mistakes, or the areas in which it can improve.

is is simple accountability. Accountability to any system begins with each primary healthcare provider and his/her individual relationship with each patient.

As NDs, we are trained to treat the root cause of each illness. Perhaps, as Canadians, we have been lulled into submissiveness by the original premise that we should trust a national, socialized healthcare program. But isn't that the root cause of our current problem? How can we trust when we encounter blatant disregard for human welfare at the provincial and national levels of healthcare reform consistently? How can we trust a national healthcare system that states that a two-tiered healthcare system does not exist in our own country, while our patients struggle to pay out of pocket for consultations with NDs and naturopathic products? As a practitioner in a border city, I listen daily to tales of cross-border shopping for healthcare, where patients receive what amounts to a 40% discount on services (MRIs, oncology consultations, etc.) when paid for in cash at a medical facility in Detroit, Michigan. ese patients are seen by a medical professional in Michigan within days of making an appointment, yet the same tests and consultations are postponed for weeks or months just one kilometre away here in Windsor, Ontario. So, what will it take?

It is going to take a coherent and organized healthcare profession of grassroots naturopathic doctors respecting each and every patient with equality, fairness, and humane guidance towards wellness, regardless of outcome. It is going to take a consistent message and practice of a patient-centered medical paradigm shift across all disciplines. Naturopathic doctors are the leaders in integrative medicine, the ambassadors to the other healing professions, and we need to invite all to celebrate diversity within our communities and strive for universally accessible healthcare without limitation, bias, or disregard for what we all have in common – basic humanness, interconnected with each other, and with our environment.

About the Author

A graduate of CCNM Class of 2000, **Dr. Denis Marier**, MA, ND has brought a wide array of medical travel, relief-work and Ecopsychology teachings to his clinic in Windsor, Ontario. He taught the Art and Practice of Naturopathic Medicine for several years at CCNM, where he was also a TA for Health Psychology, and supervisor at the RSNC. He has co-facilitated trainings in Core Shamanism, and is a trainer for the Out and Aging Project in Windsor. Dr. Marier has also recently been named to the Advisory Board of the International Network of Integrative Mental Health and is a two-time nominee for the Dr. Roger's Prize for Excellence in Complementary and Alternative Health.

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Dr. Jeanne Paul, ND, Medicine Woman

Dr. Isis van Loon, ND

Dr. Jeanne Paul is a naturopathic physician and a traditional healer. She is a member of the Sliammon band whose traditional lands are near Powel River BC, and she is a graduate of NCNM, class of 1991. She has a particular focus in traditional plant medicines, and this year won the University of BC's prestigious Aboriginal Capacity and Development Research Environment (ACADRE) award for her work on "Traditional Healing Knowledge and Practices with a concentration on native wild crafting and how to make medicines." She has recently realized her long time dream of founding a college of traditional medicine. This interview took place at her home in rural Chilliwack, at the foot of the coastal range mountains.

Isis van Loon: What was your early life like?

Jeanne Paul: I went to two Residential Schools in my first 12 years of education. As I was the sixth generation since acculturation of native people there was not that much left of our culture. We were separate, couldn't go into town to go to hospital, or school.

ey (the dominant white culture) did accept our money to buy groceries… It is a long story of having been a people that were not accepted.

It was compulsory for all Native children to attend residential school. Fortunately I came from a very powerful mother who believed in education. She told me: "Although it's not good with the white people, you still need education." Residential school was very di cult for me at the beginning because I only spoke my language.

I am Coast Salish Tribe from the Sliammon Band and we speak the Sliammon language. ere are many languages spoken within the Coast Salish Tribes.

IvL: What brought you to naturopathic medicine?

JP: By the time I came along there was no understanding of medicine really in terms of what was in our "Back 40", because (the knowledge) all was gone. Only after many, many years of my own study, and going to naturopathic school where I specialized in botanical medicine did I really understand what our people had. How our people used it as their first medicine.

is is how I started out wondering: wouldn't it be nice to go to

a place and learn all these facts about health? And what do you know, there was such a place. Dr. Joseph Boucher introduced me to that, a place that you could learn alternative healthcare to match the basic philosophy that I had in me and what I was trying to find, the cultural background of my people. I found in studying there were people who were already doing traditional medicine in Canada and the United States. Traditional medicine for native people was making teas, always teas. To learn that there are other forms of making medicine other than water/tea was a big eye opener for me.

I graduated from NCNM in 1991, at the age of 51, which was quite an accomplishment. My health was shot to hell from the stress of school. I always think it is ironic to go to medical school to get the sickest in your life. I think now is the best I ever felt in

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1. Sun, QQ; Xu, SS; Pan, JL; Guo, HM; Cao, WQ (1999). "Huperzine-A capsules enhance memory and learning performance in 34 pairs of matched adolescent students.". Zhongguo yao li xue bao = Acta pharmacologica Sinica 20 (7): 601–3
2. Shulgina GI (1986). "On neurotransmitter mechanisms of reinforcement and internal inhibition". Pavlov J Biol Sci 21 (4): 129–40

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my life, 25 years later. It keeps getting better and better as you find yourself.

I am very fortunate with the education I have had as a naturopathic doctor, I specialized for five years in botanical medicine (at NCNM). We never went out to see what the plants looked like, this was missing with my training. It was only after I left school that I ran around in the woods to see what the plants looked like.

is is why when I teach we go out to see what is out there.

IvL: So you took the route of naturopathic medicine to go full circle?

JP: Yes, that is exactly the word. Going full circle, finding about medicines in a very traditional way. Do traditional medicines fit into the western mode of healing? ey do. You don't throw out the baby with the wash because you are so anal about drugs and about your idea of medicine. If you need your drugs to survive then you should do that. I have that much respect for life. ere are other things you can do, of course that is what naturopathic doctors do: help encourage the body back to health by all these di erent therapies that we know and have been trained in, especially for me the use of traditional medicines.

I have chosen some very, very important medicines that are out there that are number one for me: elderberry is my big sister, and devil's club is my big brother.

Elderberry we call *ewaquo*. My mother would say "Jeanne, it's out, you go pick me a jar." She didn't know what it was for but she knew we always had to have a jar. One jar. She would can them, on the stove, with lots of sugar, which is called a rub. Elder opens all your tubes. I really stress that to my students when we are picking it in March. If we take care of ourselves by drinking elderberry tea, this is the naturopathic philosophy of prevention.
Devils club: All the bands I have spoken with know about devil's club. All these various bands seemed to understand devil's club was used for "Ahhahum" in my language which is soreness in the joints. Everybody drank it for their arthritic conditions. I am very fond of devil's club. It has a lot of uses and its actions are mainly anti-inflammatory.

IvL: How do you define healing, and what is healing to you?

JP: I have looked a lot into 'what is healing?' I went to di erent churches, talked to di erent groups of people, traditional healers – medicine men they called them at that time. No one could really give me an answer. I have come to find out that healing was within myself. It had to come from myself and I used my training as an ND to encourage what I felt within myself. I learned two main answers to my question. How did our people know what plants to use if they were in the woods and they walked around and saw something? People aren't stupid enough to eat it to see if they are going to die… there is something innate about it, they watched the birds, and the animals. Basically, what I discovered was the doctrine law of signatures. Whatever the plant looks like is what it is going to heal. at knowledge is innate in all of us, as a people.

e second answer is more spiritual. I only learned this when I had decided I didn't want to pursue anyone anymore – medicine people, books – I gave them up. I had a spiritual experience and I found my answer. I was wide awake, I experienced something that is very di cult to describe. When it was over, I knew what I was supposed to be doing – I was told by this experience, "this is your job." At first, I really didn't want it, then I found that my practice changed. I knew what to do. How do you know? It's in your soul. It's not me at all, I watch the healing… I am a conduit between the spiritual powers, like an electric cord, I am in between. It is such an honour for me to watch people heal.

Considerations for NDs Working With First Nations

For NDs interested in working with first nations, one can apply as a doctor to service their community. The band will hire you and then people of that village make appointments to see you.

If you are not affiliated with a band and a first nations person comes to see you, advise the patient to ask their individual band to see if they would cover your services and tell them the amount. The patient would consult with her band to see if they would cover your services. Otherwise they would have to pay out of pocket. Many can't afford our services because ND coverage may not be on the plan. So, I did a lot of trades, with fruit, veggies and fish. I always had a lot of fish in my freezer. Of course many of the natives have good jobs so they would be able to pay your costs.

I realized that the basis of all healing is to capture what has been lost. I have found this through lots of people I have worked on. When trauma has happened to you, you leave a part of your soul there. Either you leave it there or somebody selfishly, evilly took it from you. at is what healing is for me now, capturing parts of a person's soul that have been lost and giving it back. But how is a healer really able to give it back to another person? at person has to do their journey too.

For example, giving back their childhood to a person changes everything. It follows Hering's Law of Cure, like playing your LP record from the backwards to the core… It eats away at that LP record of tunes that have happened to you. It works at all the levels – mental, emotional, physical – at once.

Not everybody believes this kind of thing, but finding lost parts of peoples' souls is very important. You are not defined by what it is that has dragged you down.

IvL: And what are you planning now?

JP: Now in my semi-retirement I have decided to dedicate my life to traditional medicine making, looking for these brothers and sisters out in the woods to use as medicines. ere is so much interest now in traditional medicine in all forms because we are finding our voice as a nation and as a people, and realizing that we do have something to contribute to the world and to ourselves. ere is big interest in learning how to make medicine, and it fit in with my interests to open a college of traditional medicine for as many of the native people that want to learn how to continue this important work.

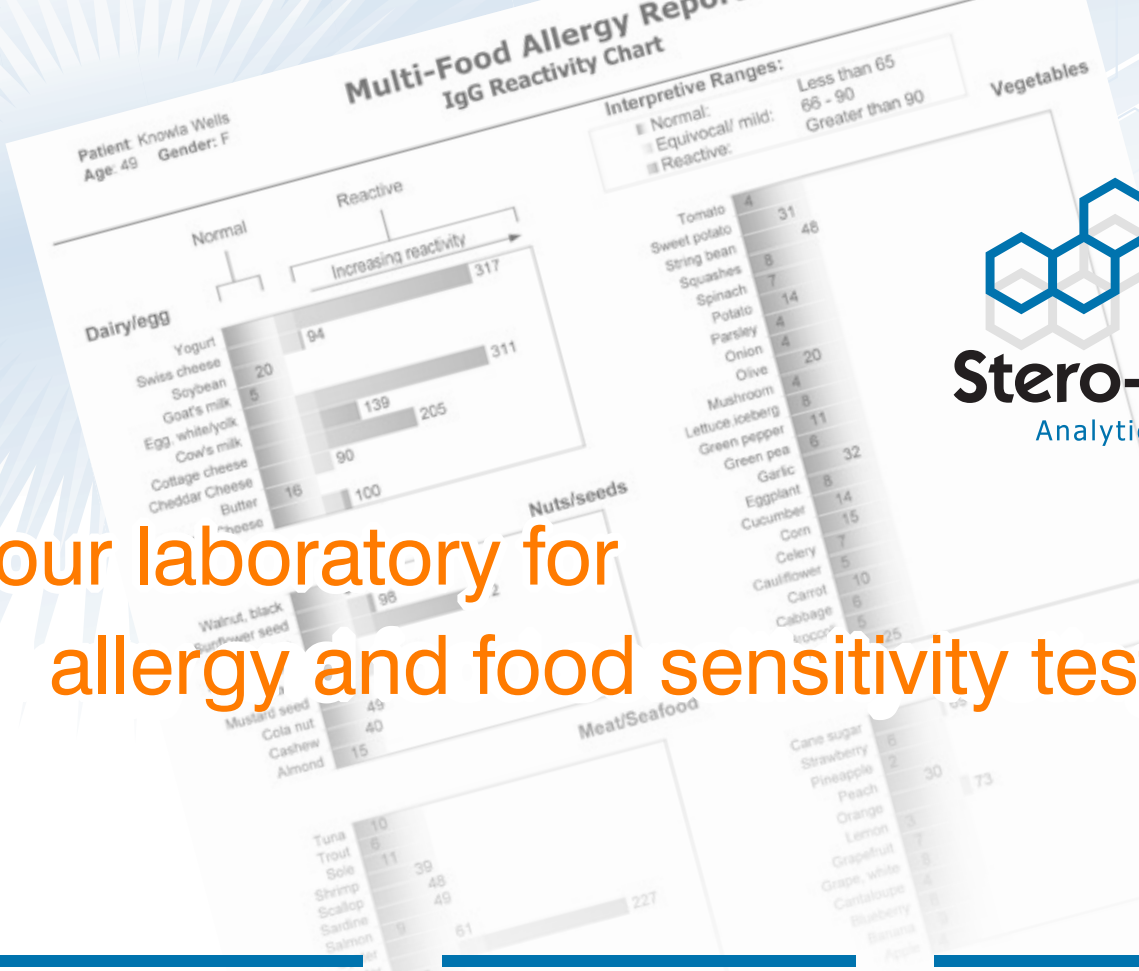
I work for Seabird Island. ey are very progressive. ey really want to encourage the culture of the bands under their umbrella. I was originally hired to help teach herbal medicine as part of breast cancer research last year. I travelled around to the 11 bands, and I spread my time working with whoever would come. ere were people that would follow me as I visited each of these bands.

I graduated 10 students in June. at is how it started. en Seabird Island approached me and asked if I would be willing to start a college of traditional medicine in the village. Of course I said yes - this has been my dream for 40 years. e first lecture was held on September 22.

What is unique as an ND and having a medical background is that I am able to incorporate the body systems with the medicines. In the first lecture we study the musculoskeletal (MSK) system, then two days later we go out and study the plants that a ect the MSK system. In a basic way we study biochem and anatomy so that they have some background as to what is going on before they are able to make a formula. Before people learned by "this medicine, Gramma says it was pretty good for cleaning you out." Now they know why it works because of the chemical composition. I want the students to understand this. In that sense my teaching is unique, and not just a cookbook thing. People appreciate that indeed there is some thought behind the teaching and not just "pick this, it's good for you."

I will do this as long as I can, while I still have grey cells working and I still have the energy – which I have a lot of – and I still can think. e interest in traditional medicine, especially in herbal medicine is catching on with all the bands. Just this week I received two phone calls which relate to this. ere are two forthcoming conferences on traditional medicines where they want to hear something about mental, emotional, physical and spiritual medicines. It's really good to hear that you want to incorporate the spiritual aspect to the whole healing process. Isn't that what we are all about as naturopathic doctors, we look at the whole person and not just the sick part of you?

I am very happy with the direction of my life which has given me happiness, peace and joy. I am still fulfilling my every dream. What more can anyone want? And thank you for allowing me to share this with you.



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Working as a Naturopathic Doctor with the Transgender Population

Dr. Que Areste, ND

Most people living in western societies believe there are two genders: male and female, whereas many other cultures have long recognized that there are more. At a North American lesbian, gay bi-sexual, and transgender (LGBT) health conference I attended 15 years ago one aboriginal speaker mentioned that in his culture nine genders are recognized.

Throughout human history there have been those who do not fit into the male/female dichotomy. e idea that one can identify as having a gender other than that which they were born is slowly becoming more acceptable in some North American communities. However, there is still a stigma attached to questioning the dominant gender paradigm.

Transgender is the term referring to any individual who expresses or identifies their gender di erently from the gender assigned to them at birth. Although it is a small community it is quite diverse. It includes but is not limited to transsexuals, male to female (MTF or trans-woman) and female to male (FTM or trans-man), people who identify as gender queer, drag queens and kings, people who cross dress either fully or partially, and two spirit people.

People who identify as transsexual are not comfortable living as their birth gender. ey will often state that they feel trapped in the wrong body. ey may or may not fully or partially transition to their preferred gender. For many reasons people who identify as gender queer often to not want to fully transition. Few transsexual people will transition fully either, but are more likely to have some surgery and take appropriate hormones on a regular basis. Many FTM transsexuals will have their breasts removed. Building a functional penis is di cult. If the trans-man is heavyset it is virtually impossible. Many trans-women will have breast implants, fewer will have the testicles removed and fewer still have the entire surgery including vaginal implant done.

One aspect of hormonal transition is safety. All women who take oral forms of estrogen are at greater risk of blood clots and trans-women are no exception. I prefer using injectable forms of hormone both for my transsexual population and genetic women and men who need hormones, however, one of my patients who began to transition later in life had great di culty injecting herself so I have her on oral estrogen. is particular trans-woman comes to me every 2-3 months just to talk about things her other health care practitioners wouldn't understand. As an ND I have the time and training to listen.

One requirement for receiving hormones to transition from one gender to another is a letter from a therapist stating that the therapist has worked with the individual for a period of time and that this person is a candidate for gender reassignment therapy including hormones.

One of the youngest transsexual patients I have seen is 20 years-old. He came to me with his mother and her partner. Although his parents are divorced they are both supportive of his transition. He had been taking his father's Androgel but had stopped before seeing me. As he wanted to continue using Androgel I prescribed it for him, as he did present the letter from his therapist, but I also spent time going over the risks of transferring testosterone to other people and wrote out for him the precautions necessary to avoid that. A month later he decided to change to injectable testosterone. I have worked with him to optimize his dose and timing.

It is becoming more common for parents to be supportive of the gender transition of younger children. Although the younger a person is when they transition the more complete the transition will appear, most children who state that they are really members of the opposite gender later become quite comfortable living in the gender they were assigned at birth. ere are some children who are fluid as to gender, neither wanting to always be male or female. ere are medications called gonadotrophin-releasing hormone (GnRH) inhibitors that have been used for many years in North America to treat precocious puberty and in countries like the Netherlands to stop puberty in children who may be transsexual. ey can be given to a child who thinks they are in the wrong body and may be truly transsexual. Growth will slow as will cognitive development triggered by adolescent hormones.

ere do not appear to be any side e ects and within six months of discontinuation they will catch up with their peers. When the child decides for sure that they want to transition they can begin appropriate hormone treatment and discontinue the GnRH inhibitors.

I treat a trans-man and his wife, a genetic woman. Last time I saw him he mentioned that his libido was gone and that he had experienced spotting. When I asked him about his testosterone dosing he turned out to be taking a smaller dose than most trans-men take and he is a big guy. I told him to raise the dose. If his libido is still low or he is still spotting I may give him

an aromatase inhibitor as testosterone is metabolized to estradiol via aromatase. ere are two plant derived aromatase inhibitors, Myomin, a combination of the herbs Smilax glabra, Curcuma zedoria, Cyperus rotundus, and Aralia dasyphylla; and Chrysin, a naturally occurring flavinoid extracted from blue passionflower.

I treat a trans-man for his asthma and allergies. Recently we taught him Buteyko Breathing. Many people are able to take lower doses of many medications when their breathing improves, so I told him that in a few months to a year he may need to reduce his dose of testosterone and other medications he uses.

ere are many considerations a naturopathic doctor needs to be aware of when treating transsexual people. Because the liver metabolizes hormones, periodic liver function testing is imperative. Trans-men usually need regular PAPs and Pelvic exams. ey often no longer have a uterus or ovaries but usually have a vagina and cervix. Trans-women need mammograms, even if they have breast implants as they are now taking estradiol. ey also have the same health issues as everyone else. ey just need a non-judgmental physician to work with, one who is aware of their whole self, not just one dimension. Trans-men need much higher doses of testosterone and trans-women need higher doses of estradiol than genetic people do, so bioidentical hormone replacement therapy (BHRT) is not often used. However, some trans people don't do well with hormone replacement and BHRT or some botanical therapies with plant versions of hormones may work better for them.

Many herbs and foods are thought to contain hormone analogue. Some actually contain small amounts of estrogens such as the estradiol in pomegranate, while others are converted by some into estrogens; for example, soy isoflavones (although highly converted by Asian women, soy isoflavones are poorly converted by Caucasian women). Herbs including alfalfa and licorice are known to be estrogenic. Others, used for menopausal symptoms actually are not estrogenic, and operate via di erent mechanisms. Male enhancement herbs include tribulis which has several good studies and appears to enhance testosterone receptors in the brain. Another is tongkat, which has several good studies but is expensive and many companies (in the U.S.) sell an inferior product. Maca does not contain testosterone or estrogen, but it enhances natural production of these hormones. If a trans-male takes maca as a testosterone source, they might want to add Myosin as well to reduce the progression of testosterone to estrogens. However, the author has not used maca in this way.

Some transgender people, especially younger ones, will take black market hormones or their friend's hormones. Some gender queer people who are born female don't realize that some of the e ects of testosterone are permanent. It is part of good naturopathic care to inform them of this and to let them know the dangers of taking unregulated substances that have such a powerful e ect on our bodies.

ose who have decided to transition need counseling. As I mentioned above, they need counseling before they receive gender reassignment hormones. ey need to be clear of the realities of gender transition, and be realistic about what they can expect from the process. One thing many transsexual people don't think about is STIs. Before transitioning they may not have wanted to be sexual in a body they could not identify with. Trans-men taking testosterone do find they have increased libidos. People who have transitioned need to be counseled about safe sex and STI testing. People choosing to transition in the 21st century are fortunate that there are many resources available to them. ere are great websites and most large cities now have support groups for transsexual people. ere is also an international conference for transgender people called Gender Odyssey (see sidebar).

Resources for transgender care

Stephanie Brill, Rachel Pepper
e Transgender Child,
A Handbook for Families and Professionals
Cleis Press 2008

http://transhealth.vch.ca/resources/careguidlines
has current clinical guidelines

www.transhealth.ucsf.edu
also has primary care transgender protocols

www.firelily.com
Diane Wilson's gender transition website, including information from Gianna Israel a therapist and trans-woman

www.genderodyssey.org
Gender Odyssey Conference

www.hrc.org/transgender/issues
Human Rights Campaign

About the Author

Que Areste graduated with her ND from Bastyr University when it was still known as Bastyr College, in 1993. She also got her MS in Acupuncture in 1992 from Bastyr University. She started her practice in a group o ce, New Health Medical Center, in Edmonds, WA and was able to move into her own o ce two and a half years later. She has had a small solo practice since then, treating a variety of people from newborn babies to those in their 90s. She works with students from Bastyr University as a preceptor most quarters. She has known a number of transgendered folks since she was in her 20s and has worked with that population since she began volunteering at a LGBT health entity called Verbena, which folded a few years ago.

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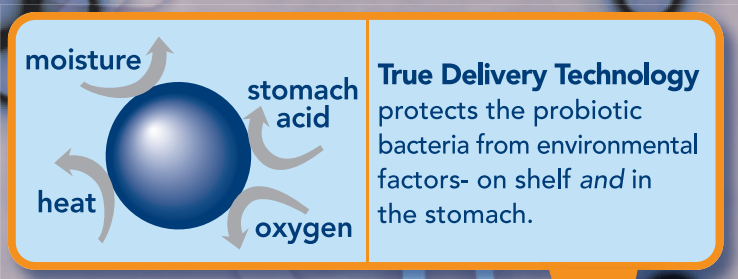

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Developing Cultural Competence: supporting lesbian and bisexual women during the process of conception

Dr. Urszula May, MHSc, ND

Family planning for lesbian and bisexual women (LBW) is a process of negotiating among numerous participants, sources of information, resources and services, technologies, drugs and expertise.[1]

The LBW population will often have significant contact with the healthcare community throughout the intimate process of creating a family, despite the fact that they seek assistance with conception rather than infertility. Lesbian and bisexual women who choose to use Assisted Human Reproduction (AHR) to conceive have needs and experiences that are uniquely di erent from those of heterosexual women navigating the process of family creation.

It is in our best interest as naturopathic doctors to become both familiar and knowledgeable in the treatment of LBW. When surveyed, this population reported that when choosing a healthcare provider, the factor they considered most important was practitioner competence.[2] For most participants in the survey, a practitioner's sexual orientation was regarded as less important than their training, experience and level of understanding of lesbians. Lesbian and bisexual women also have a history of interest in alternative medicine.[2,3] In a recent Statistics Canada survey report a statistically significant di erence was seen between LBW and heterosexual women with respect to alternative health care use. Interestingly, 31.1% of lesbians and 27.3 % of bisexual women reported having seen an alternative health care provider in the last 12 months, compared to 26% of heterosexual women.[4]

An examination of the process involved for LBW trying to conceive highlights the barriers and challenges experienced by this population, as well as the important changes all health care providers, including naturopathic doctors, can make in their practices to help provide LBW with high quality health care.

The Process

Lesbian and bisexual women attempt to achieve pregnancy either through intercourse with a male partner or though donor insemination. For those women who choose to pursue parenthood using donor insemination, it will be necessary to reach outside of their immediate relationship for the next phase of the complex decision-making process. e first choice is whether to use a known donor or an unknown donor. *Known* donors are known to the inseminating woman, her partner, or to a third party, whereas the identities of *un*known donors are managed by sperm banks. Unknown donors can be anonymous, meaning that their identity is protected by a sperm bank, or identity-release, meaning donors remain anonymous until the o spring turns 18 years of age, at which point the sperm bank helps to facilitate contact between the adult o spring and the donor. e semen samples of unknown donors will always be cryopreserved (cryogenically frozen) by a sperm bank or fertility clinic, and are rigorously tested both as fresh samples and after a 180-day quarantine period. Known donor samples can also be cryopreserved, for a cost, in which case they too will be tested, quarantined and retested. Cryoprocessing sperm therefore provides a level of safety not possible to ensure with fresh semen.

Once the donor type (known vs. unknown) has been chosen, the donor himself must be selected. If the choice is to use an unknown donor, the woman can select from a number of domestic and Canadian compliant international sperm banks. Canada has very stringent screening and testing requirements of semen donors, with only 3-5% of candidates satisfying all the requirements to be accepted.[5] Donor screening requires completing an extensive medical and personal questionnaire, passing a physical exam, a review of relevant medical records, a semen analysis, and testing for infectious and genetic diseases. Screening must include a CBC and urinalysis, as well as tests for many commonly sexually transmitted infections such as HIV-1 and HIV-2, HTLV-1 and HTLV-2, Hep B and C, CMV IgG/IgM, *Syphilis*, *Chlamydia*, *Tricomonas*, and *Gonorrhoea*. Additional genetic screening is performed by some sperm banks for conditions such as Tay-Sachs, hemoglobinopathies, thalassemia, and Cystic Fibrosis (CF). Donor profiles can be searched online for a fee, and include medical and personal information. Often adult photos, childhood photos, and audio recordings are available for purchase as well.

Human T-lymphotropic virus types I and II (HTLV-I and -II) are presumed to have derived from primate T-lymphotropic viruses with which they share significant nucleotide sequence homology. They are transmitted by sexual intercourse, by parenteral modes, and from mother to child (predominantly by breast feeding). HTLV-I has been causally associated with adult T-cell leukemia and HTLV-associated myelopathy. HTLV-II has also been associated with HTLV-associated myelopathy, but not with leukemia.

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Having chosen the donor, the next step is choosing a method of insemination. Women can choose home/self insemination or insemination at a fertility clinic, using fresh semen or cryopreserved semen or sperm. Cryopreserved samples can either be 'washed' or 'unwashed'. *Washed* samples have the seminal plasma removed prior to freezing. (Seminal plasma contains prostaglandins that cause uterine cramping), while *unwashed* samples are frozen without removing the seminal plasma. With home/self insemination, either fresh semen from a known donor or frozen and thawed semen (unwashed) or sperm (washed) from a known or unknown donor can be used. Health Canada regulations mandate that semen used for AHR be under the supervision of a physician.[6] Frozen sperm for use in home insemination must therefore be released by a physician to their patient.

If the woman chooses to use the services of a fertility clinic, several additional options are available for 'how' insemination will take place.

Fertility clinics provide intravaginal insemination (IVI), intracervical insemination (ICI), intrauterine insemination (IUI), and In vitro Fertilization (IVF) services for their LBW clients. With IVI, sperm or semen is delivered via syringe into the vagina. With ICI and IUI sperm is delivered via catheter just inside the cervical os (ICI) or into the uterus (IUI). A lesbian or bisexual woman can use IVF to implant into her uterus her own fertilized egg, that of her female partner, or of an egg donor.

Now that the 'who' and the 'how' have been decided, the 'when' must be established. If performing a home insemination, women may simply try to monitor for their ovulation and inseminate at that time. If using a fertility clinic, the process can often be more complex. Fertility clinics' assessment of a woman trying to conceive typically consist of abdominal and trans-vaginal ultrasounds, a hysterosalpingogram or sonohistogram, blood work including CBC, TSH, hormone panel, Hep B, HIV, *Rubella*, *Chlamydia*, *Gonorrhoea*, CMV, blood type and factor, and random glucose. Additional drugs such as clomiphene (clomid) or HCG may be suggested to promote ovulation.

Insemination requires precise timing. Fresh sperm cells can live up to five days in fertile vaginal mucous, but frozen thawed sperm lives for only 12-24 hours.[7] Ovulation prediction and detection is therefore crucial to maximize the likelihood of a successful fertilization.

Heterosexism and Homonegativity

Some of the biggest barriers faced by LBW trying to conceive using AHR are heterosexism (the assumption that everyone is heterosexual unless they say they are not) and homonegativity (the discrimination towards people who identify as gay, lesbian, or bisexual) amongst health care professionals.[8] e Government of Canada Assisted Human Reproduction Act 2004 (AHRA) states that persons seeking to use assisted reproductive procedures must not be discriminated against based on sexual orientation.[6] e proclamation of this Act put an end to the practice of refusing AHR to LBW, but has not eliminated the culture of discrimination that continues to exist in many medical clinics. e persistence of heterosexism and homonegativity can be seen in forms that assume female and male partners, images posted in clinics of two parent heterosexual families only, and non-biological mothers or partners consistently being ignored by health care providers.[9]

Both anticipated and actual heterosexism and homonegativity amongst health care providers has been identified as one of the factors that deters LBW from reaching out to health care services.[2,4,10] When Canadian women were asked if they had had unmet health care needs in the past 12 months, only 14.8% of heterosexual women said they had, compared to 19.6% and 28.6% of lesbian and bisexual women respectively.[4] e unwillingness of health care providers to welcome family structures that di er from the prescribed social norm of heterosexuality can lead to 'lesbian invisibility' in health care.[2]

Research shows that fertility clinics have not typically provided a welcoming environment for LBW. LBW have been

Common tests performed on female patients at Canadian fertility clinics

- Complete Blood Count
- Hormone panel: Estradiol, Progesterone, Leutinizing Hormone, Prolactin, Free Testosterone, Androstenedione, DHEA, TSH
- Infectious Diseases: Hep B, HIV, HTLV, Rubella, Chlamydia, Gonorrhoea, Cytomegalovirus, Syphillis, Trichomonas palladium, Parvovirus
- Blood type and factor
- Random glucose
- Abdominal and trans-vaginal ultrasounds: to assess the size, shape and health of the uterus and ovaries, as well as monitoring follicular growth and ovulation.
- Hysterosalpingogram: A Radiographic procedure where radiopaque dye is injected into the uterine cavity through the cervix. If the fallopian tubes are open, dye fills the tubes and spills into the abdominal cavity. Uterine fibroids and polyps can be visualized on x-ray, and the patency of the fallopian tubes can be assessed.
- Sonohystogram: Similarly to the hysterosalpingogram, this procedure is used to visualize the uterine cavity and fallopian tube patency, however pelvic ultrasound and saline are used in place of x-ray and radiopaque dye.

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dissatisfied with the environment of the fertility clinics, describing them as 'homonegative' and unsupportive. e counselling services o ered by these clinics have been seen as directed toward heterosexuals, and are unable to address the unique health care needs of LBW.[11] An unfortunate consequence of this type of health care environment is that these LBW, tying to conceive, often lower their expectations from seeking positive experiences to simply seeking out tolerance.[2]

The Medicalization of Conception

Canadian regulations require that cryopreserved sperm be controlled by a physician.[6] Historically, LBW have not been the 'targeted users' of biomedical fertility services. Lesbian and bisexual women enter into a system designed to accommodate heterosexuals with fertility concerns, and are often transformed into fertility patients not (or not only) because of their physical conditions, but because of the conception needs related to their sexual identity".[1] LBW often feel pressured into multiple medical interventions (e.g., blood work, ultrasounds, medications) that are standard practice in infertility treatment, but may be unnecessary for them.[9,11] Lesbian and bisexual women bring diverse meaning to the label of 'infertility' and can perceive the medicalization of conception in di erent ways. For example, LBW may see the use of assisted reproduction as the reinforcement of heteronormative ideals, or, as a pragmatic way to meet one's goals. Whereas heterosexual individuals and couples are often dealing with negative emotions such as stress, failure and depression commonly associated with infertility,[12,13,14] many LBW trying to conceive experience donor insemination as a joyful process focussed on wellness and normalcy rather than disease and pathology.[1]

The High Cost of Donor Sperm Insemination

Currently the cost of purchasing cryopreserved sperm in Canada can range from $700-$900 per sample.[15,16,17] Add to this the cost of testing, processing, storing and inseminating the sperm, and the first round of insemination can cost as much as $1800. Some extended health care plans may cover a portion of these costs, but most will need to be covered by the patient. Lesbian and bisexual women trying to conceive must also take into account the cost of absence from their jobs, which, if they are undergoing cycle monitoring via blood work and ultrasounds, can be between four and ten mornings a month. e financial burden of a single attempt at cryopreserved conceptions can be quite significant, and clearly places home insemination with fresh semen as the most cost-e ective method of conception.

Recommendations for Change

e task we as naturopathic doctors face is how we can contribute in a positive and meaningful way to LBW's reproductive health care and experiences. e first step must be to examine our own potential heterosexisms and homonegativities, both on personal and professional levels. Lesbian and bisexual women have spoken of the importance of their health care providers normalizing lesbianism and bisexuality, providing positive support, and being "queer friendly/positive" or 'lesbian sensitive'.[2,8] We can learn from our midwife, doula and public health nurse colleagues whose lesbian and bisexual patients report high levels of satisfaction with their care.[11] ese professions not only provide health care, they demonstrate a willingness to act as patient advocates in their interactions with other health care providers.

Ross, Steele and Epstein (2006) made the following recommendations to help AHR facilities deliver culturally competent services to Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) communities, many of which can be implemented into naturopathic practices:

- Ensure that sta is trained to be culturally competent regarding LGBTQ needs
- Ensure that intakes and forms include and recognize di erent types of family structures
- Facilitate the involvement of all parties desired by the patients, including same-sex partners and sperm donors
- Incorporate inclusive language and treatment that recognizes that LBW access fertility clinics as part of normal family planning
- Provide cues that services are LGBTQ positive, including positive space imagery depicting LGBTQ families, and the use of gender-neutral language
- Make information available about local LGBTQ supports and resources

Many fertility clinics are missing the mark with culturally inappropriate counselling, and we can provide 'culturally competent' information based on an understanding of the unique issues faced by LBW using AHR services to create their families.

Finally, preconception is an area where we as NDs can flourish in providing care to our LBW patients trying to conceive. We can enter into discussions regarding the risks and benefits of donor choice (fresh semen from a known donor, frozen semen from an known donor, or frozen semen from an unknown donor), donor testing, as well as ordering sperm that is both Canadian Compliant and meets Health Canada's requirements.[18] We can help our patients make informed decisions regarding what interventions are in their best interest and are consistent with their known or presumed (in)fertility. Lastly, providing guidance on how patients can monitor fertility patterns and ovulation cycles, including changes in vaginal mucous, emotional states, basal body temperature and urinary LH surge detection, can be tremendously empowering for LBW using AHR, a medicalized process that for some can be perceived as principally under the control of others.

Lesbian and bisexual women have become knowledgeable about the reproductive possibilities associated with AHR and are seeking it out in order to conceive. Naturopathic doctors are perfectly poised to help our LBW patients achieve one of their greatest desires with a sense of empowerment and pride.

Glossary of Terms[6,9]

Assisted human reproduction (AHR): Any activity undertaken for the purpose of facilitating human reproduction. AHR can involve the prescription of ovulation-inducing drugs and intrauterine insemination, as well as assisted reproductive technologies such as *in vitro* fertilization, that involve the manipulation of both sperm and eggs outside the body in order to facilitate fertilization, and *in vitro* embryo transfer.

Assisted reproductive technologies (ARTs): e collective name for all procedures used to help people build their families through assisted human reproduction.

Bisexual: A person whose intimate, a ectionate, romantic or sexual feelings may be for people of any sex.

Homophobia/Homonegativity: Irrational fear and/or hatred of, aversion to, and discrimination against people perceived to be gay, lesbian or bisexual.

Heterosexism: e assumption that everyone is and should be heterosexual, and that heterosexuality is the only normal form of sexual expression for mature, responsible human beings

Lesbian/gay: People whose primary intimate, a ectionate, romantic or sexual feelings are for people of the same sex. e term **gay** is sometimes used to refer to both men and women, although many women prefer the term **lesbian.** Both words describe more than sexual orientation; for many lesbians and gay men they also reflect a sense of community, shared history, culture and experience.

LGBTQ Cultural Competence: A deep level of knowledge translated into behaviours and practices that recognize and acknowledge the histories, cultures and values of LGBTQ communities.

Queer: An identity proudly used by some people to defy sexual or gender restrictions.

Transgender: An umbrella term used to describe people whose gender varies or is complex, including those who are transsexuals, cross-dressers, or two-spirited.

Transsexual: A person who was born of one sex, and grows up to identify and live as the opposite sex. Some transsexuals may undergo surgery and/or hormone therapy in order to make their bodies fit what they feel is their true gender.

Two-spirited: An umbrella term used in First Nations communities to describe people who house both male and female spirits.

About the Author

Urszula May, MHSc., ND is a naturopathic doctor and birth doula. She completed her BA and MHSc. before practicing as a Speech-Language Pathologist in Toronto. She is a graduate of the Canadian College of Naturopathic Medicine, and serves on the Board of Directors for the Ontario Association of Naturopathic Doctors. Urszula has eclectic practices in Toronto and Markham, Ontario, with a specific focus on pediatric care and LGBTQ wellness.

Useful Resources

Examples of Sperm Banks compliant with Canadian Regulations:

Can-Am Cryo Services www.canamcryo.com

Repromed www.repromedltd.com

Xytex Corperation www.xytex.com

Lesbian Pregnancy and Parenting Books

Brill S. e New Essential Guide to Lesbian Conception, Pregnancy and Birth. Pittsburgh, New York: Alyson Books, 2006.

Luce J. Beyond Expectation: Lesbian/Bi/Queer Women and Assisted Conception. Toronto: University of Toronto Press, 2010.

Mamo L. Queering Reproduction: Achieving Pregnancy in the Age of Technoscience. Durham: Duke University Press, 2007.

Websites

LGBTQ Parenting Network, Sherbourne Health Centre and Queer Parenting Programs, e 519 Community Centre www.lgbtqparentingconnection.ca

Rainbow Health Ontario www.rainbowhealthontario.ca

Proud Parenting www.proudparenting.com

Brochures and Guidelines

Queer Parenting Info Brochure Series: Insemination Procedures (2009).
Available at: http://www.lgbtqparentingconnection.ca/resources.cfm?mode=3&resourceID=12913d3c-3048-8bc6-e828-68358d05fc97

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The Context of Aboriginal Health in Canada

Dr. Johanne McCarthy, BA (hons), ND

The Great Law of Peace of the *Haudenosaunee* (Six Nations Iroquois Confederacy) mandates that in all deliberations it is essential to consider the impact of our decisions on the seven generations yet to come. This concept recognizes the importance of our interconnectedness to our ancestors as we walk into the future.

It emphasizes the value in examining the current situation in relation to the historical context of how things came to be the way they are today.

As naturopathic doctors we value wholistic care of the individual's physical, mental, emotional, and spiritual state of being. Our profession acknowledges the limitations of looking at health through the lens of the biomedical model of health care, as the model interprets health as a physical process focusing on pathology, biochemistry and physiology. It attributes disease to biological agents, requiring treatment via biological means such as pharmaceuticals and surgery. e 2002 Royal Commission on Health care in Canada also acknowledges the barriers of this model in its tendency to view the body and mind separately, its focus more on the curative rather than preventative medicine, and its lack of attention to the social determinants of health.[1]

ese considerations have fuelled a public paradigm shift towards understanding the value of the social determinants of health.

e health determinants model expands the approach to health intervention by considering the complex interaction between social, economic, political, environmental and cultural challenges faced by a population.

Although this perspective facilitates a better understanding of the existing health disparity of the Aboriginal population compared to the non-Aboriginal population in Canada it does not tell the entire story. Along with the government's recognition that "it is the combined influence of the determinants of health that determines health status,"[2] it is important for care providers in Aboriginal communities go beyond merely understanding the complexity of the impact of the determinants of health and consider 'how things came to be the way they are today'. e goal of this article is to introduce the disparity in health of Aboriginal vs. the non-Aboriginal population and briefly outline what every clinician in Canada should know about the historical factors that have impacted the health determinants for Aboriginal populations. In this way, by understanding the root cause or the historical context of the current situation we will be more equipped to support a strategy of healing that empowers progress through telling a story of courage, resilience, and perseverance for Aboriginal people.

Aboriginal Health Statistics

"Aboriginal" is the term accepted by the Canadian government to define the Indigenous people of North America and includes First Nations (North American Indian), Métis and Inuit populations combined. Together, this very diverse group comprises an estimated 4.5% of the Canadian population.[3] In Canada there are 615 Aboriginal communities ("reserves" or "bands") with the largest number being in British Columbia (198) followed by Ontario (153). Ontario has the highest population of Aboriginal people in Canada (243,000) and a larger number of remote Northern Aboriginal Communities than in any other region.[3]

e diversity of this population is often not well reflected in the collection and interpretation of statistical information. When grouping all Native Nations together in examining the determinants of health under the category of 'Aboriginal', statistical impressions run the risk of reinforcing stereotypic generalizations of the 'Aboriginal' condition. In presenting these statistics it is important to recognize that each group is as diverse and unique as their geographic variability. An inadequacy of the health determinants model stems from the politically accepted definition of 'Aboriginal' in Canada. Aboriginal people prefer to be addressed by their individual Nation names and do not generally embrace the term 'Ab-original' due to its connotation of 'not being original'.

at being said, overall statistics are presented to illustrate what knowledge is used to inform health policy and understanding.

Compared to the non-Aboriginal population, it is well documented that Aboriginal people in Canada score significantly lower on conventional health status indicators such as death rates, disease occurrence and disability.[1] As a broad measure of overall health, the 2001 census recorded the life expectancy of both Aboriginal women and men to be an estimated 6.7 years less than the non-Aboriginal population in Canada. ese overall health measures are influenced by a variety of prevalent disease conditions and circumstances. For example, statistics have identified particularly high occurrences of Tuberculosis, HIV/AIDS and diabetes mellitus in Aboriginal populations in Canada. In 2005, 19% of active tuberculosis cases reported in Canada were

The 12 Determinants of Health as Identified by Health Canada[1]:

- **Income and Social Status** - higher income and status often results in more control over life circumstances and discretion to act on key factors influencing health thereby reducing stress
- **Social Support Networks** - a feeling of societal caring and respect helps people to deal better with adversity and crisis
- **Education and Literacy** - closely tied to socioeconomic status thereby equipping people with increased opportunity for healthy choices as well as knowledge and skills needed for e ective problem solving
- **Employment/Working Conditions** - unemployment or underemployment leads to more stress and fewer safe work environment choices
- **Social Environments** - extends to organizational and institutional relationships with the broader community which is founded on resource sharing and healthy understanding of values and norms
- **Physical Environments** - exposure to environmental contaminants in air, water, food and soil can significantly influence our well-being
- **Personal Health Practices and Coping Skills** - prevention, promotion and the development of self-reliance and self-control over lifestyle choices
- **Healthy Child Development** - early experience impacts brain development and ability to learn coping skills in later life
- **Biological and Genetic Endowment** - our inherited predisposition to certain conditions and susceptibility to other socioeconomic and environmental determinants of health
- **Health Services** - access to treatment and secondary prevention support
- **Gender** - based on an array of socially determined roles governing practices and priorities of responsibility and power
- **Culture** - incongruence with dominant cultural values can lead to marginalization, stereotyping and lack of access to culturally appropriate care

Aboriginal compared to 13% Canadian born non-Aboriginals.[4]

is is reflective of poor housing conditions and overcrowding. HIV/ AIDS rates from 1998 to 2005 reveal that Aboriginal women and youth make up 47% of all new HIV diagnoses compared to 21% among non-Aboriginals[4] with one in three newly diagnosed Aboriginals being under the age of 30. Another example is diabetes mellitus, which a ects 20% of the Canadian Aboriginal population. Key health determinants such as education, employment, income, social conditions and access to healthcare have been linked to diabetes mellitus.[4] Diabetes mellitus was very rare in Aboriginal communities before the 1950s and has doubled in the last two decades due to drastic and rapid environmental, lifestyle and nutritional changes.[5] Measurements of the mental/ emotional health of Aboriginals also highlight disparity compared to the non-Aboriginal population. Statistics reveal higher rates of accidental deaths, experiences of discrimination and racism, major depressive episodes and substance abuse with suicide and self-injury representing the leading causes of death for Aboriginal youth. Rates of suicide are shocking at eight times higher for females and five times higher for males than in the non-Aboriginal population.[6]

Health Statistics from a Health Determinants Perspective

From a health determinants perspective, the education of Aboriginals on-reserve lags behind that of other Canadians. Aboriginal youth, for example, are 26% less likely to complete high school and 17% less likely to acquire a university certificate, diploma or degree.[7] Unemployment rates for Aboriginals are a reported 20.4% higher than Canadian standards with males being more likely than females to be unemployed. Not reflected in these statistics are the proportion of Aboriginal people who live traditionally, hunting, fishing and gathering foods for their livelihood.[7]

Similar to education and employment, income also influences socioeconomic status and the resulting ability to assert control over living conditions, quality of housing and accessibility to nutritious food and water. e average Aboriginal income is also approximately $11,500 less than that of the non-Aboriginal Canadian population.[7] is is reflective of the translation of education to employment opportunities to improved income. Other quantifiable data such as housing conditions, water quality, sewage services, fire protection, and community isolation are used to statistically analyze the physical environmental determinants of health. Disturbing statistics emphasize a disproportionate accessibility to health promoting behaviours including information on the frequency of such diagnostic tests as routine screening for cervical, breast and prostate cancers.

All of the measured health determinants statistics appear to justify the health disparity experienced by Aboriginal populations. However, **if we do not look beyond** this explanation and examine the context of this situation, it reinforces a bleak image of the helpless, hopeless, unemployed, substance abusing, irresponsible Indian who needs 'help' in order to be 'saved'.

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Looking at Aboriginal populations through this lens and reinforcing this perception through research does very little to empower health through the recognition of resilience, courage, strength and perseverance.

The Context

Seven generations ago Aboriginal people lived a very di erent life than they live today. e truth, recognition and reality of our historical context of invasion, torture, slavery, genocide and colonialism are what needs to be acknowledged and understood in order to make sense of our current health disparities. For the purpose of brevity only a few significant historical events impacting Aboriginal health will be mentioned in order to facilitate a fair explanation as to why major gaps exist in the comparison of the health determinants in Aboriginal communities.

The Royal Proclamation of 1763 – The Beginning of the Reservation System

e Royal Proclamation of 1763 is a legal agreement between the British and North American Natives issued by King George III on October 7, 1763 in recognition of Aboriginal support in the Seven Years' War between French and British Colonists.

is proclamation o ciated a boundary line referred to as the "proclamation line" which separated and controlled colonial expansion in order to manage the newly ceded French colonies. It also restricted colonists from settling beyond that line and regulated the sale of land without appropriate land negotiations involving the Crown and Aboriginal representatives.

Prior to colonization and Royal Proclamation, Native concepts of land ownership were not in existence. Cultural values and beliefs, passed down through oral history, were documented symbolically on strings of *wampum*. Wampum are shell-crafted beads strung in an order as a reminder of our traditional concepts and agreements. In Haudenosaunee culture there is an important wampum called 'the dish with one spoon'. is Wampum outlines the law of Native relationships to the land. Its estimated date of origin is prior to the 1690s where it was proposed as a treaty between the Ojibway and the Haudenosaunee Five Nations. e dish represents the land from which we all derive our sustenance for survival. From this dish we are to take only what is necessary leaving whatever is available for others. It teaches our obligation to share this land using one spoon so that we are able to conserve its bounty for the faces of the next seven generations yet to come. e Wampum teaches that no one person shall own the land since it belongs to everyone including other beings and the unborn generations. e Royal Proclamation signifies the first agreement and understanding of land resources from an ownership perspective. is agreement like the Wampum is a legal treaty recognizing and establishing a relationship honouring friendship and peace. Many more treaties marked by the creation of documents and wampum were established following this Royal Proclamation. Negotiations by Aboriginal representatives in these agreements focused on conserving resources, sovereignty and guaranteeing benefits for future generations according to a cultural belief system which values being one with nature and not apart from it.

e beginning of this system of 'land reserved for use by Natives', restricted and confined Natives throughout the years to smaller and smaller tracts of land impacting the use of resources, cultural relationship and concepts of identity within the natural environment. Settlers arbitrarily claiming entitlement to lands using the Royal Proclamation to their benefit and the subsequent dispossessing of lands under colonialism have disastrously impacted the health of land-based Indigenous cultures.

The Indian Act of 1876 – The Negation of Self-Determination

Established in 1876, e Indian Act marked a watershed change in social relationships, with authority over Aboriginals being switched to the hands of Canada's newly formed federal government. It defined Aboriginal identity and registers 'Indians' providing them with a card proving their *status*. Prior to 1985, non-Aboriginal women who married Aboriginal men could acquire 'Status' thereby granting them the right to live on lands reserved for 'Indians'. However, Aboriginal women who married non-Native men lost 'Status' thereby losing the right to live on reserve. e impact of this patrilineal imposition should not be underestimated, as many North American Aboriginal societies were matrilineal in structure. Matrilineal societies pass heritage, family name, values and traditions through the woman's side of the family; Haudenosaunee culture, for example is representative of this matrilineal system. Subdivisions of each nation consist of clans named according to animal totems, for example, Beaver, Bear, Turtle, Wolf, etc. Clan membership is passed down through the mother's line and governs social support relationships in tragic circumstances as well as in marriage. e Indian Act enforced legal restrictions which served to break down these family systems of support and knowledge transmission. e Indian Act continues to exist today with modifications in 1985 (Bill C31) and recently in 2011 (Bill C3) to account for the document's overt sexism — however, its patrilineal perspective is still embedded at the document's core.

e Indian Act governs more than 'Indian' identity. Historically it outlined legal restrictions against leaving reserves, the requirement of permission to sell goods, restrictions against having a will, the sale of land, and the ability to secure a mortgage. Natives could revoke status and participate in Canadian society if 'enfranchised'. 'Enfranchisement' (viewed as a 'privilege' for Aboriginals by the Canadian government) provided Indians with the entitlement to vote and attend post-secondary education. However, 'enfranchisement' attracted very few volunteers because it required an alienation of self-identity and a severed a liation with reserve living.[8] Compulsory 'enfranchisement' began in response to this lack of interest in 1920 with the objective of forcing assimilation into Canadian society in order to eliminate the 'Indian Problem'.[9] is policy reinforced the loss of 'status' to Aboriginal women marrying non-Aboriginal men and instituted the "loss of

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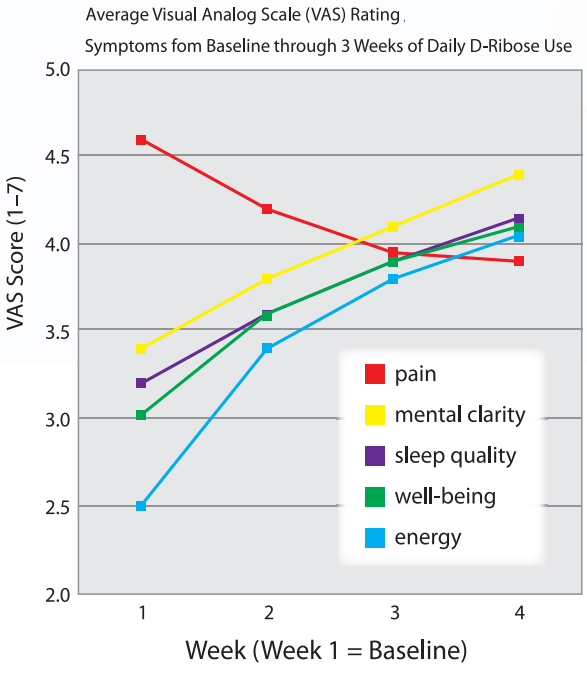

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status to any Aboriginal who received a university degree or who became a doctor, lawyer or clergyman, regardless of their desire to lose their status".[9] is Compulsory Enfranchisement law was not abolished until 1959 and marked the first time in Aboriginal history that people could achieve a post-secondary education while maintaining a connection to their community, their culture and their relations. is calculated, legally enforced disincentive is why many Aboriginal adults today are under-educated.

Despite the oppressive history of this document, the Indian Act is the only system in place protecting the lands reserved for Aboriginal nations and what's left of the notion of Native Sovereignty. Aboriginal communities are still considered as nations within a nation and therefore taxes are not collected on reserves to be paid to the provincial or federal governments of Canada. Status or treaty agreements o -reserve grant tax exemption from the provincial portion of taxable sales under section 87 of the Indian Act. However, some of the restrictions of the Act, such as the limitations on the opportunity for development, do not necessarily negatively impact Aboriginal communities as they have di erent priorities and di erent perspectives with regards to acquisition of wealth, development and land use.

The Residential School System — The Abuse Against Self-Identity and Self-Worth

Established in 1892, the Residential School System placed children in boarding schools where they were forbidden to speak their own languages and practice cultural behaviours and ceremonies. It was mandatory for most of these children to attend once they reached their third year of age.[4] e priority of this system was to 'Kill the Indian and Save the Man'[10] using aggressive civilization to accomplish colonial goals grounded in a perspective that Native land would be better used under private ownership and Native people would be better o if they were civilized.[11] Many children su ered physical, mental, emotional, social, and sexual abuse at these institutions.[12] Conditions of poor sanitation, overcrowding and lack of access to medical care lead to very high death rates among children; in some cases death rates were as high as 69%.[13] Additionally, students were kept from their parents for 10 months out of the year and all correspondence was to be written in English. ese barriers to connecting with family and experiencing normal family life, love, structure and support created enormous experiences of psychosocial stress for adults, children and community. ose who survived residential school most often did not feel like they belonged upon returning to their community.

e tragic impact on individual perspectives of self-value, confidence and knowledge of basic family dynamics in adulthood has been well documented over the years.[11] What many people do not realize is that this legacy is not a part of distant history but a part of contemporary Aboriginal reality. e peak of the residential school system was in 1931 with 80 schools operating in Canada. A total of 150,000 Aboriginal children were forcibly removed from their families and their communities to attend these institutions.[12]

1763 Royal Proclamation – a legal document between the British and North American Natives

1867 British North America Act – marking Canadian Confederation

1876 Indian Act – outlined Canada's federal government authority over Indian and Lands Reserved for Indians; defined Indian identity under the eyes of the law

1892 Establishment of the Residential School system – with the purpose of "killing the Indian Child"

1920 Compulsory Enfranchisement – loss of status to any Aboriginal woman marrying non-Aboriginal man and her children; loss of status to any Aboriginal achieving a University education.

1959 Aboriginal could achieve post-secondary education and maintain identity

1960 First time Aboriginal people could vote in Canada

1998 Closing of the last Residential School in Canada

2008 Stephen Harper, on behalf of the Government of Canada offered a public apology to all former students of Indian Residential Schools in Canada

e last residential school in Canada was the White Calf Collegiate Institute in Saskatchewan which closed in 1998, only 13 years ago.[14]

A Future of Healing for the Next Seven Generations to come

Evaluating the health of Aboriginal people through the analysis of the health determinants model does not necessarily reflect culturally appropriate healthcare. In order to understand 'why things are the way they are' clinicians need to go beyond statistics and attempt to understand the context of the current situation. We can all learn from the 'Aboriginal journey' that one cannot take a paternal role directing health from the guise of our own goals and expectations. Often, our own goals and expectations can be skewed or irrelevant despite best intentions. Reflecting on the impact of colonization and forced assimilation e orts, it is important to acknowledge that Aboriginal people in Canada are dealing with the realities of invasion, torture, slavery, and genocide. is historical perspective is not often respected, acknowledged or discussed when talking about the health and healing of Aboriginal people and communities. To be good clinicians, we need to strive to hold true to our naturopathic doctrine and meet the patient where they are in the healing process. On our patient's journey we can hope to facilitate a relationship of sharing, peace and support so that they are empowered to tell their history, their perspective,

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their experience and share their goals with us. We can support our Aboriginal patients by reminding them of the resilience, strength and perseverance it has taken for them to make it this far on their journey and encourage them that the choice to be who they want to be is in their control. Now that Aboriginal people are legally in a position in Canada to achieve post-secondary education and vote (should they so choose) without alienating their identity and connection to their cultural values we will hope to see a more positive trend in health and healing. When dealing with all marginal/minority populations as clinicians, we cannot assume that healing means fixing the patient's problems on our terms. It is more helpful to be conscious of our own goals and make an e ort not to let these goals warp our perception and misguide our judgement of our patients' goals and interpretations of their own health and healing. We need to step away from a paternal guiding role and really get to know 'why things are the way they are' from the patient's perspective. It is our job to empower each individual on their journey by taking the time to respect, validate, and listen to their history, their perspective, their experience and their goals… not our own.

About the Author

Dr. Johanne McCarthy is from the Onondaga Nation of the Six Nations of the Grand River and is a happy mother of two. She is the founder of the Healing Journey Naturopathic Clinic established in 2005, in Caledonia, Ontario and the first Naturopathic member of the Indigenous Physicians Association of Canada.

Johanne is also an Aboriginal Student Counsellor at Mohawk College in Hamilton, Ontario. She has published many educational articles about Aboriginal health and healing including co-authoring a paper titled, "Naturopathic Medicine for the Improved Health Care within Canadian Aboriginal Communities" conducted by the Department of Research and Clinical Epidemiology at the Canadian College of Naturopathic Medicine.

Johanne has also published a paper on the Great Peace CD Rom which is an educational tool distributed to elementary schools across Ontario titled, "Ecological Well Being: An Exploration of the Intimate Relationship between Haudenosaunee Medical Practices and the Environment". Johanne is an avid public speaker who enjoys sharing her research at McMaster University, Mohawk College, George Brown College, the Canadian College of Naturopathic Medicine and within her community. She enjoys her role at Mohawk College supporting students to achieve their personal and academic goals. Johanne continues to work particularly close with Mohawk's Practical Nursing with Aboriginal Communities program to help both Native and non-Native students respect the context of health and the importance of incorporating wholistic, nature based, culturally relevant practices into care. She hopes that her contribution to education and her community will reverberate to make life a little easier for the coming faces of the next seven generations and is grateful that her ancestors made decisions with her future and the future of her own children in mind.

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Working as a Naturopathic Doctor within a Community Healthcare Setting

Dr. Jennifer Hillier, ND

The cost of healthcare is rising, resulting in extended wait times and limited resources. As we all struggle to make ends meet, a two-tiered system of healthcare is developing to ease the burden. While a system like this is convenient and provides more timely care to those who can afford it, those who cannot are left with no recourse.

With no extended insurance, or the ability to pay fees out of pocket, many individuals are unable to access naturopathic care and hence the power of preventative medicine. While most NDs may never expect to see low-income patients in their practices, the possibility of providing free or subsidized care may help to address the growing gap in healthcare between the rich and the poor.

Working in a community healthcare setting can expose practitioners to a wide range of people, each presenting us with a unique opportunity to learn and grow. In a fascinating study that identified poverty as a determinant of poor health,[1] researchers conducted interviews with health practitioners in Toronto to understand how our universal healthcare system fails to meet the needs of low-income populations. It was found that a significant barrier to care arose from physicians' unfamiliarity with the issues associated with the daily experience of living in poverty. In interviewing low-income patients, the study recognized several areas where physician education would result in better care and health outcomes.

Lack of physician awareness of personal details

One of the most inspiring and rewarding parts of being a naturopathic doctor is the experience of getting to know our patients and recognizing the factors in their lives that may act as barriers to health. While not included in our standard review of systems, it is important to incorporate questions regarding a patient's access to resources in order to inform your assessment. Asking what their monthly diet looks like can give you a rough indication of how much money they have available for groceries, whether they are accessing food banks, or if their budget allows for foods such as vegetables and meat. It is critical to remember that much of the food that we prescribe comes with a higher price tag than pre-prepared or non-perishable foods. Visiting local grocery stores, food banks and soup kitchens can be a useful exercise in understanding how far a limited food budget may be stretched. Many individuals who access community resources for food express a desire for healthier options.[2] Creating and sharing recipes that incorporate economical foods like rice, tubers, root vegetables, onions and dried beans may improve compliance, and decrease the financial burden of your treatments.[3]

In addition to recognizing what patients are eating, asking about where they are living is an important component of a thorough intake. In one study housing insecurity was correlated with poor health in children, decreased growth rates and lower weight.[4] e stress of housing instability can be wide-ranging and have an impact on all members of the family. Taking a strong, patient-centered initial intake is the first step towards creating positive change with a patient, and asking the right questions will inform a truly individualized treatment protocol.

Lack of access to transportation

Whether you are practicing in an urban centre or a more rural setting, transportation can act as a significant barrier. From personal mobility issues to lack of public transit, being aware and proactive about a patient's ability to access your services may improve quality of care and decrease frustration. In a recent study, it was noted that women who had access to a private vehicle did not cite travel as a barrier to care, whereas transportation was a significant barrier to attending appointments for those who relied on public transit.[5] Individuals who rely on a service for their travel like Wheel-Trans may present with challenges in arriving on time or finding accessible ramps and toilets.[6] As many of these services require advance booking and must adhere to strict schedules and weather changes, patients may have considerable stress when it comes to getting to your practice. Understanding that most forms of transportation cost money, many not-for-profit organizations have systems of reimbursement to keep their services accessible, paying for taxis, subway or bus fare, and community drivers to enable clients to travel to their appointments. Looking into community resources may uncover options for individuals unable to a ord the cost of transportation to your services. Considering phone consults may also help to overcome this barrier, while home visits are yet another way of making your services accessible to these individuals.

Barriers to Health As Identified by a 2011 Study[1] Include:

- Lack of physician awareness of personal details
- Access to transportation
- Di culty making and keeping appointments
- Poverty stigma and shame
- Low literacy levels
- Substance abuse
- Cognitive impairment
- Knowledge of community-based resources

Making and keeping appointments

In the best of practices, visit cancellations and no-shows are a frustrating part of doing business. When working in a community health setting, this frustration can erode positive feelings around involvement and decrease motivation. Understanding the reasons behind missed visits can open up a dialogue and decrease resentment on both sides. In one study it was determined that full-time physicians experienced fewer cancellations as compared to part-time physicians, perhaps due to a stronger patient relationship.[7] Common reasons for missed appointments for people with lower income include the opportunity for longer hours at work, substance abuse issues, variability around being a caregiver for children or parents, poor access to transportation, and conflict with other appointments or opportunities. Discussing the reason for a missed appointment with a patient can help you to understand their situation. Support can then be given to help overcome limitations or to create a more convenient scheduling system. If a patient misses appointments frequently, moving them to a booking system where they can only book the day of the appointment can help you both in organizing your days.

Limited help-seeking due to stigma and shame

In an interesting study on low-income individuals and their experience of the health care system in Canada, the reasons why people did not access universal health care resources were explored.[8]

e study focused on the stigma associated with poverty, and investigated how this stigma manifested itself in daily behaviour and social patterns. ose who were in a lower socioeconomic bracket identified a belief that the rest of society looked down upon them because they were perceived as lazy or unmotivated.

is perception was translated into action in many ways, with some reaching out to care for others in a similar situation, withdrawing from society, or avoidance of social contact for fear of stigmatization. Another strategy included hiding financial facts from people to conceal poverty. Being aware of the sensitivity of low-income patients is a critical step towards building rapport. It is important to never assume an income level, a patient's ability to comply with treatments and visit schedules, or their access to resources to things as simple as food and a warm bed. Significant shame may exist in those who are accessing provincial or federal support programs, food banks, or the shelter system.

Shame around housing options and the ability to contribute in a meaningful way to society may also negatively impact patients. Issues around substance abuse, the loss of guardian rights of children, a history of incarceration or of mental illness can all contribute to shame and stigma. Familiarizing yourself with street terms for drugs, activities and welfare organizations can help you to communicate with patients and shrink the distance between your understanding and their experience. Being open and honest in your visits and asking questions creates a give and take that can be empowering for patients not used to prolonged conversations with a practitioner. When you leave prejudices at the door and find common ground between yourself and your patients, you can reduce the perceived gap on both sides. Beginning with something as simple as dressing in casual attire, knowing current events in the neighbourhood and being aware of the social and political issues present in the community can go a long way towards decreasing the e ects of poverty stigma.

Poor literacy

Recognizing that an astounding four out of ten adults have a low level of literacy can greatly impact the ways in which you communicate with your patients.[9] It is important to note that individuals who fall into this category have an inhibited ability to fully engage in meaningful employment requiring a basic level of reading comprehension. is includes di culty in filling out medical forms, job applications, reading test results and prescriptions, and understanding health literature and treatment protocols. Since many NDs use relatively long intake papers with possibly unfamiliar words, this can create a significant barrier to care before a patient even begins treatment. Moving these questions into an interview format can reduce this barrier and provide you with more accurate information. Alternately, using forms with simplified language, shorter questions and fewer requirements for writing can increase patient compliance. Many resources exist to support the creation of readable resources. Tools in Microsoft Word can even gauge the level at which a document is readable.[10] Creating materials that consistently incorporate low literacy accommodations can be helpful in both private practice and the community health care or low-income setting and can increase patient comprehension in all walks of life.

Substance abuse

While substance abuse is not limited to a community health setting, it has been well documented that there is a higher prevalence of addiction in low-income populations. Current best practices around treating addiction adopt a harm reduction approach. In a study that looked at the treatment of substance abuse it was noticed that the best approach involved understanding the experience of the patient and then starting the journey to healing from there.[11] By fostering supportive relationships and adopting a non-judgmental approach, the women in this study

noted that when underlying issues were addressed, smoking cessation was easier.[12] Significant barriers to cessation included the absence of support networks, lack of access to childcare and elevated stress in daily life. While naturopathic doctors are trained in health psychology, we may not have tools to deal with the daily issues that accompany substance abuse or how best to support someone struggling with addiction issues. The Centre for Addictions and Mental Health (CAMH) is an invaluable resource for learning about addictions and treatments. Offering courses, webinars and helpful documents, the CAMH website (www.CAMH.net), can provide relevant information and help to expand skills for treatment.

Cognitive impairment

While cognitive impairment is identified as a barrier to health in low-income populations, it does not exist in isolation. Whether it is due to congenital issues, injury, illness or decline with substance abuse or aging, cognitive impairment has varying degrees of impact on our patients' daily lives and the ways in which we interact with them. Training yourself to communicate in a very clear, simple, and compassionate manner, meeting the patient at their level, and checking in periodically can ensure that your message is getting through. Patient care may include assisting patients in setting and achieving daily goals, or may inspire you to find resources for their support. In a study from the Netherlands, it was found that physicians were unfamiliar with community resources to help patients with mild cognitive deficiencies, and this acted as a significant barrier to patient improvement.[13] Current trends in primary care include specialized training for physicians treating dementia through specialized memory clinics.[14] In terms of treatment and therapies, it is critical to explain the treatments thoroughly in order to obtain informed consent. If the patient is not able to provide consent, it must be obtained from a guardian or trustee.[15] Once consent is obtained, it then falls to the practitioner to find ways of communicating daily routines or treatments in an accessible way. This may involve the use of low-literacy materials, pictures, or videos to illustrate your point and increase compliance. Depending upon the level of impairment, regular reminder phone calls and sending notes home to caregivers and support staff can all help to maintain effective treatments.

Knowledge of community-based resources

Understanding patient issues around health and socioeconomic factors furthers the process of naturopathic care in a community health setting. Knowing what to do with the information is a different skill and requires the support of the community. In a study in British Columbia, it was found that amongst low-income senior women, those with a strong social support network accessed health care resources less and required fewer health interventions.[16] Finding or creating these supports can be an important part of care through empowering patients to live healthier lives. If the neighbourhood in which you practice is unfamiliar, take some time to see where basic resources exist. Are there economical grocery stores within walking distance to your patients? Are there easily accessible, low cost forms of transportation, or safe, sidewalked streets for walking? Is there a local infestation of bed bugs, increased crime, or lack of green space? In one study, it was found that those who shopped at corner stores for groceries had a less healthy diet than those who had access to supermarkets.[17] Many urban centres lack large, affordable supermarkets in low-income areas, and patients are limited to shopping within walking distance of their homes. Our recommendations often centre on diet and lifestyle and thus may need to be adjusted to suit certain communities should resources be lacking.

It is also very useful to know about community organizations that may facilitate treatment plans in an inexpensive way. Foodshare is a non-profit organization that strives to provide cost-effective produce options to people from all walks of life. Starting at $13 per week, people can get fruits and vegetables that would be much more expensive in a grocery store, or absent from a corner store. Their program "The Good Food Box" is accessible in many communities and can be an important adjunct to changes in diet. Information on Foodshare and its programs can be found at www.foodshare.net. In terms of lifestyle recommendations, programs at organizations like the YMCA/YWCA or community centres can be inexpensive or free. Many patients do not have the resources to find and contact local programs, so handouts outlining community services can provide much needed social support.

Some of the barriers to health in the community can be obvious, and others as innocuous as to be invisible; as naturopathic doctors we need to be ready for anything. Incorporating community health work into our practices can be challenging as we pursue our medicine, and can range from a full-time practice to one afternoon per month. Whether you work out of a community health centre as part of a multidisciplinary team or see occasional low-income patients in your current business, there are many ways to incorporate low-income patients into your practice. Recognizing the common barriers to health and how to address them will aid you in creating a receptive and therapeutic environment for each of your patients and broaden your therapeutic and personal horizons.

About the Author

Jennifer Hillier graduated from CCNM and started a free clinic in Vancouver at the British Columbia Persons with AIDS Society while collaborating on a research project examining the use and efficacy of CAM with that community. She has also been the supervisor of the Anishnawbe Health Toronto Naturopathic clinic working with indigenous peoples in the downtown core as well as running a private practice at the University of Guelph. Jennifer is full-time faculty at CCNM and a contributing author of *Clinical Naturopathy* published by Elselvier.

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TM

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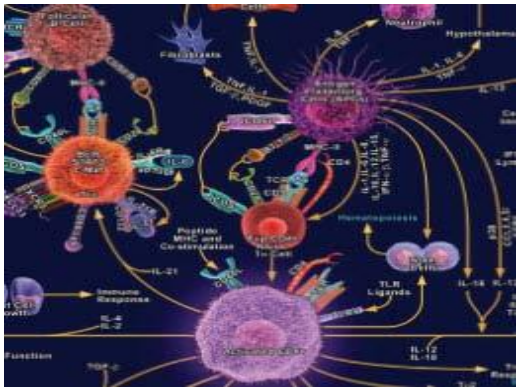

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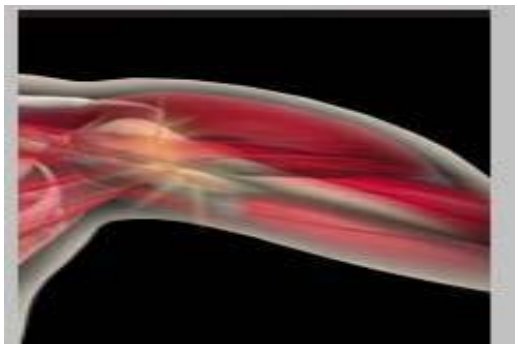
- **Pain**
- **Sports medicine**



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