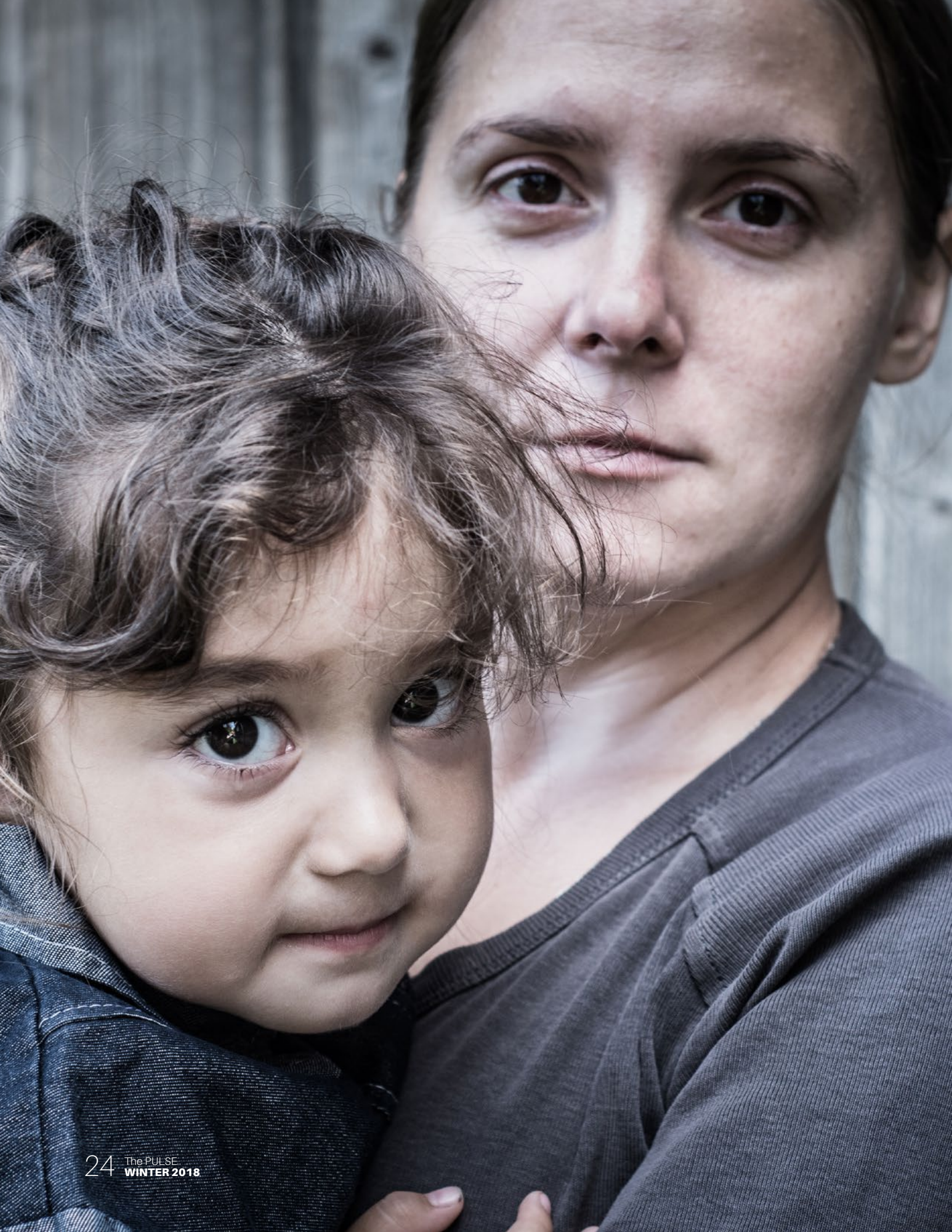
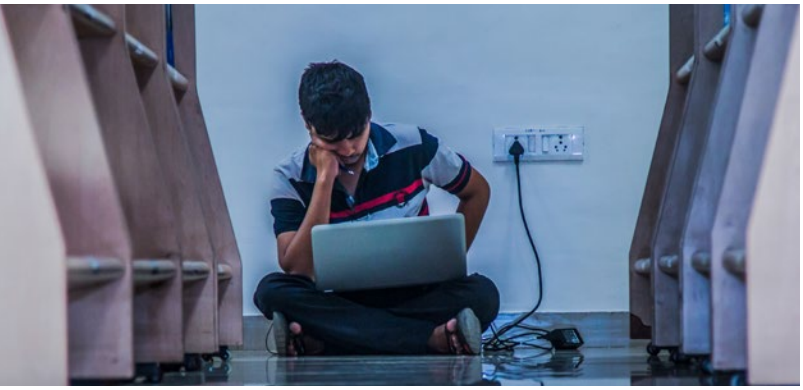


WORKING WITH UNDERSERVED COMMUNITIES

DR. CYNDI GILBERT, ND



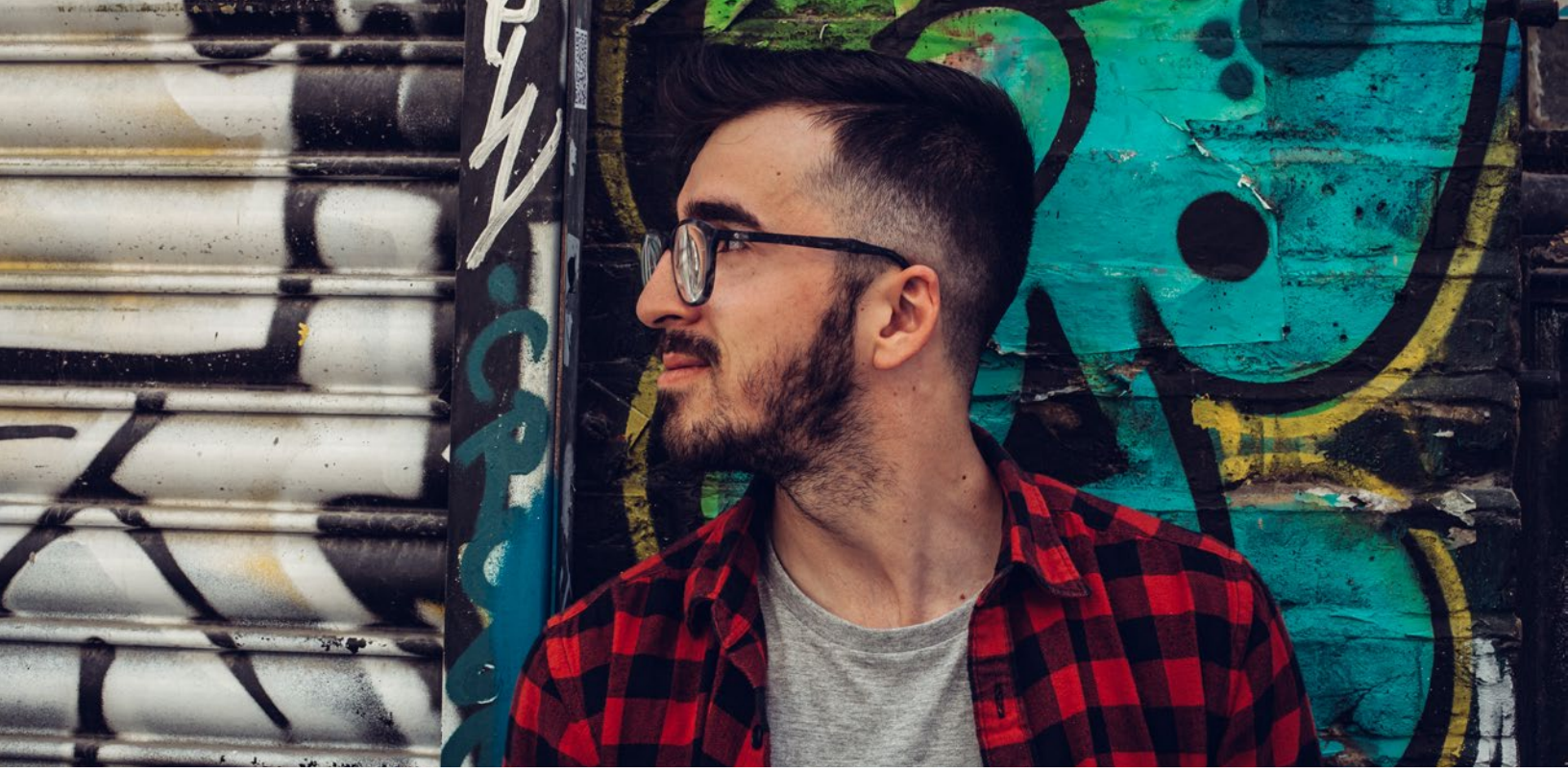
Trust – it's something we take for granted in our initial interactions with patients. We assume that the person sitting across from us trusts that we will keep their health information confidential and make treatment recommendations that are in their best interest. We talk to them about confidentiality and informed consent, however we assume that they already consent by virtue of having made the appointment. In general, people make appointments with a Naturopathic Doctor so that they can share their health story with a skilled provider whose job it is to help guide them towards their health goals. Trust, is a basic ground rule for care; it is the confidence that your patient has in you as a reliable and able Naturopathic Doctor. Trust differs from rapport. *Trust* is the belief in the truth of someone, whereas *rapport* is a close relationship or harmonious bond or mutual understanding. Rapport is dependent upon trust.

Ever since my first day at Queen West Community Health Centre (Queen West CHC) in Toronto when I was a student intern in the spring of my fourth year at the Canadian College of Naturopathic Medicine (CCNM), I realized that I can't take trust for granted. One of my first patients ever in the clinic refused to sign the consent forms when they were presented to her at the reception desk. Her lack of trust wasn't related to a delusion or paranoia. Rather, she couldn't trust because she had too many experiences in her life where that trust was absent or was betrayed. Working with her, as well as other patients at Queen West CHC since returning as a clinical supervisor over five years ago, has broadened my understanding of the social determinants of health and the complexities of how these factors impact people's access to health care.

IMPACTS OF EXPERIENCES, ISMS & DISCRIMINATION

Research shows that social determinants of health have a major impact on health. Systematic conditions and the circumstances in which people are born, develop, and age have a larger impact than any other factors. A patient's income, (dis)ability, education, gender, culture, race, early childhood development, housing, and working conditions make up approximately half of the social determinants contributing to illness.[1] Implicit in many of these factors are social disparities and inequities. For example, recent analyses have highlighted a 21 year difference in the average of age at death between the neighbourhoods in the city of Hamilton with the highest and lowest socio-economic variables (e.g., median income, percentage of children living below the poverty line, government transfers, etc.).[2]

Other social factors also have significant impacts on health outcomes. Research into the impacts of adverse childhood



experiences (ACEs) show a dose-response relationship between ACEs and negative health outcomes. For a person with an ACE score of 4 or more, their relative risk of COPD or hepatitis is 2.5 times higher than someone with a score of zero. Their risk of depression is 4.5 times greater; their risk of suicidality, 12 times greater. If their score was 7 or more, their lifetime risk of lung cancer was tripled and their relative risk was for ischaemic heart disease 3.5 times greater.[3] Unfortunately, social inequities themselves are not the only barriers to health care experienced by many people in our communities. Patients' interactions with health care providers, and the social inequities between patients and providers, compounds an already complex issue.

Since I first started in private practice, I have included a question on my intake form that asks people what obstacles are getting in the way of their health. Usually, people respond by listing their work stress or their love of sugary treats, or some other behaviour that they believe to be unhealthy. Then one day, relatively early in my career, a patient wrote 'racism and homophobia.' They certainly weren't the first LGBTQ patient I'd had. Nor were they the first person of colour in my practice. I was struck by their answer, not because racism and homophobia don't present real live obstacles to health, but because they were the first person to explicitly identify social issues as an obstacle – an obstacle I wasn't sure how I could help change.

Discrimination in our doctors' offices (and Naturopathic Doctors' offices) is more common than many of us like to admit. Twenty eight percent of trans-identified people reported verbal harassment in a medical centre, 19% said they were denied care, and 28% postponed care for fear of discrimination. Studies consistently show that physician implicit bias impacts patient care and medical decision-making.[4] Amongst Indigenous Canadians, studies report trivialization or dismissal of symptoms, as well as misdiagnosis.[5] Overall, Black and African American patients receive poorer quality healthcare for many conditions than their White counterparts. Black and Hispanic patients presenting to emergency rooms are less likely to receive analgesia than White patients, and women are less likely to receive analgesia than men.[6–8] Although there are not yet any studies looking into the role of implicit or explicit bias in Naturopathic Medical care, it is likely that we are no more immune to bias than medical doctors. The more research I read about the health impacts of social inequities, the more I understood why some of my patients didn't implicitly trust me, or the health care systems they interacted with.

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WORKING AT QUEEN WEST CHC

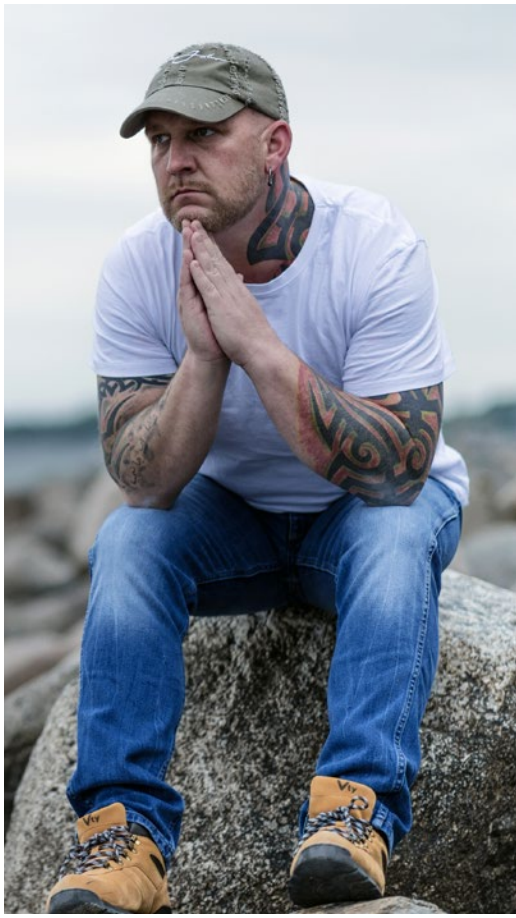
I am very grateful that I have the opportunity to work at Queen West CHC. Our patient population is broad, and often quite different than the majority of patients seen by Naturopathic Doctors in private practice in downtown Toronto, or elsewhere in Ontario. Access to the full range of health care services at Queen West CHC is provided to anyone living in the geographic catchment area, although priority is given to people who are undocumented, street-involved or unhoused, trans-identified, and/or are living with complex mental health/addiction histories. Intersections between these prioritized populations are common. For instance, a patient may have arrived in Toronto as a political refugee from a conflict zone in addition to being persecuted in their country of birth for their gender or sexuality. Another patient may be an undocumented migrant, working in precarious employment situations while living in

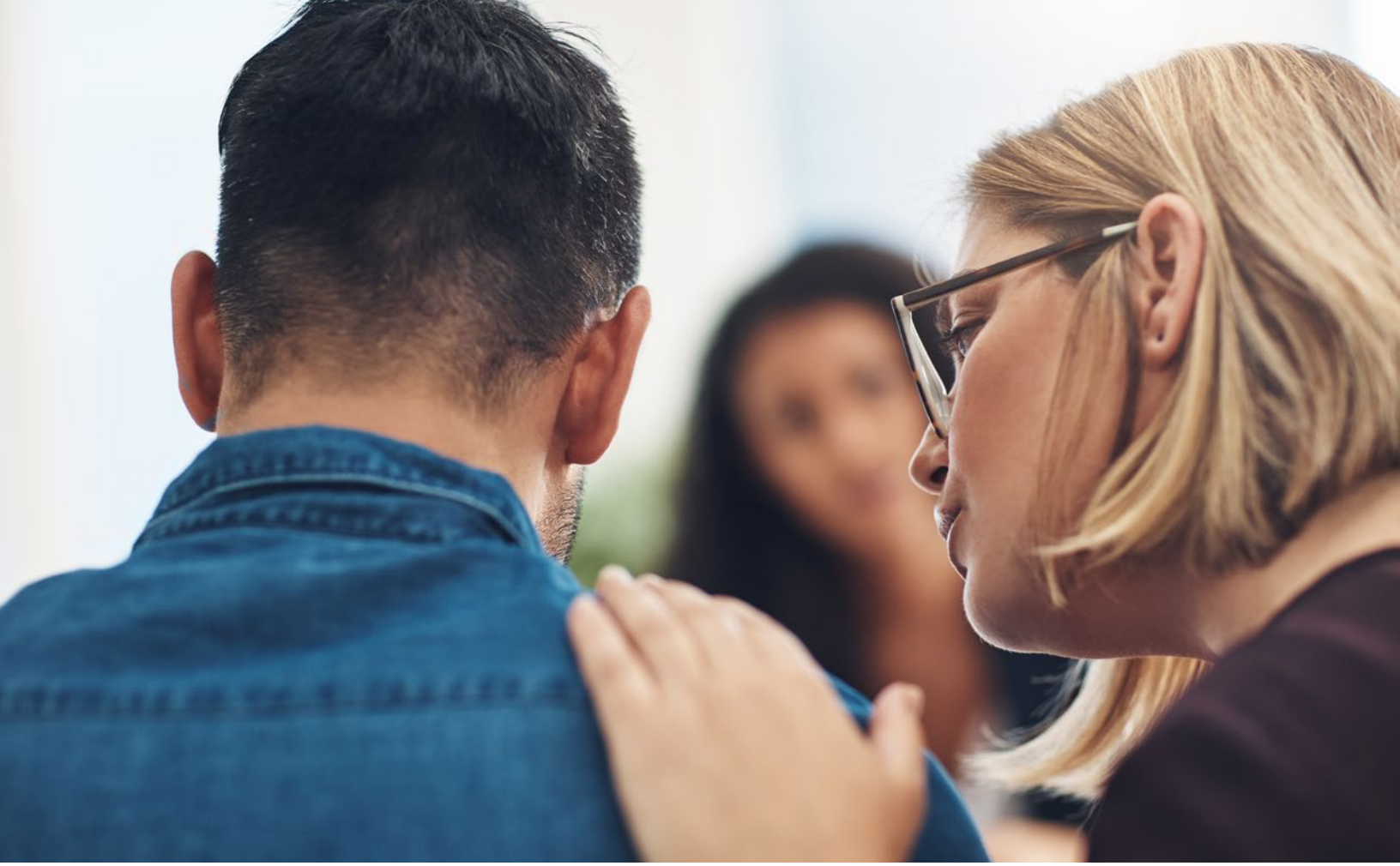
shelters and struggling with chronic pain. Another may be a non-binary ex-sex worker with a history of hospitalizations for mental health conditions, while another may be a woman of colour trying to reduce her use of crack-cocaine. The vast majority of our patients are receiving some kind of social assistance. Most are referred for adjunctive naturopathic care through their case management worker or their primary care provider at the CHC.

Trauma is a broad term often applied like a brush stroke across underserved and marginalized populations. Although it is true that most of the patients we serve at Queen West CHC have had traumatic experiences, that categorization can also serve to depersonalize and further marginalize folks who are unique individuals with unique health concerns, histories, and lifestyles. Their life and health stories can be challenging to bear witness to, both because they may be drastically different than our own but also because they highlight the systemic and institutional disparities and inequities that exist within our society. Additionally, as pediatrician Dr. Nadine Burke Harris, MD, has suggested, we may find it difficult to address the existence of adverse childhood experiences, not because it doesn't apply to us but because it *does* apply to us. Trauma is easier to see in other communities or other postal codes because it's uncomfortable to admit how close to home this issue really is. The single most important thing that we need today, according to Dr. Burke Harris, "is the courage to look this problem in the face and say this is real, and this is all of us."[9] Hopefully, as health care providers, we are able to acknowledge the problem and reflect on our roles in supporting, minimizing, and promoting health inequities. Only then can we begin to develop ideas about how to address these issues in practice.

NATUROPATHIC COMMUNITY HEALTH

As Naturopathic Doctors, we are trained to address the underlying causes of disease and help modify preventable risk factors. The naturopathic principle of *tolle causam*, or treat the cause, asks us to identify the factors that determine health in order to understand what disturbs health. *Tolle causam* implores us to assess the determinants of health, to understand the factors contributing to illness, and to remove the obstacles to cure. This is also the foundational step in the naturopathic theory of the therapeutic order, as described by Drs. Zeff, Snider, Myers, and de Grandpre.[10] If we understand health to be the natural state, and illness to have started with a disturbance to this natural state,





then identifying and removing the disturbance is the obvious first step of treatment. The process of establishing the conditions for health starts by eliminating the disturbances that originally precipitated the disease process and then working to institute a more healthful regimen. Therapeutic treatment proceeds with stimulating the patient's self-healing mechanisms (*vis medicatrix naturae*), strengthening the functions of various body systems, correcting structural integrity, and addressing pathology using a variety of natural therapies.

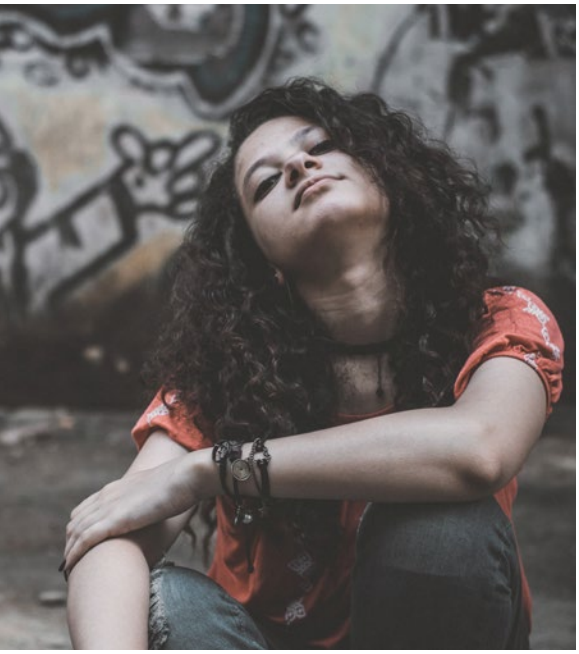
Naturopathic Doctors are skilled in helping patients modify some of these social determinants of health.[11] We can advise and guide people on making dietary or exercise changes, even provide them with new tools for stress management through the use of cognitive-behavioural therapy or mindfulness-based stress reduction. We can recommend they get outside more often and increase their exposure to nature in order to improve a variety of health outcomes. We can also use biofeedback techniques and postural exercises to improve their breathing, heart rate, and other aspects of their autonomic nervous system. But what about the social determinants of health which are systemic? What do we do about the ones we may not be able to change? How do we address or work around obstacles to cure that we cannot easily remove, such as racism or homophobia or poverty or adverse childhood experiences?

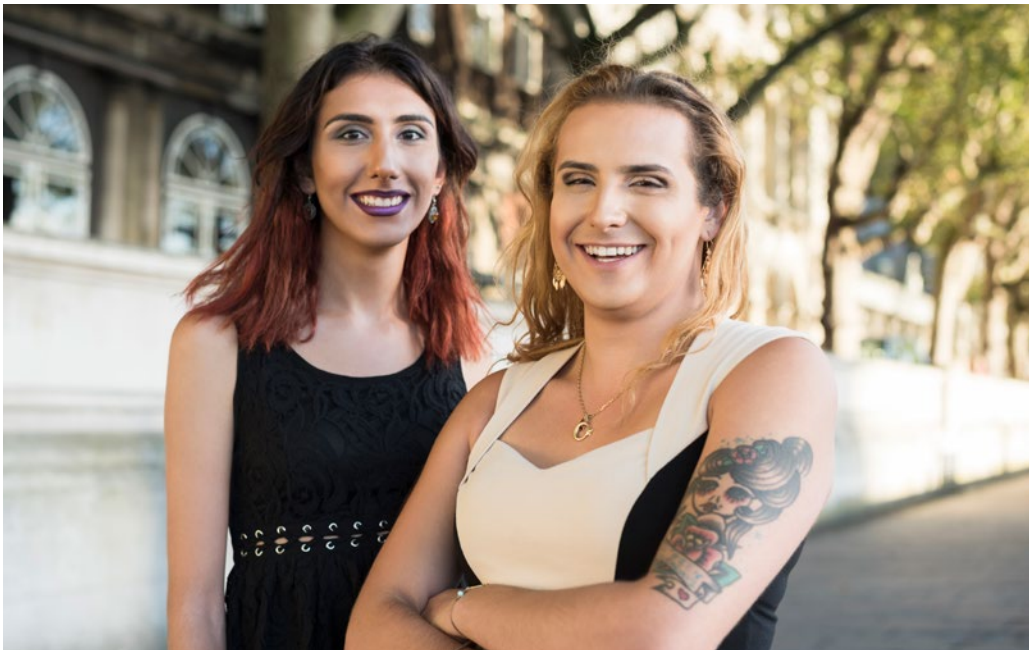
This article can only scratch the surface of how NDs can better serve people from underserved communities. Here are a few tips to improving naturopathic care for patients not well represented in mainstream medical systems. Implementing these strategies is a good idea in any practice, even if you don't think of yourself as working with underserved communities nor plan to in the future. Based on available statistics, it's quite likely that you already are.

Develop awareness of your own biases and how those might affect the care you provide. Recognize that discrimination is a universal tendency embedded in socialization, and that unconscious biases can guide decision-making. Reflect on your own positionality and culture and any social determinants of health that may have impacted your own access to healthcare. Identify examples of health inequities in your community and get training in cultural competency relevant to the communities you serve. Ensure that you train all staff in your workplace and develop workplace policy that improves inclusivity and accessibility. Improve accessibility and display diversity in both your clinic space and your online presence. Audit your cultural competency and accessibility at regular intervals.

> It is the difference between referring to someone as an addict versus referring to them as a person living with addiction or a person who uses drugs.

Get to know the social services available in your communi-





ty and where to refer people as needed for care. Naturopathic Doctors, especially those working in primary care, can help direct and navigate patients to help them access a variety of programs and services that may be relevant in addressing those difficult to change social determinants of health. Develop a list of community centres, community kitchens, family service associations, crisis lines, and shelters. Learn about the process of applying for employment insurance or social assistance. Make connections with local services and organizations that support and advocate for clients with concerns including income support, housing, immigration, gender, sexuality, mental health, trauma, abuse, and life transitions.

Think outside the box. All NDs can benefit from expanding beyond our usual protocols and strategies. This is even more important when working with people from underserved communities since most of us have limited personal experience or even awareness of the day-to-day experiences of someone navigating social services, mental health institutions, or refugee claims. Working in community health settings has ensured that I continually grow my toolbox. It regularly pushes me to think about alternate and creative solutions, while staying focused on the basics of instituting a healthier lifestyle and stimulating the vis medicatrix naturae with food, air, sunshine, water, and sleep.

The free naturopathic teaching clinic at Queen West CHC, like most of CCNM's satellites, relies exclusively on donations, as our patients often lack the financial resources to follow a whole foods diet, much less purchase nutritional supplements. Patients living in shelters may lack access to basics like a kettle to make a botanical infusion or a bathtub to use for hydrotherapy. Some of our patients are on more than fifteen pharmaceuticals or have recently been incarcerated or hospitalized and not yet settled into life outside of an institution. Each of them is a unique person with unique histories and current health goals. As William Osler is often quoted, "it's more important to know what sort of patient has a disease, than what sort of disease a patient has." Osler's quote can also remind us to use person-first language to help centre the person instead of focusing on their disease, (dis)ability, gender, race, sexuality, etc. It is the difference between referring to someone as an addict versus referring to them as a person living with addiction or a person who uses drugs.

One of the most important things that I've learned is that I can't make assumptions. I can't make assumptions about what patients know about health or their gender or their living situation or their finances or their sexual practices or their health goals. I've learned that meeting the patient wherever they are means adopting a harm reduction approach. I've learned how to ask questions in a neutral way and explain why I am asking those questions. I am continually working on simplifying my language to help increase health literacy and encourage patients to take control of their health. I've adapted our intake forms to include spaces for patients to indicate their sex assigned at birth, gender, and pronouns. I ask about partners when asking about a patient's sexual or relationship history, and about parents rather than mothers and fathers. When asking patients about cancer screening exams, I ask which set of screening questions and physical exams are relevant for them rather than assume what organs they may or may not have.

Working in community health is an ongoing challenge, and a great opportunity. Health care providers are important allies in the fight against poverty, racism, environmental injustice, trans-

phobia, and other forms of discrimination. Naturopathic Doctors are trained to assess, understand, and address the relationships between biopsychosocial determinants of health, treat the whole person, and embody patient-centred care. We are in an ideal position to contribute to public health due to our emphasis on prevention, lifestyle modification, patient empowerment, and education. Most importantly, NDs can help advocate for, and effect, social change.

Doctors whose careers encompass medical care and social activism often find great personal rewards and an extraordinary sense of fulfillment. This is not to say that taking on the challenges of health care on the frontlines is easy. It isn't. But |neither is trauma care or ophthalmology. The point is that working to provide excellent medical care to folks for whom access to decent, compassionate services has been a chronically difficult ordeal is exactly what many of us had in mind when we chose medical school in the first place.[12]

10 Tips For Working With Patients Not Well Represented In The Mainstream Medical Systems

1. Develop awareness of your own biases.
2. Get training in cultural competency.
3. Look for ways to increase accessibility of your services.
4. Learn about the social services available in your community.
5. Don't make assumptions (just like the idiom).
6. Use person-first language.
7. Use plain, neutral language that applies to all patients and all patients can understand.
8. Use accessible naturopathic therapies and several treatment options – be innovative and flexible.
9. Transfer knowledge to your patients about how to care for their health.
10. Be accountable. Audit your accessibility on a regular basis, admit and apologize when you make a mistake, and create policy for all staff.