An Eventful 2021

Marianne Trevorrow,[1] MA, ND

This will be our second digital edition of the *CAND Journal*, and the last edition for 2021. So it seems like a good point to reflect on some of the changes we have undergone as a profession as well as at the *CAND Journal*. As I write this, we are closing out our second year living with the COVID-19 pandemic, and while the new case rates in Canada are declining once again, it appears that we may have a long winter ahead, as rates are increasing in several European countries, including Germany, Ireland, Russia, and Greece.[1] Still, here in Canada, it looks as if we are through our fourth COVID wave,[2] and, in several provinces, gradually relaxing public health restrictions on our daily lives, including in schools, restaurants, gyms, and places of worship.

In practice, however, many of us are now seeing patients with symptoms arising from isolation and a lack of social connectedness, with stress from career/business setbacks or increased caregiving, or who are grieving lost loved ones or colleagues due to COVID. We are also seeing patients who have been obliged to delay preventive care or who have not had access to screening exams or surgeries due to pressures on our health-care system from the pandemic. And finally, many of us are seeing patients with significant illnesses related to "long COVID" dysfunctions, well after they are discharged from hospital-based care. Never has there been a greater need for the kind of personalized, compassionate care that NDs provide. Yet we, ourselves, are struggling through many of the same stresses and setbacks as our patients and our communities. In this environment, we also have a great need to treat ourselves and our colleagues with renewed patience and compassion.

The challenges of these COVID years have also led many in the Canadian ND community to reflect on where we are going as a profession, and what will be our future role in the Canadian health-care ecosystem. Perhaps it's only fitting, then, that in this issue we have two commentaries on a subject that is increasingly on people's minds: namely, with the COVID pandemic, should NDs now be involved in public health vaccination clinics and campaigns? In British Columbia (B.C.), NDs with full registration and prescriptive authority can gain the additional certification to administer vaccines by completing the B.C. Centre for Disease Control (BCCDC) upgrading classes for registered nurses (RNs) or pharmacists. To date, over 150 B.C. NDs are certified immunizers, and many of these colleagues participated in community immunization programs in the B.C. Health Authorities this year. While B.C. is so far the only Canadian province to adopt this additional Protected Act for NDs, it may be a model for other provinces in the future.

Christopher Halldorson leads off this issue with a first-person narrative of his experience immunizing patients with the B.C. Interior Health Authority last summer, arguing that immunization is congruent with the accepted principles of ND philosophy and the therapeutic order. Similarly, Sarah Hourston writes that treating unimmunized patients with COVID in Utah as a US-based ND/MD student gave her a unique perspective on how catastrophic COVID infections can be in unimmunized people. She asks her colleagues to reflect on the price of dissention from public health mandates in human terms.

We recognize that some colleagues will find these commentaries challenging and difficult, and we encourage people to read them with an open mind, because these are voices *within* our naturopathic community asking us to reconsider beliefs that some of us may have about public health and vaccination, and by extension to consider how this affects our relationships with the conventional health-care community, where there is strong consensus on these issues. Indeed, we may ask ourselves whether now is the time to step up in a more collaborative manner with our front-line health-care colleagues who have made heroic efforts to save lives over the last 20+ months.

We also have a Perspectives article in this edition from Shakila Mohmand and Sumar Chams on the cultural considerations of chronic pain treatment, where they discuss recent work in this area and lay out a framework for clinical competency in ND treatment of diverse populations.

Finally, we finish with the first Commentary of a series on planetary health by David Nelson of the Nova Institute, linking naturopathic clinical care and the vitality of surrounding communities and arguing for bidirectional connections between the health of persons, places, and the planet. He ends with a call to action for our community to integrate a stronger planetary focus in both our undergraduate and professional naturopathic education.

Correspondence to: Dr. Marianne Trevorrow, MA, ND, Canadian Association of Naturopathic Doctors, 20 Holly Street, Suite 200, Toronto, ON, Canada M4S 3B1.
E-mail: drmtrevorrow@cand.ca

To cite: Trevorrow M. An eventful 2021. *CAND Journal*. 2021;28(4):1-2. https://doi.org/10.54434/candj.98

Received: 3 November 2021; **Accepted:** 3 November 2021; **Published:** 15 December 2021

As always, we encourage our readers to submit letters and commentary on any of our articles through our new online submission portal or by emailing the editors. We believe that by bringing these debates to light, we will advance the conversation on these difficult issues, and ultimately help contribute to improved standards of care for our patients and communities.

AUTHOR AFFILIATIONS
[1]Editor in chief, *CAND Journal*.

ACKNOWLEDGEMENTS
Not applicable.

CONFLICTS OF INTEREST DISCLOSURE
I have read and understood the *CAND Journal*'s policy on conflicts of interest and declare that I have none.

FUNDING
This research did not receive any funding.

REFERENCES
1. Ritchie H, Mathieu E, Rodés-Guirao L, et al. Coronavirus pandemic (COVID-19). OurWorldInData.org. Accessed November 1, 2021. https://ourworldindata.org/coronavirus
2. Government of Canada. COVID-19 daily epidemiology update. Updated November 2, 2021. Accessed November 2, 2021. https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html

Update from the Canadian Association of Naturopathic Doctors

Mark Fontes, ND, and **Shawn O'Reilly**

Dear Members,

We hope you and your families are keeping well as we continue to face the challenges presented by the ongoing pandemic. As 2021 draws to a close, we have been encouraged to hear of more Naturopathic Doctors returning to their clinics and seeing more patients for in-person care while maintaining all required safety precautions. Thank you for your dedication to the naturopathic profession and for bringing such high-quality health care to Canadians.

At the Canadian Association of Naturopathic Doctors (CAND), we are thrilled with the success of the launch and inaugural issue of our new peer-reviewed fully searchable online journal, *CANDJ*. We are pleased to read and hear all the positive feedback from our members, corporate partners, and those in the naturopathic research field. In only one month, we have had over 2,300 users accessing and reading the *CANDJ*; there have been 2,329 total abstract and article views and over 400 article downloads. "Evidence-based practice attitudes, skills and usage among Canadian naturopathic doctors: a summary of the evidence and directions for the future" tops the list of most-read articles.

Keeping members up to date on changes to the government's COVID-19 emergency relief benefits has continued to be a focus for the CAND this fall, along with continued participation as a member of the Public Health Agency of Canada (PHAC)'s Health and Allied Health Sector Table. With the increase in research on the positive impact of a number of natural health products in the fight against the pandemic, other stakeholders have joined their voices with ours in advocating for PHAC to take a serious look at the research and consider the use of these low-cost products.

With the return of a minority Liberal government, the CAND will have the opportunity to continue working with Ministers, policy-makers, bureaucrats, and staff with whom we have established relationships. While this will be of great help, work will be required to build relationships with the new Ministers in charge of several of the portfolios that are key to our advocacy work—Health, Indigenous–Crown Relations, and Indigenous Services. We look forward to working with the newly appointed Minister of Mental Health and Addictions and Associate Minister of Health, Carolyn Bennett, who is familiar with the CAND, as well as with returning Veterans Affairs Minister, Lawrence MacAulay, to ensure naturopathic doctors have access to restricted substances, such as cannabis, for medical purposes, and that the growing numbers of veterans seeking care from naturopathic doctors have coverage for naturopathic services under the Veteran Affairs Canada (VAC) plan. Letters of congratulation have been sent to all Ministers and we are actively engaged in setting up meetings as all parties prepare for a return to the House of Commons in late November.

In November, the CAND board will be holding the second of its semiannual planning sessions. At this weekend-long meeting, your Board of Directors and the CAND staff will review the work we have carried out on behalf of the profession in 2021, identify ongoing issues and challenges for both the profession and the association, outline areas of focus for the work ahead, and plan for a successful 2022. We have a dedicated and hard-working Board and staff, all of whom are committed to ensuring effective advocacy, support, and representation for you, our members. We are excited about the opportunity presented by the planning session to develop our work plan for the year ahead. As always, we look for member engagement, and if you have any suggestions and/or feedback on the work we have done to date, please contact the CAND office.

Dr. Mark Fontes, ND, is Chair of the Canadian Association of Naturopathic Doctors.
Shawn O'Reilly is Executive Director and Director of Government Relations of the Canadian Association of Naturopathic Doctors.

To cite: Fontes M, O'Reilly S. Update from the Canadian Association of Naturopathic Doctors. *CAND Journal*. 2021;28(4):3. https://doi.org/10.54434/candj.96

Received: 3 November 2021; **Accepted:** 3 November 2021; **Published:** 15 December 2021

Naturopathic Medicine on the Frontline of the COVID-19 Pandemic

Christopher Halldorson,[1] ND

As a Naturopathic Doctor (ND), I was fortunate to spend the summer of 2021 providing naturopathic care on the frontline of the COVID-19 pandemic. I had the opportunity to work for a regional health authority in British Columbia, as part of British Columbia's COVID-19 immunization campaign. When the community immunization campaign accelerated, in March 2021, the Provincial Health Officer called on all qualified health professionals to contribute their skills to protect their communities and help end the COVID-19 pandemic by working as immunizers at mass immunization sites around the province. In BC, NDs, who hold Prescriptive Authority and are Immunization Certified through the BC Centre for Disease Control, are qualified to administer vaccines. Along with physicians, nurses (RN, LPN, RPN), and pharmacists, NDs are part of a core group of health professionals who can administer vaccines within their scope of practice.[1] Due to the scale and urgency of the COVID-19 immunization campaign, additional professions were "deputized" to assist in the campaign by Special Order.[2] This all-hands-on-deck approach had the goal of immunizing our population as quickly, safely, and effectively as possible. At the time of this writing, 3,837,848 people in BC have been fully immunized.[3] I am proud to be one of the many health-care providers in BC who contributed to this achievement, particularly because working on the immunization campaign followed the principles of naturopathic medicine.

Even before I was asked to join the COVID-19 immunization campaign, support for vaccines within the naturopathic community had been growing steadily. Currently, at least 156 NDs in BC have immunization certification, allowing them to provide vaccines to clients 12 years of age and older.[4] Perhaps this is due to the increased acceptance that immunization should be considered naturopathic care, since it adheres to both the Naturopathic Therapeutic Order[5] and the six principles of Naturopathic Medicine.[6] The safety and efficacy profiles[7-12] of the COVID-19 vaccines, while not perfect, are impressive and follow the principle of *do no harm*. As the COVID-19 pandemic becomes a "pandemic of the unvaccinated," unvaccinated individuals are more likely to be harmed through contracting the virus or being admitted to the hospital and/or ICU[13] than by receiving a vaccine. Both the viral vector and mRNA vaccines capitalize on the *healing power of nature* to *stimulate our self-healing mechanisms* by generating an immune response to COVID-19 without community exposure. Once immunized, our own immune systems are able to identify and fight off the COVID-19 virus, *preventing* infections from occurring. As health-care providers, NDs play an important role in educating the public about the COVID-19 vaccines. The College of Naturopathic Doctors of British Columbia has recently reminded BC NDs of the important role of *doctor as teacher* and warned against participating in the spread of misinformation.[14]

A typical day at a COVID-19 immunization site would begin with a daily briefing for all the staff present. The briefing included identifying which vaccines and lot numbers were available that day, the number of appointments that had been scheduled, client eligibility for drop-in appointments, any update on the information, safety, efficacy, or adverse events of the COVID-19 vaccines, and of any special security considerations. Clients would be greeted by community volunteers, and office staff would ensure that each person was registered with the provincial immunization tracking system. While waiting for an immunizer, each client had access to take-home information[15] about the risks of contracting COVID-19, and details about the protection offered by and possible adverse reactions to the COVID-19 vaccines. Finally, when a client met with an immunizer, they went through an initial assessment process to determine their suitability to receive a vaccine. Each client was provided accurate information about the possible risks associated with contracting COVID-19 and how the vaccines work to protect them. This was all part of the informed consent process and was presented in clear and plain language. Only after all questions were answered and consent was obtained was a vaccine administered. Afterwards, clients were monitored for 15 minutes to ensure no immediate allergic reactions occurred. By and large, this process was a simple and easy process for a client.

Although immunization is part of the scope of practice for NDs in BC, it is rare for NDs to provide regular immunization services. This is because immunization is typically performed through the publicly funded health-care system and Canadian NDs practice as private health-care providers who work separate from the public system. The COVID-19 immunization campaign provided NDs with a rare opportunity to work within the public system. This

Correspondence to: Dr. Christopher Halldorson. **E-mail:** drhalldorson@gmail.com

To cite: Halldorson C. Naturopathic medicine on the frontline of the COVID-19 pandemic. *CAND Journal*. 2021;28(4):4-6. https://doi.org/10.54434/candj.94

Received: 01 October 2021; **Accepted:** 16 October 2021; **Published:** 15 December 2021

is of importance to the profession for a number of reasons. The first, and most important reason is that NDs helped to protect our communities from COVID-19, one shot at a time. Second, it improved public awareness of NDs and elevated the profession's profile as one that recognizes the scientific evidence supporting the safety and efficacy of the COVID-19 vaccines.[16,17] Support for COVID-19 immunization is widespread throughout the medical community and it is formally recommended by the National Advisory Committee on Immunization,[18,19] the College of Family Physicians of Canada, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada,[20] the Society of Obstetricians and Gynaecologists of Canada,[21] and the Canadian Paediatric Society.[22] Third, participation in the campaign builds bridges between the public system and the naturopathic profession. There is no better way to demonstrate the competency and proficiency of NDs to our medical colleagues than to work beside them as reliable partners. Fourth, it served a political purpose, as NDs showed that we can be called upon and work reliably when Canada's public health-care system needs assistance. Lastly, the COVID-19 immunization campaign is historic in scope. This was not just a Canadian effort but a global one to end the COVID-19 pandemic. By the end of September 2021, 6,136,962,861 COVID-19 vaccine doses had been administered globally.[23] The development and deployment of safe and effective vaccines to protect such a large proportion of the global population is truly a remarkable achievement in medicine, one to which NDs can proudly say that they have helped contribute.

As Canada progresses through the fourth wave of COVID-19 infections, and severe complications from the infection primarily affect the unvaccinated and under-vaccinated, NDs who participated in the COVID-19 immunization campaign should be aware of how working in the campaign has had immeasurably greater impact on our communities than not participating. We helped protect individuals and our communities. We helped our clients make informed choices on their health and we did it in a way that respects our naturopathic principles. Finally, we provided much-needed relief to our colleagues in the public health system and demonstrated that we support evidence-based preventative health measures.

AUTHOR AFFILIATIONS

[1]British Columbia Naturopathic Association, Vancouver, BC, Canada.

ACKNOWLEDGEMENTS

Not applicable.

CONFLICTS OF INTEREST DISCLOSURE

I have read and understood the *CAND Journal*'s policy on conflicts of interest disclosure and declare that I have none.

FUNDING

None.

REFERENCES

1. College of Naturopathic Physicians of British Columbia Standards and requirements for Immunization Certification. Accessed September 23, 2021. https://cnpbc.bc.ca/for-registrants/resources/certification-requirements/immunization
2. Regulated and unregulated health professionals SARS-CoV-2 Immunization – March 24, 2021. Accessed September 29, 2021. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-19-pho-order-ruhp-immunization.pdf
3. British Columbia Centre for Disease Control COVID-19 Dashboard. Accessed October 13, 2021. https://experience.arcgis.com/experience/a6f23959a8b14bfa989e3cda29297ded
4. British Columbia Naturopathic Association Bulletin, fall 2021, p. 14.
5. Zeff J, Snider P, Myers S, Degrandpre Z. A hierarchy of healing: The therapeutic order. Pizzorno J, Murray M, ed. The Textbook of Natural Medicine, 4th Edition. Elsevier Editors; 2013, p. 18-33.
6. Association of Accredited Naturopathic Medical Colleges. The six principles of naturopathic medicine. Accessed September 23, 2021. https://aanmc.org/6-principles/
7. Polack FP, Thomas SJ, Kitchin N, et al. Safety and efficacy of the BNT162b2 mRNA COVID-19 vaccine. *N Engl J Med.* 2020;383:2603-26015. https://doi.org/10.1056/NEJMoa2034577
8. Frenck RW, Klein N, Kitchin N, et al. Safety, immunogenicity, and efficacy of the BNT162b2 COVID-19 vaccine in adolescents. *N Engl J Med.* 2021;385(3):239-250. https://doi.org/10.1056/NEJMoa2107456.
9. Baden L, El Sahly H, Essink B, et al. Efficacy and safety of the mRNA-1273 SARS-CoV-2 vaccine. *N Engl J Med.* 2021;384:403-416. https://doi.org/10.1056/NEJMoa2035389
10. Ali K, Berman G, Zhou H, et al. Evaluation of mRNA-1273 SARS-CoV-2 vaccine in adolescents. *N Engl J Med.* 2021. https://doi.org/10.1056/NEJMoa2109522
11. Falsey AR, Sobieszczyk M, Hirsch I, et al. Phase 3 safety and efficacy of AZD1222 (ChAdOx1 nCoV-19) COVID-19 vaccine. *N Engl J Med.* 2021. https://doi.org/10.1056/NEJMoa2105290
12. Vaccine Safety. The BC Centre for Disease Control. Accessed September 29, 2021. http://www.bccdc.ca/health-info/diseases-conditions/covid-19/covid-19-vaccine/vaccine-safety
13. The Government of Alberta. COVID-19 Alberta statistics – vaccine outcomes. Accessed October 12, 2021. https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#vaccine-outcomes
14. College of Naturopathic Doctors of British Columbia Newsletter, September 2021.
15. Healthlink BC File 124. Accessed September 23, 2021. https://www.healthlinkbc.ca/healthlinkbc-files/covid-19-vaccines
16. BC Centre for Disease Control. Two doses prevent about 95 per cent of COVID-19 hospitalizations: B.C. COVID-19 vaccine effectiveness results. Accessed October 12, 2021. http://www.bccdc.ca/about/news-stories/stories/2021/covid-19-vaccine-effectiveness-results
17. Institut national de santé publique du Québec. Efficacité de deux doses de vaccin contre la COVID-19 chez les adultes Québécois vivant dans la communauté. Accessed October 12, 2021. https://www.inspq.qc.ca/covid-19/vaccination/efficacite-2-doses
18. The National Advisory Committee on Immunization. Recommendations on the use of COVID-19 vaccines. Accessed October 12, 2021. https://www.canada.ca/content/dam/phac-aspc/documents/services/immunization/national-advisory-committee-on-immunization-naci/recommendations-use-covid-19-vaccines/recommendations-use-covid-19-vaccines-en.pdf
19. The National Advisory Committee on Immunization. Recommendations on the use of mRNA COVID-19 vaccines in adolescents 12–17 years of age. Accessed October 12, 2021. https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/recommendations-use-covid-19-vaccines/mrna-adolescents.html#a6
20. The Canadian Medial Association. Canadian Medical forum supports the COVID-19 vaccines authorized in Canada. Accessed October 12, 2021. https://policybase.cma.ca/en/viewer?file=%2fdocuments%2fPolicyPDF%2fPD21-06.pdf#search=covid-19&phrase=false
21. The Society of Obstetricians and Gynaecologists of Canada. SOGC statement on COVID-19 vaccination in pregnancy. Accessed October 12, 2021. https://sogc.org/common/Uploaded%20files/Latest%20News/SOGC_Statement_COVID-19_Vaccination_in_Pregnancy.pdf

22. The Canadian Paediatric Society. COVID-19 vaccine for children. Accessed October 21, 2021. https://www.cps.ca/documents/position/covid-19-vaccine-for-children

23. World Health Organization. COVID-19 dashboard. Accessed September 29, 2021. https://covid19.who.int

Planetary Health and the Naturopathic Profession: Back to the Future

David H. Nelson[1]

The term "planetary health" emerged from the holistic and alternative medicine movement of the 1970s and 1980s. It was used to signify that the relationships between personal health, the health of communities, and the planet itself are one and the same. Of course, this health continuum was already part of the ancestral wisdom of Indigenous cultures—"to harm the Earth is to harm the self."[1] In 1980, a Canadian Chapter of Friends of the Earth expanded the World Health Organization's well-known definition of health to include ecological and planetary health perspectives: "Health is a state of complete physical, mental, social and ecological well-being and not merely the absence of disease—personal health involves planetary health."[2] In 1997, Canadian physician and public health expert, Trevor Hancock declared that among the many individual and collective factors that influence health, planetary health may be the ultimate determinant.[3] Given the historic and growing interest in planetary health and its relationship to personal health, it is time for the naturopathic doctors' profession to underline the connection between people, place, and planet in its priorities.

It is difficult to disagree with Dr. Hancock. Today, fueled by the landmark Lancet Planetary Health Commission Report of 2015, medical interest in the relationships between the health of persons, places and planet—individuals, communities and the Earth's natural systems—has increased considerably.[4] In April 2018, a diverse group of international experts, including Dr. Hancock, convened in Canmore, Alberta, to discuss the interdependence of personal, public, and planetary health. Participants with varied and diverse professional and disciplinary backgrounds presented research and perspectives on some of the most pressing issues of our time. These included, but were not limited to, infectious and non-communicable diseases, biodiversity losses, climate change, environmental degradation, socioeconomic inequality and poverty, health disparities, the dominance and marketing of ultra-processed foods, and mental health and its biopsychosocial underpinnings. The meeting produced the Canmore Declaration, which underscores that human vitality (i.e., what every naturopathic doctor seeks for their patients and the surrounding community) depends intimately on planetary vitality, which in turn depends on the behaviours of humankind, human kindness, empathy, mutualism, responsibility, and reciprocity at the individual, community, societal, and global levels.[5,6] I was thrilled to be in attendance at Canmore along with Canadian College of Naturopathic Medicine (CCNM) graduate Dr. Nicole Redvers, whom I had previously met at CCNM in 2014. Dr. Redvers has since gone on to become one of the leading voices in the planetary health movement, has published dozens of studies with international colleagues from different medical professions, and has even co-authored an updated version of the Hippocratic Oath in the *Lancet*—the Planetary Health pledge.[7]

Representatives of physician organizations, medical schools, and allied health professions have made urgent calls for the incorporation of planetary health principles into medical training. Sadly, there is a common perception that planetary health is merely another term for a focus on toxic environments or the study of climate change. Individual clinicians often find it difficult to see how planetary health is relevant to their day-to-day clinical efforts. Yet, the entire concept of planetary health proposes that the total lived experience, with its positive assets and detrimental exposures, shapes the health of the person in the waiting room. Dr. Redvers wrote recently that "[g]one are the times when focusing solely on human-centric approaches to health will make us and our communities well."[8] I couldn't agree more; the absence of a larger context in the clinical encounter is a significant deficiency in traditional clinical encounters, even in our own profession.

In order to move past the typical human-centric approach that Dr. Redvers speaks of, my colleagues and I refer to planetary health in the health-care encounter as clinical ecology. We argue that the easiest way to understand planetary health in the clinic is through the microbiome, an ecological perspective that illustrates the bidirectional links between the health of person, places, and planet. For further details, the reader is referred to our long-form article in the journal *Challenges*.[9] Briefly, we contend that the clinician must learn to see the patient through the lens of the holobiont, that is, the multicellular eukaryote and the inseparable colonies of persistent symbionts, which together form a critically important unit of anatomy, physiology, immunology, growth, and evolution. It is no longer tenable to view ourselves as functionally separate from microorganisms "residing" on and within us. Through advances in

Correspondence to: David H. Nelson, 79 Montclair Dr., Woodstock, ON N4V 1C5, Canada. **E-mail:** info@davidhplanet.com

To cite: Nelson DH. Planetary health and the naturopathic profession: Back to the future. *CAND Journal*. 2021;28(4):7-8. https://doi.org/10.54434/candj.95

Received: 24 October 2021; **Accepted:** 01 November 2021; **Published:** 15 December 2021

microbiome science and associated "omics" technologies, we can now see that the patient in the waiting room—their state of flourishing, or "dis-ease"—is a product of the *οίκος* ("*oikos*"), that is, the "house," from which the term ecology is derived. We can now look to the "the houses of the houses." Understanding how ecosystems in the halls of power (and the ways in which they are influenced by multi-national traffickers of ultra-processed foods, tobacco, alcohol, etc.) facilitate the global transmission of unhealthy goods allows us to see how the vitality of the person in the waiting room is connected to the vitality of the surrounding community and to the flourishing of the Earth's natural systems.

Once upon a time, the holistic health movement, including the naturopathic profession in particular, was celebrated for its progressive outlook and deep understanding of the connections between personal health and the natural environment.[10] Is this what we are known for today? I don't think so. Why is it that naturopathic doctors make headlines for the use of dubious modalities and suspect interventions? Media bias? Perhaps. Nevertheless, as a profession, we have little control over that; even if our professional organizations had the funds to invest in the best advertisement agency, it is doubtful much would change in the short term.

Dream with me for a moment. I propose that the path towards a better future for our profession, as well as for the health of patients and the places in which we work and play, is one that doesn't involve PR flaks. It is an investment of mind and resources that prioritizes planetary health ideologies. And I don't mean just tinkering around the edges of the curriculum in our schools and Canadian medical education (CME) courses. No, I am referring to a paradigm shift, a core curriculum that works from the perspective that the health of the individual, the community, and the Earth's natural systems are indistinguishable. I am referring to a curriculum that genuinely reflects the line [emphasis is mine] in our own Naturopathic Oath—"I will assist and encourage others to strengthen their health, reduce risks for disease and preserve *the health of our planet for ourselves, our families and future generations*."[11]

Can we really say that our core curriculum matches that line of our pledge? How do we know? Knowledge of the person, place, and planet health continuum is not tested. It isn't tested on Board exams, but it could be. We have to decide where our priorities lie. Is our profession merely a Potemkin house that only pays lip service to our pledge? Or do we have the foundation—and the will—to get this right? Frankly, the patients in our waiting rooms, even the profession itself, cannot wait. And yes, this is a call to action.

AUTHOR AFFILIATIONS

[1]inVIVO Planetary Health Network of the Nova Institute for Health of Persons, Places and Planet, Baltimore, MD, USA.

ACKNOWLEDGEMENTS

Not applicable.

CONFLICTS OF INTEREST DISCLOSURE

I have read and understood *the CAND Journal*'s policy on conflicts of interest disclosure and declare that I have none.

FUNDING

None.

REFERENCES

1. Booth AL, Jacobs HM. Environmental consciousness—native American worldviews and sustainable natural resource management: An annotated bibliography. CPL Bibliography, no. 214. Chicago: Council of Planning Librarians, 1988, p. 9.
2. Friends of the Earth. Conservation society notes: Health care. *Alternatives*. 1980;9:2.
3. Hancock T. Ecosystem health, ecological iatrogenesis, and sustainable human development. *Ecosyst Health*. 1997;3:229-234
4. Whitmee S, Haines A, Beyrer C, et al. Safeguarding human health in the Anthropocene epoch: Report of The Rockefeller Foundation-Lancet Commission on planetary health. *Lancet*. 2015;386:1973-2028.
5. Prescott SL, Logan AC, Albrecht G, et al. The Canmore Declaration: Statement of Principles for Planetary Health. *Challenges*. 2018;9(2):31
6. Logan AC, Berman SH, Scott RB, Berman BM, Prescott SL. Wise ancestors, good ancestors: Why mindfulness matters in the promotion of planetary health. *Challenges*. 2021;12(2):26.
7. Wabnitz KJ, Gabrysch S, Guinto R, et al. A pledge for planetary health to unite health professionals in the Anthropocene. *Lancet*. 2020;396(10261):1471-1473.
8. Redvers N. Patient-planetary health co-benefit prescribing: Emerging considerations for health policy and health professional practice. *Front Public Health*. 2021;9:678545.
9. Nelson DH, Prescott SL, Logan AC, Bland JS. Clinical ecology—transforming 21st-century medicine with planetary health in mind. *Challenges*. 2019;10(1):15.
10. Prescott SL, Logan AC, Katz DL. Preventive medicine for person, place, and planet: Revisiting the concept of high-level wellness in the planetary health paradigm. *Int J Environ Res Public Health*. 2019;16(2):238.
11. Association of Accredited Naturopathic Medical Colleges. 2021. *The Naturopathic Doctors' Oath – AANMC*. Accessed 19 November 2021. https://aanmc.org/the-naturopathic-doctors-oath/

COVID-19 in the Hospitals

Sarah Hourston[1]

I went down to the Emergency room one afternoon to take a history from a patient who needed to be admitted for COVID-19 pneumonia with minor respiratory distress. I put on a yellow gown, blue gloves, N95 and surgical mask, and a face shield to go in to see him.

I cannot say I was a comforting sight.

The patient was a middle-aged man. He had hypertension, but he was otherwise healthy. He had no chronic lung diseases, he was not immunocompromised, he was fit and active. He had a cough for a few days, so he got a COVID-19 test at a pharmacy and it was positive, but he felt okay and stayed home. A few days later, he was having trouble breathing and came to the Emergency room.

He looked terrified.

He was a very nice man. He wanted to know what could be done to help him. He was already on 6 litres of oxygen through an oxygen face mask. The patient clinically qualified for dexamethasone and remdesivir treatment, so I told him we were going to give him those therapies as part of the standards of care at our institution.

I asked him if he was vaccinated.

He cried.

He did not want to get a vaccine because he was not sure they were safe. He looked at me. Tears filled his eyes and spilled down his face. Through his oxygen mask he said, "I guess that was stupid."

That was a moment when time seemed to slow down. How does one respond to that? I looked at this man who was scared for his life and wondered what you tell someone when they have realized they made a grave mistake because they listened to the wrong information. What do you tell someone who is now facing a critical illness that is more severe than the vaccine side effects he was worried about?

I tried my best to console him. I told him that he was sick, needed oxygen, and needed to be in the hospital, but at least he was not so sick that he had to go to the ICU. He would be coming to the medical wards and we would do our best to take care of him and take it one day at a time.

I went to tell my attending physician about him and confirm the plan, then I waited for the patient to come upstairs.

He did not come. Turns out I was wrong.

Within half an hour, he decompensated and had to go straight to the ICU.

I am a naturopathic doctor (ND), but I am also a fourth-year medical student at an allopathic medical school in the United States. As a medical student, I have seen COVID-19 patients, including the patient described above, and I see how hard COVID-19 is still hitting hospitals.

Every COVID-19 patient I personally saw in the hospital was unvaccinated or was vaccinated but immunocompromised, although there are reports of other breakthrough infections.[1] Except for a couple of patients, our ICU was entirely occupied by COVID-19 patients. Several patients who normally would have been in the ICU were being carefully monitored on the medicine wards waiting for an ICU bed when I was last on service.

Other hospital resources are also stretched. Our nursing staff has had a huge turnover due to the burnout rate during the initial waves of the pandemic. It takes an emotional toll to take care of patients who are in the ICUs for weeks, being weaned on and off ventilators, with many of them dying at the end of a complicated course of COVID-19. As such, the physicians, advanced practice clinicians, and nurses who are taking care of patients with COVID-19 are currently facing burnout.

Vaccinations significantly reduce the rates of hospitalization. In the United States and Canada, over 80% of COVID-19-associated hospitalizations are unvaccinated patients.[1,2] With vaccinations being the best preventive option, it can feel frustrating when you are tired and struggling to keep patients alive to then see people refusing this therapy that largely prevents infection and hospitalization. It is no wonder compassion fatigue and burn out are high among health-care professionals.[3]

I have heard on multiple occasions from providers that they wish patients understood how well studied the vaccines are compared with our treatment options once patients are in the hospital with severe infections. The dexamethasone and remdesivir treatment we gave our patient is our best option, but it only goes so far. The RECOVERY trial showed that dexamethasone reduces mortality from COVID-19 by 12.1% in patients requiring mechanical

Correspondence to: Sarah Hourston. **E-mail:** sarah.hourston@hsc.utah.edu

To cite: Hourston S. COVID-19 in the hospitals. *CAND Journal*. 2021;28(4):9-10. https://doi.org/10.54434/candj.97

Received: 3 November 2021; **Accepted:** 15 November 2021; **Published:** 15 December 2021

ventilation and by 2.9% in patients who are on non-invasive oxygen therapy but has no benefit in those who do not require oxygen.[4] The ACTT-1 trial showed remdesivir decreased recovery time from COVID-19 but did not reduce mortality.[5] Some monoclonal antibodies and DMARDs (disease-modifying anti-rheumatic drugs) have shown some mortality benefit in addition to dexamethasone, but only for very select patient populations who meet certain criteria.[6,7] To date, the most robust randomized trial on ivermectin has shown no benefit for symptom resolution and, due to its toxicity, it is not recommended outside of a clinical trial setting.[8] Likewise, hydroxychloroquine has also not shown any clinical benefit against COVID-19.[9]

After meeting this patient, I felt a new frustration at those who were spreading misinformation. After all, patients are only trying their best to stay healthy by finding out what they can from the news and media, and when most people have encountered COVID-19 misinformation, we cannot be surprised that people are hesitant to receive a vaccination.[10]

What role do NDs play in this pandemic? Most NDs are not working in hospitals, and providing vaccinations is not always in our scope of practice across North America. However, NDs are in a position of trust with their patients. When patients come to our offices, we should listen to their concerns about COVID-19 and do our best to answer their questions with the most up-to-date information. We can provide our patients with resources through Health Canada or the United States Centers for Disease Control and Prevention. Many health-care universities and hospitals also have evidence-based patient information that can be useful.

Many NDs are out there doing amazing work for their communities. In the United States, there are NDs who are working at community health centres administering vaccines and working in vaccine drives to help protect their patients.

Vaccinations have historically been a controversial topic in the ND field. There are NDs who are discouraging vaccinations and allegedly falsifying vaccination cards.[11] Naturopathic doctors who are broadly discouraging vaccinations are most likely trying to do what they believe is best for their patients, and perhaps they do not have a full understanding of the scientific literature, as many NDs may not feel comfortable with research literacy.[12] However, these patients are still at risk from COVID-19 complications. These NDs are also in a privileged position as they will not have to be the ones to see their patients in the hospital struggling to draw breath, being placed on ventilators, and dying in front of them.

I never saw my patient again. His family will never see him again. He died several weeks later in the ICU from COVID-19 complications. Meanwhile, other people are permitted to carry on and continue to spread COVID-19 misinformation.

As I go through the hospital halls and see all the red caution signs on the doors of the COVID-19 patients, I am grateful to the people who are providing vaccinations to patients. Naturopathic doctors who are able should continue to provide vaccinations. Those who do not have this in their scope of practice can still continue to read the literature on COVID-19 and provide evidence-based counselling to their patients. The naturopathic profession is well positioned to exemplify our goals of prevention to mitigate the spread of both COVID-19 and misinformation.

AUTHOR AFFILIATIONS

[1] University of Utah, Salt Lake City, UT 84132, USA.

ACKNOWLEDGEMENTS

Not applicable.

CONFLICTS OF INTEREST DISCLOSURE

I have read and understood the *CAND Journal*'s policy on conflicts of interest and declare that I have none.

FUNDING

This research did not receive any funding.

REFERENCES

1. Rates of laboratory-confirmed COVID-19 hospitalizations by vaccination status. CDC. Updated August 28, 2021. Accessed November 12, 2021. https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination
2. COVID-19 daily epidemiology update. Public Health Infobase. Updated November 10, 2021. Accessed November 12, 2021. https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html
3. Moreno-Mulet C, Sansó N, Carrero-Planells A, et al. The impact of the COVID-19 pandemic on ICU healthcare professionals: A mixed methods study. *Int J Environ Res Public Health*. 2021;18(17):9243. https://doi.org/10.3390/ijerph18179243.
4. RECOVERY Collaborative Group, Horby P, Lim WS, et al. Dexamethasone in hospitalized patients with COVID-19. *N Engl J Med*. 2021;384(8):693-704. https://doi.org/10.1056/NEJMoa2021436.
5. Beigel JH, Tomashek KM, Dodd LE, et al. Remdesivir for the treatment of COVID-19 – Final Report. *N Engl J Med*. 2020;383(19):1813-1826. https://doi.org/10.1056/NEJMoa2007764.
6. Kalil AC, Patterson TF, Mehta AK, et al. Baricitinib plus Remdesivir for hospitalized adults with COVID-19. *N Engl J Med*. 2021;384(9):795-807. https://doi.org/10.1056/NEJMoa2031994.
7. RECOVERY Collaborative Group. Tocilizumab in patients admitted to hospital with COVID-19 (RECOVERY): A randomised, controlled, open-label, platform trial. *Lancet*. 2021;397(10285):1637-1645. https://doi.org/10.1016/S0140-6736(21)00676-0.
8. López-Medina E, López P, Hurtado IC, et al. Effect of Ivermectin on time to resolution of symptoms among adults with mild COVID-19: A randomized clinical trial. *JAMA*. 202113;325(14):1426-1435. https://doi.org/10.1001/jama.2021.3071.
9. WHO Solidarity Trial Consortium, Pan H, Pet R, et al. Repurposed antiviral drugs for COVID-19 – Interim WHO solidarity trial results. *N Engl J Med*. 2021;384(6):497-511. https://doi.org/10.1056/NEJMoa2023184.
10. Garneau K, Zossou C. Misinformation during the COVID-19 pandemic. Statistics Canada. February 2, 2021. Accessed November 12, 2021. https://www150.statcan.gc.ca/n1/pub/45-28-0001/2021001/article/00003-eng.htm
11. Napa woman arrested for fake COVID-19 immunization and vaccine card scheme. US Department of Justice. July 14, 2021. Updated July 16, 2021. Accessed November 12, 2021. https://www.justice.gov/usao-ndca/pr/napa-woman-arrested-fake-covid-19-immunization-and-vaccine-card-scheme
12. Senders A, Erlandsen A, Zwickey H. The importance of research literacy. *Nat Med J*. 2014;6(8). https://www.naturalmedicinejournal.com/journal/2014-08/importance-research-literacy

Cultural Considerations in the Management of Chronic Pain

Shakila Mohmand,[1] ND, and **Sumar Chams,**[2] BSc

ABSTRACT

Cultural competency within health care helps eliminate racial and ethnic health disparities. When assessing and treating patients with chronic pain, practitioners should feel confident in using information regarding a patient's individual cultural beliefs due to their significant impact on the pain experience. Culture impacts perception, outlook, and communication of pain, as well as coping mechanisms. These are aspects of subjective history that influence important decisions regarding the management of chronic pain. Becoming more aware of what to look for and which questions to ask can allow naturopathic doctors and other health-care providers to continue improving therapeutic relationships and patient outcomes.

Key Words Cultural competency, pain management, naturopathic medicine, integrative health, holistic medicine, interdisciplinary care, health care, health intake, health-care practitioners

INTRODUCTION

Chronic pain is a condition with various etiologies and is experienced differently by each individual.[1] When people live with chronic pain, the pain experience often becomes a part of their identity. Therefore, to understand the pain experience, we must take into consideration all the dimensions of pain, not only the physical.[2] Addressing thoughts, emotions, and behaviours related to the pain is just as important in achieving optimal outcomes as looking after the physical component. Certain social conditions and cultural norms can either assist with the management of pain or act as barriers.[1] Being aware of these gives practitioners an advantage when it comes to treating patients.

It is becoming increasingly clear how important access to culturally competent health care is. Cultural competency in health care reflects the ability of health-care providers to successfully provide care which meets the unique social and cultural needs of diverse patient populations, thereby improving quality of care and health outcomes.[1] Cultural competency training is essential to help eliminate health disparities and ensure patient safety, because failure to address culture can lead to diagnostic errors and treatment interactions.[3] Patient engagement and collaboration are also impacted because cultural competency increases understanding of what the patient is experiencing and leads to increased trust within the doctor–patient relationship.[3] Recognizing that individual values and behaviour surrounding health care are shaped by cultural, social, and other individual factors is an important part of cultural competence.[1] Integrating these factors into health-care delivery and providing high quality, individualized care regardless of differences in cultural background is what forms the basis for a culturally competent health-care system.[1] Developing cultural competence requires more than merely discussing a set of skills and knowledge in a classroom setting. An overall approach to health care that incorporates concepts of cultural humility, questioning of one's biases, respecting differences and addresses cultural values in health promotion tools, results in culturally competent care that can make a significant impact.[1]

Role of Naturopathic Medicine

With its patient-centred and holistic approach, naturopathic medicine has the ability to elevate cultural competence within the health-care system. Naturopathic doctors are able to spend time with patients and gain a deep understanding of their condition and experience.[4] Through the therapeutic order, a guide to how naturopathic principles can be used effectively, naturopathic doctors aim to establish the foundations for optimal health. In order to do so, the barriers to healing must be removed. This involves addressing lifestyle aspects, such as diet, activity, stress management, rest, and socioeconomic stressors.[5] Culture can impact these determinants of health but is less often taken into consideration.

Chronic Pain and Culture

Chronic pain is a growing public health concern leading to increased medical costs and loss of productivity.[6] It can have a significant impact on daily activities and is often associated with medication dependence, anxiety, depression, and overall poor

Correspondence to: Shakila Mohmand. **E-mail:** sue.mohmand@gmail.com

To cite: Mohmand S, Chams S. Cultural considerations in the management of chronic pain. *CAND Journal*. 2021;28(4):11-13. https://doi.org/10.54434/candj.93

Received: 11 September 2021; **Accepted:** 7 October 2021; **Published:** 15 December 2021

quality of life.[6] This is likely to become an even more significant issue, based on the knowledge that chronic pain conditions are often closely correlated with stress, which, in the current pandemic context, has been at an all-time high for many people.[7]

Chronic pain is a biopsychosocial condition, meaning that social, emotional, and cultural factors play a role in shaping the pain experience and a patient's attitudes and behaviours towards it.[2] Across cultures, the chronic pain experience differs in terms of communication, perception, and coping.[8] Due to the intricate ways in which biopsychosocial factors influence pain, treatment must be highly personalized to fit the needs and lifestyle of each patient.[2] Appreciating the role that culture plays in patients' health helps practitioners recommend treatments that are consistent with the patient's cultural worldview.[8]

Dimensions of Pain

Communication of Pain

Communication of pain differs across cultures, and research has shown that health-care professionals are more likely to be responsive to pain communication coming from people who belong to the same culture, and are less attuned to that of other cultures.[9] Since providers rely on subjective reports to determine pain response, an accurate assessment of the severity or impact of pain will require consideration of possible cultural influences.[10] For some patients, the chronic pain experience becomes a prominent part of their life, whereas others will choose to avoid talking about it even if they are experiencing high levels of pain.[10] Due to this varying pain response, culture can impact health-seeking behaviours and acceptance of interventions.[11]

The way in which pain is expressed, either directly or indirectly, is also influenced by the cultural background of the patient.[10] Cultural responses to pain can range from expressive to stoic.[10] Some cultures believe they should endure pain quietly and serve as a role model to others; therefore, they may be more likely to express pain through non-verbal cues.[10] Building awareness of verbal and nonverbal cues, such as tone, silence, eye contact, and body language, will help practitioners identify and understand these cues in practice.[9] Cultural differences in pain response can also lead to either over- or underestimation of pain tolerance in certain populations.[10] A decreased pain expression may be viewed as an absence of pain, leading to under-treatment, which is detrimental to patient care.[10] It is also important to note that language barriers may come into play when it comes to describing pain. Being clear with explanations and providing examples of types of pain during the patient encounter can help overcome this.[10] Using medical interpreters or technology can also help optimize patient communication in the case of language barriers.[12] Cultural interpreters are preferred, as they are trained to provide clear translations and pick up on cultural nuances. If unavailable, professional virtual language services can be used as an alternative.[12]

Perception of Pain

Health professionals need to acknowledge that the meaning of pain often differs between cultures. Cognitive, emotional, and biological factors significantly affect perception of pain and can impact the trajectory of a patient's improvement.[2] Therefore, understanding how an individual patient feels about pain is as important as the fact that they have pain.[8] For example, some cultures may believe pain is a sign of progress towards recovery, whereas others may believe it is a test of faith.[9] Some patients are so accustomed to pain that they don't ever expect to see a full recovery.[9] Therefore, pain beliefs can impact a patient's ability to be proactive about addressing their pain. It is important to assess stages of change and understand at which level the patient is situated in terms of outlook and motivation for change.[9]

Coping Responses

Views on appropriate coping responses differ across cultures, and this will significantly impact treatment outcomes.[11] Some cultures promote activity as a means of coping with pain; others promote rest.[2] Education regarding appropriate levels of rest versus activity is therefore paramount because this is a situation where assumptions could lead to less than favourable outcomes.[2]

Locus of control also differs between cultures.[11] External locus of control tends to result in less favourable outcomes, while internal locus of control is related to preferable outcomes.[11] Assessing locus of control will open up opportunities for cognitive behavioural interventions that can lead to positive change overall.[11]

Tools for Culturally Competent Care

Various tools exist to assist practitioners in facilitating clear communication with and understanding of patients across cultures. The LEARN model is a framework generated to support cross-cultural communication and can be used as a general guideline for patient interactions.[12] The acronym LEARN stands for the following:

Listen: Assess each patient's understanding of their health condition including causes, potential treatments, and expectations.

Explain: Convey your own perceptions of the condition while being mindful of the patient's perspective.

Acknowledge: Be respectful when discussing differences between views. Point out areas of agreement as well as differences, and determine obstacles to care.

Recommend: Develop a treatment plan.

Negotiate: Ensure that the plan is culturally appropriate and fits with the patient's perceptions of healing.[12]

To ensure that all aspects of the patient's health history are taken into consideration, it is important to assess the patient's understanding of pain and the beliefs surrounding it.[9] This can be achieved by using specific and directed questions which will influence important decisions regarding the management of chronic pain. Asking the patient what they believe is the cause of their pain is important because this will also help determine

whether the patient can identify any potential barriers to their health. To determine how the pain is impacting their life, it is important to ask this directly, as well as determine which emotions the pain brings up for them and whether they have any coping mechanisms to deal with the pain. Asking the patient's opinion regarding what healing looks like for them, the type of treatment they believe is best suited for them, and their expectations regarding treatment outcomes will also increase compliance. With these types of open-ended questions, practitioners are more likely to gain an in-depth knowledge of the patient experience, which will aid in providing more culturally competent care.

Clinical Implications

Culturally competent care recognizes that treatments developed for one culture may not be relevant or effective in another culture.[2] This is especially important when recommendations are related to cognitive and behavioural changes.[2] In the case of chronic pain management, it is essential to discuss lifestyle modifications surrounding diet and exercise. In order to ensure patient compliance, clinicians need to be aware of appropriate treatments and adapt them to make culturally relevant suggestions. For example, asking a patient to remove a staple from their cultural diet will likely lead to poor adherence and is not a long-term solution unless the patient makes that decision on their own. Patients can be supported by directing them to culturally relevant resources which can help them make the most beneficial and long-lasting changes. This type of culturally informed evaluation of patients strengthens doctor–patient relationships and leads to better health outcomes.[10]

CONCLUSION

Practitioners who are aware of diverse cultural backgrounds as well as the values of current medical models are more prepared to offer culturally appropriate treatment plans.[12] Being aware of personal biases can prevent ethnocentrism, which, left unaddressed, can hinder appropriate care.[12] Overall, developing a deeper understanding of the role of culture in the experience of pain can help providers tailor treatments to better match the worldview of their patients.[8] This can be supported using tools such as the LEARN model as well as a more in-depth culturally oriented health assessment during medical encounters.

AUTHOR AFFILIATIONS
[1]Independent Scholar, Ottawa, ON, Canada; [2]Independent Scholar, London, ON, Canada.

ACKNOWLEDGEMENTS
Not applicable.

CONFLICTS OF INTEREST DISCLOSURE
We have read and understood the *CAND Journal*'s policy on conflicts of interest disclosure and declare that we have none.

FUNDING
This research did not receive external funding.

REFERENCES

1. Cultural competence in health care: Is it important for people with chronic conditions? Health Policy Institute. Published 2019. Accessed September 7, 2021. https://hpi.georgetown.edu/cultural/
2. Sharma S, Abbott J, Jensen M. Why clinicians should consider the role of culture in chronic pain. *Braz J Phys Ther*. 2018;22(5):345-346. https://doi.org/10.1016/j.bjpt.2018.07.002
3. Cultural competence and patient safety. Psnet.ahrq.gov. Published 2019. Accessed September 7, 2021. https://psnet.ahrq.gov/perspective/cultural-competence-and-patient-safety
4. Bradley R, Harnett J, Cooley K, McIntyre E, Goldenberg J, Adams J. Naturopathy as a model of prevention-oriented, patient-centered primary care: A disruptive innovation in health care. *Medicina (B Aires)*. 2019;55(9):603. doi:10.3390/medicina55090603
5. The Therapeutic Order. AANMC. Published 2021. Accessed September 7, 2021. https://aanmc.org/featured-articles/therapeutic-order/
6. Kuehn B. Chronic pain prevalence. *JAMA*. 2018;320(16):1632. doi:10.1001/jama.2018.16009
7. Clauw D, Häuser W, Cohen S, Fitzcharles M. Considering the potential for an increase in chronic pain after the COVID-19 pandemic. *Pain*. 2020;161(8):1694-1697. doi:10.1097/j.pain.0000000000001950
8. Kolski M, O'Connor A. *A world of hurt*. St. Louis: Thomas Land Incorporated; 2015.
9. Peacock S, Patel S. Cultural influences on pain. *Rev Pain*. 2008;1(2):6-9. doi:10.1177/204946370800100203
10. Givler A, Bhatt H, Maani-Fogelman P. The importance of cultural competence in pain and palliative care. *StatPearls*. 2021.
11. Orhan C, Van Looveran E, Cagnie B, Mukhtar NB, Lenoir D, Meeus M. Are pain beliefs, cognitions, and behaviors influenced by race, ethnicity, and culture in patients with chronic musculoskeletal pain: A systematic review. *Pain Phys*. 2018;21:541-558. doi:10.36076/ppj.2018.6.541
12. Ladha T, Zubairi M, Hunter A, Audcent T, Johnstone J. Cross-cultural communication: Tools for working with families and children. *Paediatr Child Health*. 2018;23(1):66-69. https://doi.org/10.1093/pch/pxx126

Comment on "Evidence-Based Practice Attitudes, Skills, and Usage Among Canadian Naturopathic Doctors: A Summary of the Evidence and Directions for the Future"

Gudrun Welder,[1] ND

I was happy to read the article "Evidence-based practice attitudes, skills, and usage among Canadian Naturopathic Doctors: A summary of the evidence and directions for the future"[1] in the last issue of *CANDJ* because I think it is important to continue to have dialogue around evidence-based practice and what it means for naturopaths.

I believe it can be very harmful for naturopaths, themselves, to buy into the supposed public perception that naturopaths do not use as much evidence-based medicine (EBM) as medical doctors. I wish the article referenced above had compared EBM among naturopaths and medical doctors instead of implying that naturopaths use less EBM without showing the evidence for such a claim.

I believe that when we, as naturopaths, identify our profession as lacking in EBM, we are adopting outdated and damaging attitudes set up long ago by controlling paradigms of thought like the Flexner report.[2] This report proposed that nature-based doctors, women doctors, and Aboriginal/Native American and Black physicians should no longer be considered as health-care practitioners because they were not rigorous enough in their "scientific" ideology. Flexner successfully advocated for the idea that medical schools needed to primarily recommend treatment with pharmaceuticals made from petroleum products. Nature-based medicine was labelled as "outside of empirical science," and therefore not "evidence-based." Flexner also reported that African American physicians should be trained in "hygiene rather than surgery" and should primarily serve as "sanitarians," whose purpose was "protecting Whites" from common diseases like tuberculosis.

When the Flexner report came out in the early 1910s, medical schools for women, African Americans, and Aboriginals/Native Americans existed and many of these schools used nature-based medicine. Some used nature-based medicine in conjunction with petroleum-based pharmaceuticals. By 1912, all of those schools were closing or closed. Only schools for White men focused on prescribing petroleum-based pharmaceuticals remained.

Today, EBM still typically refers to large, randomized double-blind clinical trials done with pharmaceutical interventions. Trying to adopt EBM as our path into legitimacy does not make sense. We need to find new ways of portraying exactly how serious we are about individualized health care without playing into outdated dogmatic medical structures many of which the public has lost trust in.

The article in *CANDJ* states that "evidence-based practice also emphasizes the development of critical appraisal skills, which are important in navigating the scientific literature, where conflicting findings and biased results are frequently present."[1] If we, as naturopaths, are not able to identify the bias that has been laced through medical terminology, such as "evidence-based practice," for the last 100 years, we are in trouble and also sadly out of touch with much of the public thinking that is rapidly becoming aware of the inherent bias in such terminology.

I believe that, as naturopaths, we need to orient ourselves to the context of what "evidence-based medicine" means today. For a great deal of the public and practising naturopaths, those words still harken back to and identify with Flexner's beliefs, and we should not pride ourselves in trying to identify with Flexner's efforts and beliefs any longer.

AUTHOR AFFILIATIONS
[1] Independent scholar, Bradford, ON, Canada.

ACKNOWLEDGEMENTS
Not applicable.

CONFLICTS OF INTEREST DISCLOSURE
I have read and understood the *CAND Journal*'s policy on conflicts of interest and declare that I have none.

FUNDING
This research did not receive any funding.

Correspondence to: Gudrun Welder, 125 Collings Ave., Bradford, ON L3Z 2G5, Canada. **E-mail:** gudrunweldernd@gmail.com

To cite: Welder G. Letter to the editor. *CAND Journal*. 2021;28(4):14-15. https://doi.org/10.54434/candj.101

Received: 9 November 2021; **Accepted:** 10 November 2021; **Published:** 15 December 2021

REFERENCES

1. Aucoin M, Leach MJ, Cooley K. Evidence-based practice attitudes, skills, and usage among Canadian naturopathic doctors: A summary of the evidence and directions for the future. *CANDJ*. 2021;28(3):9-13. https://doi.org/10.54434/candj.91
2. Flexner A. Medical Education in the United States and Canada. Washington, DC: Science and Health Publications, Inc.; 1910.

Reply to "Comment on 'Evidence-Based Practice Attitudes, Skills, and Usage Among Canadian Naturopathic Doctors: A Summary of the Evidence and Directions for the Future.'"

Monique Aucoin,[1] BMSc, ND, **Matthew J. Leach,**[2] PhD, and **Kieran Cooley,**[3] BSc, ND

Dear *CAND Journal* Editor and author of "Comment on 'Evidence-based practice attitudes, skills, and usage among Canadian Naturopathic Doctors: A summary of the evidence and directions for the future,'"

Thank you for your Letter to the Editor[1] in response to our recent article "Evidence-Based Practice Attitudes, Skills, and Usage Among Canadian Naturopathic Doctors: A Summary of the Evidence and Directions for the Future." We are pleased that our article has sparked further discussion on the topic of evidence-based practice/medicine (EBP/EBM) in the Canadian naturopathic community.

We were surprised that the reader felt the article had somehow suggested that "Naturopaths" engage with EBP/EBM less frequently than medical doctors. Our article simply highlighted that Naturopathic Medicine has been criticized for being in opposition to EBP from many outside the profession, from the media, and occasionally from members within the profession. We further added that this criticism is not fully substantiated. In fact, our article focussed heavily on the findings from our recent survey, which suggested that Canadian Naturopathic Doctors' (NDs') self-reported use of EBP was moderately high and that the sources of evidence used were consistent with the framework of EBP. In addition, when these findings were compared with assessments of other professions, the levels of EBP engagement reported by Canadian NDs was higher than levels reported by chiropractors, osteopaths, herbalists, and yoga instructors.[1] Your statement does highlight a gap in knowledge regarding direct comparisons between different professions on attitudes, skills, use, or even approach to EBP/EBM.

Of course, as with all clinical skills, opportunities should be provided to enable clinicians to refine and optimize those skills. Accordingly, our team is currently delivering a continuing education course to support EBP engagement among Canadian NDs. This course was co-designed with 22 Canadian NDs to ensure the interests, needs, and preferences of the profession were taken into consideration. We acknowledge that the reader may have inferred that by offering this course, we were in some way suggesting that Canadian NDs were using EBP inadequately or that there is a need to increase EBP use among Canadian NDs. This was certainly not the case. In fact, 93% of Canadian NDs responding to our recent survey expressed an interest in improving their EBP skills,[2] and our course is largely a response to this call.

While the roots of EBP originate in the medical world, we do not believe that EBP is incompatible with naturopathic practice, nor that it is in absolute discord with a vitalistic world view[3] or the scientific world view that comes across in Flexner's words. We believe that it is possible to take the beneficial aspects of EBP to improve the patient experience, such as continually reassessing current practices and striving for clinical improvement. While an over-reliance on scientific evidence could potentially result in care that is inconsistent with naturopathic philosophy, it is not necessarily predetermined. In fact, we are convinced that it is indeed possible to incorporate the best available scientific evidence with other sources of evidence in a way that is consistent with naturopathic philosophy and principles. We also acknowledge that attention to this balance, and acumen in finding congruence between the knowledge, experience, and needs of patient and clinician alongside evidence from research is critical. So much so that this very issue is explicitly addressed in our EBP course. Evidence-based medicine should not be conflated or confused with a reliance on (imperfect) randomized controlled trials for health-care decisions[4,5] where issues of individualization, cultural appropriateness, or evidence on pharmaceutical-style interventions might dominate the literature or attention of health-care providers.

As a final point, the reader referred to a statement in our article about the need to increase skills in identifying bias. While the

Correspondence to: Monique Aucoin, 1255 Sheppard Ave. E., Toronto, ON M2K 1E2, Canada. **E-mail:** maucoin@ccnm.edu

To cite: Aucoin M, Leach MJ, Cooley K. Reply to "Comment on 'Evidence-based practice attitudes, skills, and usage among Canadian Naturopathic Doctors: A summary of the evidence and directions for the future.'" *CAND Journal*. 2021;28(4):16-17. https://doi.org/10.54434/candj.102

Received: 15 November 2021; **Accepted:** 15 November 2021; **Published:** 15 December 2021

authors are confident that NDs are skilled in this area, we suggest there are always opportunities for refreshing, updating, or improving, as with all skills and continuing education. Although we are speculating, due to training and experience, many NDs may be aware of some sources of bias inherent in research designs (e.g., expectation, sampling), personal biases (e.g., recency or familiarity), or other biases that may influence clinical or research evidence, such as conflict of interest or industry involvement (which is what we believe the reader was referring to); they may not be as familiar with biases such as residual confounding, attrition bias, or reporting bias, which require a higher level of research literacy. It is these technical sources of bias that we were suggesting NDs could benefit from learning more about.

We genuinely appreciate the reader taking the time to respond to our article and engage in a conversation about the role of EBP in Naturopathic Medicine. We hope that other readers will also reflect on the role of evidence in this field and join in the conversation.

Warm regards,
Monique Aucoin, Matthew Leach, and Kieran Cooley

AUTHOR AFFILIATIONS

[1]Canadian College of Naturopathic Medicine, Canada; [2]Southern Cross University, Australia; [3]Canadian College of Naturopathic Medicine, Canada; University Technology, Sydney, Australia; National Centre for Naturopathic Medicine at Southern Cross University, Australia; Pacific College of Health and Science, USA.

ACKNOWLEDGEMENTS

Not applicable.

CONFLICTS OF INTEREST DISCLOSURE

We have read and understood *the CAND Journal's* policy on conflicts of interest disclosure and declare the following interests: MA, KC, and ML are involved in the creation and delivery of continuing education on EBP skills for Naturopathic Doctors that may involve direct or indirect personal benefit.

FUNDING

This research did not receive any funding.

REFERENCES

1. Welder G. Comment on "Evidence-based practice attitudes, skills, and usage among Canadian Naturopathic Doctors: A summary of the evidence and directions for the future." *CANDJ*. 2021;28(4):14-15. https://doi.org/10.54434/candj.101
2. Leach M, Aucoin M, Cooley K. A national cross-sectional survey of Canadian naturopathic physician doctors' engagement, preparedness and perceptions of evidence-based practice. Submitted to PLOS One. 2021.
3. Coulter I, Snider P, Neil A. Vitalism—A worldview revisited: A critique of vitalism and its implications for integrative medicine. *Integr Med (Encinitas)*. 2019;18(3):60–73.
4. Nichol AD, Bailey M, Cooper DJ, POLAR, EPO Investigators. Challenging issues in randomised controlled trials. *Injury*. 2010;41 Suppl 1:S20–3.
5. Frieden TR. Evidence for health decision making—beyond randomized, controlled trials. *N Engl J Med*. 2017;377(5):465–75.

Erratum: Collaboration in the Time of COVID-19: Lessons for Community Shared Care Models

In the November 2020 issue of the *CAND Journal* (formerly *Vital Link*) there appeared a misspelling of one of the authors' names for the article "Collaboration in the Time of COVID-19: Lessons for Community Shared Care Models" (*CAND Journal*. 2020;27(2):11-12. https://doi.org/10.54434/candj.61). The authors are Muna Chowdhury and Cyndi Gilbert. Dr. Chowdhury's name was misspelled as "Chowdury." We regret the error and apologize for any resulting confusion.

The author list in the online version of the article has been corrected.

To cite: Erratum: Collaboration in the time of COVID-19: Lessons for community shared care models. *CAND Journal*. 2021;28(4):18. https://doi.org/10.54434/candj.99

Received: 16 November 2021; **Accepted:** 17 November 2021; **Published:** 15 December 2021