CANDJ

Allyship

Marianne Trevorrow,[1] MA, ND

This edition's theme came together somewhat organically over the summer as we transitioned away from a flurry of updates on the editorial side. The last item on this year's list was our PubMed application, a project we have been planning since 2021 and which our publisher submitted in mid-July. While there is a multi-step and multi-month process of assessment still to come, the fact that we were ready to make this application is a big milestone for *CANDJ* and our small but dedicated editorial team.

As we were finalizing contents, it seemed that each article focused on a different aspect of listening to the lived experience of people who have been or may be treated poorly in conventional care, and who look to naturopathic doctors to provide a more knowledgeable and empathetic clinical experience—to be, in other words, better patient allies.

Doing some background research for this letter, I thought back to a conversation I had at the Saskatchewan Association's Healing Skies conference in late May with Jenny Gardipy, a Senior Policy Analyst at the Assembly of First Nations (AFN) and PhD student in Indigenous Studies at the University of Saskatchewan who joined us at the CAND table. I was listening to her discuss her ongoing PhD research studying the experiences of Indigenous people with disabilities in the Canadian healthcare system. Some of the stories were heartbreaking, and we reflected on the fact that people in the non-Indigenous community need to hear these stories and understand them so that we can learn from past mistakes and form better therapeutic alliances with the people we are looking to serve.

For many members of underserved groups, or people with complex disabilities or healthcare conditions, these negative and often traumatizing experiences can lead them to become distrustful of medicine in general. The result is that, often, we miss the opportunity to help them manage their healthcare needs before they become catastrophic. This is one of the areas where naturopathic care could provide a unique benefit to many people who have felt unheard, disenfranchised, ignored—or worse. But we must go in armed with knowledge of these patients' specific lived experiences, knowledge we can use to become more effective healthcare allies.

Our review article for the edition, discussing integrative naturopathic perinatal care for individuals with obesity, exemplifies this argument. As Priolo and colleagues describe, current perinatal care in Canada is fragmented and focused specifically on the perinatal, labour and delivery period, leaving important windows for intervention neglected in the pre-conception and postpartum timeframes. They also discuss how guideline-driven management tends to leave patients feeling stigmatized and judged, when a more empathetic and motivational approach could produce better outcomes for both subsequent pregnancies and long-term metabolic disease prevention.

Our first commentary from Lindsay takes up this theme of empathetic listening in practice, particularly as more patients present to ND offices with complex and challenging health concerns. Additionally, we have two commentaries from Inghram and Martineau, who discuss overlapping challenges faced by 2SLGBTQIA+ patients in accessing affirming, non-stigmatizing care, and the negative outcomes that result when patients can't access preventive medicines such as Pre-Exposure Prophylaxis (PrEP) for HIV prevention. Both authors ask us to think about where gaps in knowledge about the lived experience of these populations due to a variety of factors (including the current polarized political climate) may also deprive these patients of responsive, culturally informed care.

We hope these submissions will encourage other colleagues to think about contributing to *CANDJ*; we know that there are many areas of naturopathic practice that need to be highlighted in our publication and look forward to meeting more of our readers at local fall and winter conferences this year. As always, we welcome commentaries and letters to the editor through our portal at candjournal.ca and ideas for upcoming submissions to my inbox at editor@cand.ca

AUTHOR AFFILIATION
[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.

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

To cite: Trevorrow M. Editor's letter: allyship. *CAND Journal*. 2025;32(3):1. https://doi.org/10.54434/candj.223

Published by the **Canadian Association of Naturopathic Doctors.**

Supporting Perinatal Health in Individuals with Obesity: Integrative and Naturopathic Perspectives

Alexsia Priolo,[1] ND, **Carly King,**[2] ND, **Meghan McNaughton,**[3] ND, and **Kelsey Hroch,**[4] ND

ABSTRACT

Obesity in the perinatal period represents a growing public health concern with significant implications for short- and long-term maternal and fetal outcomes. This review summarizes the current recommendations related to perinatal obesity, exploring evidence-informed strategies for prevention and management from the preconception to the postpartum period.

In the preconception period, this review addresses weight management, lifestyle counselling, targeted supplementation, and behaviour strategies through motivational interviewing. During pregnancy, strategies to support optimal gestational weight gain, evidence-based supplementation to mitigate risks of complications such as preeclampsia and gestational diabetes, and lifestyle interventions aimed at reducing obesity-related pregnancy risks are reviewed. Lastly, in the postpartum period, this review examines the impact of maternal obesity on early recovery, breastfeeding initiation, and mental health, as well as the long-term risks of postpartum weight retention and strategies to support sustainable, values-aligned lifestyle changes.

Future directions should prioritize interdisciplinary collaboration, including obstetrics, primary care, nutrition, behavioural health, and community-based support systems. Research is also needed to refine diagnostic criteria, evaluate the long-term effects of prenatal interventions, and ensure equitable care for populations disproportionately affected by obesity and its sequelae.

Key Words Perinatal health, obesity, naturopathic medicine, preconception, pregnancy, postpartum, gestational diabetes, preeclampsia

INTRODUCTION

Obesity in the perinatal period represents a growing public health concern with significant implications for maternal and fetal outcomes. The rising prevalence of obesity among individuals of reproductive age has paralleled increases in pregnancy-related complications, including gestational diabetes mellitus (GDM), hypertensive disorders, Caesarean delivery, and postpartum weight retention.[1] Infants born to individuals with obesity are also at elevated risk for macrosomia, preterm birth, and long-term metabolic dysregulation.[2]

Despite the well-established risks, clinical management of obesity during pregnancy and the postpartum period remains challenging. Current guidelines emphasize early risk stratification, individualized nutrition and lifestyle counselling, and close metabolic monitoring, but implementation is often inconsistent. There is also a need for clearer consensus on effective dietary interventions, safe supplementation, and postpartum weight management strategies that support maternal health.

This review aims to synthesize current evidence on the multifaceted risks associated with perinatal obesity and to explore practical, evidence-informed strategies for prevention and management. It addresses preconception and prenatal considerations, including optimal weight gain targets and the role of micronutrient supplementation. Additionally, postpartum strategies for reducing long-term metabolic risk and promoting sustainable weight loss in individuals with obesity are discussed. Emphasis is placed on individualized, non-stigmatizing care that integrates nutrition, physical activity, and behavioural health.

By reviewing the current literature and identifying gaps in care, this paper seeks to support a more integrative, prevention-oriented approach to perinatal care for individuals with obesity—one that promotes lifelong cardiometabolic health for both parent and child.

Correspondence to: Alexsia Priolo, 656 The Queensway, Etobicoke, ON M8Y 1K7, Canada.
E-mail: alexsia@alexsiapriolo.com

To cite: Priolo A, King C, McNaughton M, Hroch K. Supporting perinatal health in individuals with obesity: integrative and naturopathic perspectives. *CAND Journal*. 2025;32(3):2-10. https://doi.org/10.54434/candj.214

Received: 31 May 2025; **Accepted:** 5 August 2025; **Published:** 18 September 2025

Published by the **Canadian Association of Naturopathic Doctors.**

PRECONCEPTION GUIDANCE

Obesity among reproductive-aged women is a pressing issue for health systems in Canada and the United States. Nearly 40% of women enter pregnancy with overweight or obesity, conditions linked with increased risks of infertility, GDM, hypertensive disorders, preterm birth, and stillbirth.[3] The metabolic dysfunction associated with obesity can also lead to changes in placental function and vascular formation in the fetus.[4] A study reviewing preconception health knowledge among women planning a pregnancy found that 51% had poor knowledge of the risks associated with obesity in pregnancy, and that 31% misperceived their own body weight, which was more likely among overweight women (71%) than those with obesity (10%).[5]

Preconception care offers a unique window to reduce these risks and improve pregnancy outcomes through comprehensive, individualized interventions. Canadian and American guidelines, particularly from the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the American College of Obstetricians and Gynecologists (ACOG), endorse integrated strategies that include weight optimization, lifestyle counselling, nutritional supplementation, and behavioural support.

Risk Assessment: BMI Classification and Limitations

Body mass index (BMI) remains the standard tool for obesity classification. According to the World Health Organization (WHO) and adopted by both SOGC and ACOG:

- Class I Obesity: BMI 30–34.9 kg/m²
- Class II Obesity: BMI 35–39.9 kg/m²
- Class III Obesity (Severe or Morbid Obesity): BMI ≥40 kg/m²

While BMI is practical for population-level risk stratification, it does not distinguish between fat and lean body mass or account for weight distribution. Waist circumference may offer additional insight into metabolic risk, particularly central adiposity, which is strongly associated with insulin resistance and cardiovascular disease. Clinical assessment may integrate both BMI and waist circumference to monitor patient progress and track change over time (Table 1).

TABLE 1 Waist circumference values by BMI for Caucasian women and high-risk waist circumference range (80–95 cm), depending on ethnicity, above which individuals face increased cardiometabolic risk.

	BMI category (kg/m²)	Waist Circumference in Women (cm)
Normal weight	18.5–24.9	≥ 80
Overweight	25–29.9	≥ 90
Obese I	30–34.9	≥ 105
Obese II and III	≥ 35	≥ 115

BMI = body mass index;
Ross R, Neeland IJ, Yamashita S, et al. Waist circumference as a vital sign in clinical practice: a consensus statement from the IAS and ICCR Working Group on Visceral Obesity. *Nat Rev Endocrinol*. 2020;16(3):177-189. https://doi.org/10.1038/s41574-019-0310-7

Weight Management and Risk Reduction

Weight loss before conception has notable benefits for women with obesity. A 5% to 10% reduction in pre-pregnancy weight improves insulin sensitivity, restores ovulation, enhances fertility, and significantly lowers the risks of pregnancy complications, such as preeclampsia and Caesarean delivery.[3] Weight management approaches should include dietary modification, increased physical activity, and behaviour change strategies. According to SOGC guidelines, even small weight reductions prior to pregnancy can improve perinatal outcomes and reduce the incidence of large-for-gestational-age (LGA) infants.[7]

Diet and Physical Activity Counselling

Evidence-supported nutrition interventions, such as the Mediterranean or DASH diets, offer substantial benefits in the preconception phase. These diets emphasize high intake of fruits, vegetables, whole grains, legumes, and healthy fats, while reducing red meat and refined sugars. They also emphasize a reduction in packaged and processed foods, which are often high in sugar or sodium, and can lead to overconsumption or take the place of more nutritional options. A low-glycemic index dietary pattern has also been linked with improved glucose control and ovulatory function.[8]

Physical activity is equally critical. ACOG and SOGC recommend at least 150 minutes per week of moderate-intensity aerobic exercise. These include brisk walking, swimming, or cycling. Regular physical activity reduces GDM risk, enhances insulin sensitivity, and improves cardiovascular function. Combining dietary and exercise interventions can reduce gestational weight gain and improve the likelihood of live birth in women with prior infertility.[3]

Evidence-Based Supplementation

Both ACOG and Health Canada recommend targeted supplementation for women with obesity planning pregnancy. Key nutrients include:

Folic acid: Women with obesity should take a minimum of 400 mcg and up to 5 mg of folic acid daily, beginning at least 3 months preconception, due to a higher risk of neural tube defects and altered folate metabolism.[7,9]

Vitamin D: Obesity is associated with lower serum 25(OH)D levels, and deficiency increases risks of GDM, preeclampsia, and small-for-gestational-age (SGA) infants. Supplementation with 1,000–2,000 IU/day is safe and effective in achieving sufficiency.[10]

Iron: Screening for iron deficiency is essential due to increased physiological demands during pregnancy and the high prevalence of dietary insufficiency. Women with low ferritin (<30 ng/mL) should receive iron supplementation to prevent anemia and ensure adequate stores for pregnancy.

Myo-inositol: Supplementation with 2 g twice daily has shown promise in reducing GDM incidence and improving metabolic

health in women with obesity or polycystic ovarian syndrome (PCOS).[11] A 2022 meta-analysis supports its role in improving insulin sensitivity and ovulatory function without significant adverse effects.[3]

Screening and Laboratory Testing

Routine preconception screening should include complete blood count (CBC), ferritin, thyroid-stimulating hormone (TSH), HbA1c, fasting glucose or insulin, 25(OH)D levels, lipid profile, renal function (including proteinuria and serum creatinine), liver function tests, sexually transmitted infection (STI) screening, and assessment of rubella and varicella immunity.[7] Additional screening may include polysomnography to assess for obstructive sleep apnea, which has been associated with increased risk of preeclampsia (odds ratio [OR] 2.5), eclampsia (OR 5.4), cardiomyopathy (OR 9.0), and gestational diabetes (OR 1.9).[12] This enables early identification and treatment of subclinical deficiencies and chronic disease, which can influence conception and pregnancy outcomes.

Motivational Interviewing and Behavioural Change

Emerging research supports the use of motivational interviewing (MI) as an effective strategy in facilitating preconception behaviour change. In a 2024 randomized controlled trial, women receiving up to 10 MI-based health coaching sessions reported high satisfaction, improved confidence, and significant lifestyle improvements.[13] The collaborative, non-judgmental approach of MI aligns well with preconception counselling, helping patients identify goals, build self-efficacy, and overcome barriers. One retrospective study looked at MI as a weight loss tool prior to fertility treatment, noting a statistical difference for the MI group compared with controls (9.3 kg loss vs 7.3 kg, $p = 0.01$).[14] Other studies have shown that pairing evidence-based weight management strategies with MI can lead to meaningful reductions in gestational weight gain and promote long-term health behaviour maintenance.[8] Motivational interviewing further enhances patient engagement, offering a sustainable model for behaviour change in this high-risk population.

Effective preconception care for women with obesity requires a holistic, evidence-informed approach that incorporates Canadian and American clinical guidelines. By combining individualized weight loss plans, dietary and physical activity guidance, targeted supplementation, and behavioural support, clinicians can significantly reduce the risk of adverse maternal and fetal outcomes.

PREGNANCY GUIDANCE

A pregnant person's BMI can affect their experience with perinatal care. Although many individuals with obesity seek guidance on nutrition and weight gain during pregnancy, they are often met with judgment and biased treatment based on their weight.[15]

A 2024 study demonstrated that pregnant people with a BMI over 30 encountered increased weight stigma, mistreatment, and disrespect by obstetric care providers.[15] Care providers can provide compassionate care by understanding that a person's ability, opportunity, and motivation to engage in healthy behaviours is impacted by social determinants of health. These include education, employment, early childhood development, food insecurity, housing, income, and stress.[16] While many pregnancies affected by obesity can have successful outcomes, maternal weight in pregnancy does carry a risk for both adverse pregnancy and adverse fetal outcomes (Table 2).[17]

In 2009, the Institute of Medicine (IOM) outlined the recommended gestational weight gain in a singleton pregnancy, based on a person's pre-pregnancy BMI (Table 3).[18,19] Gestational weight gain is defined as the amount of weight gained during pregnancy and is calculated between the weight reported at the first prenatal visit and the last visit before birth.[19] It is important to note that weight gain during pregnancy is responsible for a number of

TABLE 2 Adverse outcomes associated with obese pregnant women

Adverse Pregnancy Outcomes	Adverse Fetal/Infant Outcomes
Early pregnancy loss	Congenital malformations
Gestational diabetes mellitus	Macrosomia
Hypertensive disorders and preeclampsia	Shoulder dystocia
Anesthesia complication	Fetal asphyxia
Caesarean birth	Stillbirth
Intrapartum hemorrhage	Obesity
Thrombotic disease	Metabolic syndrome
Depression	Cardiovascular disease
	Cognitive disorders

Poniedziałek-Czajkowska E, Mierzyński R, Leszczyńska-Gorzelak B. Preeclampsia and obesity—the preventive role of exercise. *Int J Environ Res Public Heal*. 2023;20(2):1267. https://doi.org/10.3390/ijerph20021267

TABLE 3 IOM gestational weight gain recommendations

Pre-pregnancy weight category	Body Mass Index (kg/m²)	Recommended range of total weight gain (kg)	Recommended rate of weight gain (kg) per week in the second and third trimester, mean (range), kg/wk
Underweight	<18.5	12.7–18.1	0.45 (0.45–0.59)
Normal weight	18.5–24.9	11.3–15.9	0.45 (0.36–0.45)
Overweight	25–29.9	6.8–11.3	0.27 (0.23–0.32)
Obese (Class I)	30–34.9	5–9.1	0.23 (0.18–0.27)
Obese (Class II)	35–39.9		
Obese (Class III)	≥40		

IOM = Institute of Medicine; Dalfra' MG, Burlina S, Lapolla A. Weight gain during pregnancy: a narrative review on the recent evidences. *Diabetes Res Clin Pract*. 2022;188:109913. https://doi.org/10.1016/j.diabres.2022.109913

factors: fat stores, increased blood volume, increased extravascular fluid volume, uterine enlargement, breast enlargement, amniotic fluid, placenta, and fetus.[19]

Research indicates a high prevalence of gestational weight gain exceeding IOM recommendations, potentially due to factors such as reduced physical activity and suboptimal dietary intake.[20] The SOGC suggests that many women with obesity are unaware of the risks associated with excessive gestational weight gain due to insufficient counselling from healthcare providers.[21]

The IOM guidelines have been subject to ongoing debate, with some experts arguing that the recommended gestational weight gain for individuals with overweight and obesity is too high. Additionally, the guidelines do not differentiate weight gain targets among obesity classes.[9] Furthermore, due to variations in body composition across racial groups, the World Health Organization has considered using alternative obesity classification criteria for Asian women.[22]

REDUCING THE RISK OF NOTABLE ADVERSE PREGNANCY OUTCOMES ASSOCIATED WITH OBESITY

Obesity is a known risk factor for common adverse pregnancy outcomes outlined in Table 2, such as preeclampsia and gestational diabetes. Naturopathic doctors are well positioned to provide early education on these conditions and counsel on preventive strategies, particularly given that many pregnant individuals do not engage with a primary obstetric care provider until the second trimester.

Preeclampsia

Preeclampsia, affecting approximately 1.6% to 2.6% of pregnancies in Canada,[23] is a hypertensive disorder of pregnancy that most often arises in healthy, nulliparous women with no obvious risk factors.[24] However, the risk of preeclampsia is nearly threefold higher among individuals with obesity.[17]

Common strategies to reduce preeclampsia risk include:

Aspirin: Low-dose aspirin reduces the risk of preeclampsia in moderate- to high-risk individuals, with a 53% relative risk reduction (95% confidence interval [CI], 0.35–0.66) when started between 12 and 16 weeks' gestation.[25] ACOG recommends 81–162 mg daily at bedtime until 36 weeks for those with one high-risk or two or more moderate-risk factors (see Table 4).[24]

Calcium: Oral supplementation of at least 500 mg is recommended for individuals with low dietary calcium intake (less than 900 mg per day) to help prevent preeclampsia.[26] A recent meta-analysis found that when calcium supplementation is combined with low-dose aspirin, the risk of developing preeclampsia is reduced by a factor of 0.20 (95% CI 0.10–0.37).[27]

Vitamin D: According to SOGC guidelines, additional vitamin D supplementation beyond Health Canada's recommended intake is not advised for the prevention of preeclampsia.[26] However, a 2023 study suggests that vitamin D supplementation may reduce the risk of preeclampsia by up to 50%.[28] Additionally, WHO recommends vitamin D supplementation prior to pregnancy for individuals with vitamin D deficiency to help prevent preeclampsia.[29]

Gestational Diabetes

Gestational diabetes is one of the most common pregnancy complications, affecting about 10% of pregnancies in Canada.[30] Obesity is considered a strong predictor in the development of gestational diabetes.[31]

According to SOGC guidelines, individuals with obesity and additional risk factors, such as maternal age over 35, a family history of diabetes, previous gestational diabetes, or a history of delivering a macrosomic infant, may be offered either the 1-hour 50-g oral glucose challenge test or the diagnostic 75-g oral glucose tolerance test during the first half of pregnancy. If initial screening is negative, repeat testing is recommended between 24 and 28 weeks of gestation.[32]

Common strategies to reduce the risk of GDM include:

Vitamin D: Although evidence is of low quality, a Cochrane review found that vitamin D supplementation initiated before 25 weeks' gestation reduced the risk of GDM by 49% (relative risk [RR] 0.51).[33] Doses varied across studies, and baseline vitamin D status was often not reported. Nonetheless, this may represent an opportunity for naturopathic doctors to assess vitamin D status early in pregnancy.

Myo-inositol: Supplementation with 4 g of myo-inositol in the first trimester may reduce the risk of GDM; however, evidence remains limited in individuals with obesity.[34] Naturopathic

TABLE 4 Guidance of aspirin prophylaxis to reduce preeclampsia risk

High Risk Factors (≥1)	Moderate Risk Factors (≥2)
History of preeclampsia	No birth history
Multifetal gestation	Obesity
Chronic hypertension	Family history of preeclampsia
Diabetes mellitus I or II	Socioeconomic factors
Chronic kidney disease	Age >35 years
Autoimmune disorder (e.g., systemic lupus erythematosus, antiphospholipid syndrome)	Personal history factors (e.g., low birth weight or small for gestational age, previous adverse pregnancy outcome, more than 10-year pregnancy interval)

Croke L. Gestational hypertension and preeclampsia: a practice bulletin from ACOG. *Am Fam Physician*. 2019;100(10):649-650.

doctors may consider evaluating other GDM risk factors to determine whether this low-risk intervention is appropriate.

Probiotics: Supplementation with multistrain probiotics before 20 weeks' gestation has been shown to lower the risk of GDM by 33% (RR 0.67) in individuals with or without obesity.[35]

MANAGEMENT OF OBESITY IN PREGNANCY

Achieving an optimal weight prior to conception is ideal.[36] Nevertheless, primary weight management strategies during pregnancy focus on dietary modification, physical activity, and behavioural interventions.[9] Given that nearly 60% of pregnancies are planned, there is a significant opportunity to implement lifestyle changes, particularly in diet and exercise, to support maternal health and reduce the risk of adverse maternal and fetal outcomes.[1]

Minimizing Weight Gain

SOGC guidelines recommend calculating BMI at the initial prenatal visit and limiting gestational weight gain to 5–9 kg in individuals with obesity.[21] In addition, ACOG advises using BMI to guide individualized dietary and physical activity recommendations during pregnancy.[9]

Discussion of weight and gestational weight gain should begin at the first prenatal visit. Motivational interviewing techniques are recommended, including obtaining permission to discuss sensitive topics (e.g., weight gain), screening for a history of eating disorders, and asking open-ended questions when appropriate. Examples include: "What are your thoughts about weight gain during pregnancy?" or, in subsequent pregnancies, "Can you describe what weight gain was like in your last pregnancy?"[8] Responses can inform a supportive and collaborative approach to optimizing gestational weight gain.

Weight loss during pregnancy is not recommended, as inadequate gestational weight gain may increase the risk of fetal growth restriction.[20] A 2015 systematic review found that individuals with obesity who lost weight during pregnancy were more likely to deliver infants who were SGA.[37]

Diet

During pregnancy, most individuals fall short on recommended intakes of vegetables, fruits, whole grains, dairy, and seafood, while exceeding limits for sodium, saturated fat, and added sugars.[38] The International Federation of Gynecology and Obstetrics (FIGO) Nutrition Checklist (Table 5) can help naturopathic doctors assess and guide dietary intake.[38] Notably, adherence to a Mediterranean-style diet during pregnancy is linked to a 22% lower risk of preeclampsia (OR 0.78), especially among Black women, and a 36% reduced risk of gestational diabetes.[39,40]

Exercise

Exercise is recommended for all pregnant women, as there are improved outcomes and healthier gestational weight gain in those who engage in regular physical activity.[20] Despite the benefits, obese women cite lack of knowledge about appropriate exercise, conflicting advice, lack of access to correct information, support, and advice on exercise during pregnancy from their obstetrical care providers as barriers to exercise.[39] This is a critical opportunity for naturopathic doctors to provide guidance and lower these barriers.

Exercise recommendations for women in pregnancy are:

1. All women without a contraindication (see Table 6) should be physically active throughout pregnancy. Pregnant people with absolute contraindications are limited to their regular activities of daily living and nothing more strenuous. Those with relative contraindications, however, are encouraged to discuss the advantages and disadvantages of moderate-intensity physical activity with their care provider.[42]

2. At least 150 minutes of moderate-intensity physical activity should be accumulated each week, over a minimum of 3 days.

3. A variety of aerobic and resistance training should be incorporated to achieve greater benefits.[42]

Suitable exercises for people with obesity include brisk walking, stationary cycling, swimming, and aqua aerobics, as they may provide less strain on muscle and ligaments. In addition, regular monitoring of exercise is encouraged, as well as using heart rate monitoring to ensure that the appropriate intensity is achieved.

Although the SOGC guidelines for obesity in pregnancy recommend that previously sedentary pregnant people should begin exercise early in the second trimester, research demonstrates that to reduce the risk of developing gestational hypertensive disorders, such as preeclampsia, physical activity should begin in the first trimester of pregnancy.[43] In addition, the risk of developing gestational diabetes is reduced by 13% when 150 minutes of physical activity during the week are achieved in the first trimester.[44]

POSTPARTUM GUIDANCE

The postpartum period represents an underemphasized phase in the continuum of perinatal care, particularly for individuals

TABLE 5 Sample of FIGO's nutrition checklist for pre-pregnant/early pregnant women

Diet Quality	
Do you eat meat or chicken 2–3 times per week?	Yes or no
Do you regularly eat more than 2–3 portions of fruit or vegetables per day?	Yes or no
Do you eat fish at least 1 or 2 times per week?	Yes or no
Do you consume dairy products (e.g. milk, cheese, yogurt) daily?	Yes or no
Do you eat whole grain carbohydrate foods (brown bread, brown pasta, brown rice or other) at least once a day?	Yes or no
Do you consume packaged snacks, cakes, pastries or sugar-sweetened drinks less than 5 times a week?	Yes or no

Hart TL, Petersen KS, Kris-Etherton PM. Nutrition recommendations for a healthy pregnancy and lactation in women with overweight and obesity—strategies for weight loss before and after pregnancy. *Fertil Steril*. 2022;118(3):434-446. https://doi.org/10.1016/j.fertnstert.2022.07.027.

TABLE 6 Absolute and relative contraindications to exercise in pregnancy

Absolute Contraindications	Relative Contraindications
• Ruptured membranes	• Recurrent pregnancy loss
• Premature labour	• Gestational hypertension
• Unexplained persistent vaginal bleeding	• A history of spontaneous preterm birth
• Placenta previa after 28 weeks' gestation	• Mild/moderate cardiovascular or respiratory disease
• Preeclampsia	• Symptomatic anemia
• Incompetent cervix	• Malnutrition
• Intrauterine growth restriction	• Eating disorder
• High-order multiple pregnancy (e.g., triplets)	• Twin pregnancy after the 28th week
• Uncontrolled type 1 diabetes	• Other significant medical conditions
• Uncontrolled hypertension	
• Uncontrolled thyroid disease	
• Other serious cardiovascular, respiratory, or systemic disorder	

Mottola MF, Davenport MH, Ruchat SM, et al. 2019 Canadian guideline for physical activity throughout pregnancy. *Br J Sports Med.* 2018;52(21):1339. https://doi.org/10.1136/bjsports-2018-100056

affected by overweight or obesity. While prenatal care receives concentrated attention, support tends to diminish after delivery, despite evidence that the postpartum window is essential for shaping long-term maternal health outcomes. Obesity compounds the challenges of recovery, increasing the risk of surgical complications, delayed wound healing, cardiometabolic conditions, and mental health disorders.[48-50] Many individuals retain excess weight after childbirth, and this persistent weight retention is a known risk factor for developing type 2 diabetes and cardiovascular disease later in life.[48-51] Yet most postpartum care models remain generalized and reactive, rather than responsive to the specific needs of this high-risk population. Reframing the postpartum period as a strategic opportunity for prevention, recovery, and health optimization, rather than focusing narrowly on weight loss, may offer a more impactful approach to maternal care.

The Unseen Burden: How Obesity Affects Postpartum Recovery

Postpartum recovery varies significantly between individuals, but those with obesity often face additional complexities within standard care models. A higher BMI is associated not only with an increased risk of pregnancy-related complications but also with delayed healing and a more complex postpartum recovery.[52] Obesity is an independent risk factor for both elective and emergency Caesarean delivery and is linked to prolonged labour, anesthesia-related complications, extended hospitalization, and higher rates of postpartum hemorrhage and infection.[21,52]

Beyond wound healing, individuals with a higher BMI are more likely to report persistent low back and pelvic pain, fatigue, and reduced mobility, which can impact infant bonding, breastfeeding, and maternal mental health.[50] Establishing breastfeeding can also be more difficult, especially in cases involving early maternal-infant separation, such as Caesarean delivery.[55] These individuals are less likely to initiate breastfeeding and commonly experience delayed lactogenesis.[55] These physical and emotional stressors are frequently compounded by weight-related stigma in postpartum care settings, contributing to reduced follow-up and fewer opportunities for support.

Despite the substantial demands of postpartum recovery, care is often limited to a single 6-week visit, which inadequately addresses the complexities of healing, pain, mental health, and metabolic risk. This narrow window of care overlooks a critical opportunity to ensure continuity, screen for complications, and support individualized recovery plans. Integrative approaches that emphasize whole-person care, trauma-informed communication, and proactive support can help bridge the gaps and reframe postpartum recovery as an essential phase to affect long-term health outcomes.

Postpartum Weight Retention: What We Miss When We Focus on the Scale

Postpartum weight retention remains one of the most persistent challenges following pregnancy. Approximately 75% of individuals do not return to their pre-pregnancy weight within the first year, with an average retention of 4 to 5 kg.[51] This risk is even greater among those with obesity, particularly when excessive gestational weight gain occurs, a pattern observed in 35% to 50% of pregnancies.[21,48] Individuals who gain ≥20 kg during pregnancy are significantly more likely to retain weight postpartum compared with those who remain within recommended guidelines.[21] For individuals with elevated BMI or cardiometabolic risk, even modest postpartum weight reduction may contribute to the prevention of diabetes and cardiovascular disease.[51]

While the long-term risks of postpartum weight retention are well-documented, the way weight in clinical care settings is discussed can have equally lasting effects. Individuals with higher BMI report negative experiences with a provider, citing language that feels insensitive, or overly focused on risk without context.[52] This approach can cause emotional distress and damage the therapeutic relationship. While sharing risk information is important, patients have expressed that it can feel overwhelming or stigmatizing when not paired with empathy, support, or actionable solutions.[52] Patients emphasize the importance of having their diet and activity preferences considered and receiving not just warnings, but collaborative plans developed in partnership with their care team.[52]

Rather than centering care around weight loss alone, focus should be shifted to energy, function, metabolic health, and long-term disease prevention. Weight-inclusive frameworks, such as intuitive eating and mindful movement, offer more sustainable and compassionate alternatives.[52] Naturopathic strategies such as blood sugar regulation, anti-inflammatory nutrition, stress reduction, and individualized care planning align well with this philosophy. Reframing postpartum recovery around whole-person wellness, rather than just a return to baseline weight, is an effective and empowering approach.

Metabolic and Cardiovascular Risk: A Critical Window

Between 50% and 60% of individuals with obesity gain more than the recommended gestational weight, increasing the likelihood of complications such as gestational hypertension, preeclampsia, and gestational diabetes.[21] Many also enter pregnancy with

pre-existing conditions such as chronic hypertension or diabetes, factors that significantly raise the risk of severe maternal morbidity and long-term cardiovascular disease.[53]

Nearly one in three women will experience a cardiovascular event within 20 years of delivery, with risks especially elevated among those with pre-existing heart disease or adverse pregnancy outcomes.[54] Obesity further compounds these risks, particularly when postpartum weight retention is present.[55] These cumulative effects reflect broader cardiometabolic shifts initiated during pregnancy. Inflammatory activity, insulin resistance, and lipid alterations can persist postpartum, impacting blood pressure regulation, vascular health, and endothelial function.[56]

The risk for venous thromboembolism also rises significantly in the postpartum period, with the highest incidence occurring in the first 6 weeks. Individuals with obesity who have undergone a recent Caesarean birth are at even greater risk. While routine prophylaxis may not be indicated for everyone, early mobilization, adequate hydration, and the use of compression devices should be considered for those at higher risk.[21]

Despite these risks, postpartum care rarely includes cardiometabolic follow-up. Many individuals are not screened until symptoms arise, often years or even decades later.[57] One-third of those with hypertensive disorders of pregnancy develop chronic hypertension within 10 years.[57] Earlier identification of risk and implementation of preventive care beginning in the postpartum period could significantly improve long-term maternal health outcomes.

Mental Health and the Mind-Body Disconnect

Mental and metabolic health are deeply interconnected, yet mental health is often overlooked in postpartum care and lifestyle interventions. Individuals with pre-pregnancy obesity, excessive gestational weight gain, or postpartum weight retention are at higher risk for depressive and anxiety symptoms during pregnancy and the postpartum period.[21] This is a bi-directional relationship where depression and anxiety can hinder efforts to make lifestyle changes, and additional challenges such as stigma, sleep disturbances, emotional eating, and body image concerns can further compromise mental well-being.

Individuals with a pre-pregnancy BMI ≥30 kg/m^2 or a history of anxiety or depression are more likely to experience depressive or anxiety symptoms in subsequent pregnancies, especially when compounded by poor sleep.[58] Those sleeping less than 6 hours per night report lower resilience, higher stress, and increased anxiety.[58] This highlights the need for routine screening, using a tool such as the Edinburgh Postnatal Depression Score (EPDS), and early support.

Naturopathic and integrative strategies, including cognitive behavioural therapy, nutrition, exercise, and sleep hygiene, can play a vital role in reducing symptoms and supporting recovery. Supporting mental health is foundational, not optional, in comprehensive postpartum care.

What Works: Translating Evidence into Postpartum Care

Lifestyle changes can improve postpartum health outcomes, but real-life barriers, such as financial strain, lack of childcare, fatigue, and cultural expectations, often limit access to support. Traditional approaches fall short when they fail to consider these realities.

Emerging research highlights adaptable models that prioritize flexibility and community. Virtual interventions, such as Facebook-based or app-delivered group programs, have proven both feasible and acceptable for time-constrained parents.[59] Community-based group programs have also shown benefits, improving weight outcomes, well-being, and participant satisfaction by aligning with individual needs and preferences.[60]

This is where integrative care excels, offering personalized, relationship-based support that goes beyond weight or calories. Through motivational interviewing, behavioural coaching, and holistic strategies, practitioners can help patients make sustainable changes aligned with their values. Effective postpartum care must be flexible, culturally sensitive, and grounded in trust.

Looking Ahead: Postpartum as the Start of Preconception Care

Postpartum care does not end at 6 weeks; it extends into the months and years that follow, especially for those planning future pregnancies. The interpregnancy interval is a key window to reduce modifiable risk factors, optimize metabolic health, and prevent complications in the next pregnancy. When weight, blood sugar, and lifestyle are addressed during this time, outcomes improve significantly for both parent and baby.

Both the SOGC and ACOG highlight that even modest weight loss between pregnancies can reduce maternal and fetal risks, including GDM, Caesarean birth, stillbirth, and LGA infants.[9,21] A weight loss of over 2 BMI units is linked to a 40% lower risk of having a LGA infant, without increasing the risk of SGA, unless weight loss exceeds 8 BMI units.[21] Clinicians are advised to offer behavioural counselling on diet and physical activity, as combined interventions are more effective than exercise alone.[9]

Improving postpartum outcomes requires reimagining care as a year-long, multidisciplinary effort. Obesity-related complications persist beyond 6 weeks and intersect with mental health, metabolic risk, and care gaps. A collaborative model including naturopathic doctors, dietitians, mental health professionals, midwives, and obstetricians can deliver proactive, whole-person care. Shifting from reactive to preventive care reduces cardiometabolic risk, builds emotional resilience, and addresses weight stigma through culturally responsive, relationship-based support.

CONCLUSION

Obesity during the perinatal period significantly influences the trajectory of maternal and child health, increasing the risk of metabolic, obstetric, and neonatal complications. While the evidence clearly supports early and sustained intervention, clinical strategies remain underutilized and often fragmented across disciplines. Addressing obesity in pregnancy requires more than weight-based metrics; it involves comprehensive assessment of metabolic status, dietary quality, nutrient adequacy, physical activity, and psychosocial support.

This review highlights key areas for intervention, including the role of targeted laboratory testing, evidence-informed dietary strategies, safe supplementation of key nutrients, and personalized physical activity programs adapted for the perinatal period. The postpartum period is a crucial, yet often neglected, opportunity to support weight management, prevent type 2 diabetes, and address cardiovascular risk, while also supporting lactation and maternal recovery.

Future directions should prioritize interdisciplinary collaboration, including obstetrics, primary care, nutrition, behavioural health, and community-based support systems. Research is also needed to refine diagnostic criteria, evaluate the long-term effects of prenatal interventions, and ensure equitable care for populations disproportionately affected by obesity and its sequelae.

Ultimately, shifting the narrative around perinatal obesity from one of risk to one of opportunity may help improve outcomes. By engaging individuals with obesity in informed, respectful, and integrated care before, during, and after pregnancy, clinicians can play a pivotal role in breaking intergenerational cycles of metabolic disease and promoting lasting health for families.

AUTHOR AFFILIATIONS

[1]Independent Researcher, Toronto, ON, Canada
[2]McMaster University, Hamilton, ON, Canada
[3]Independent Researcher, St. Catharines, ON, Canada
[4]Independent Researcher, Sault Ste. Marie, ON, Canada

ACKNOWLEDGEMENTS

Not applicable

CONFLICTS OF INTEREST DISCLOSURE

We have read and understood the *CAND Journal's* policy on conflicts of interest and declare that AP, MM, and KH have none. CK is employed by The Confident Clinician, but this work was conducted entirely independently of that employment. The company had no role in this manuscript.

FUNDING

This research did not receive any funding

REFERENCES

1. Langley-Evans SC, Pearce J, Ellis S. Overweight, obesity and excessive weight gain in pregnancy as risk factors for adverse pregnancy outcomes: a narrative review. *J Hum Nutr Diet*. 2022;35(2):250-264. https://doi.org/10.1111/jhn.12999
2. Almutairi FS, Alsaykhan AM, Almatrood AA. Obesity prevalence and its impact on maternal and neonatal outcomes in pregnant women: a systematic review. *Cureus*. 2024;16(12):e75262. https://doi.org/10.7759/cureus.75262
3. Lim S, Harrison C, Callander E, Walker R, Teede H, Moran L. Addressing obesity in preconception, pregnancy, and postpartum: a review of the literature. *Curr Obes Rep*. 2022;11:405-414.
4. Lindsay K, Brennan L, Rath A, Maguire OC, Smith T, McAuliffe FM. Gestational weight gain in obese pregnancy: impact on maternal and foetal metabolic parameters and birthweight. *J Obstet Gynaecol*. 2018;38(1):60-65.
5. Berenson AB, Pohlmeier AM, Laz TH, Rahman M, Saade G. Obesity risk knowledge, weight misperception, and diet and health-related attitudes among women intending to become pregnant. *J Acad Nutr Diet*. 2016;116(1):69-75. https://doi.org/10.1016/j.jand.2015.04.023
6. Ross R, Neeland IJ, Yamashita S, et al. Waist circumference as a vital sign in clinical practice: a consensus statement from the IAS and ICCR Working Group on Visceral Obesity. *Nat Rev Endocrinol*. 2020;16(3):177-189. https://doi.org/10.1038/s41574-019-0310-7
7. Maxwell C, Gaudet L, Cassir G, et al. Guideline no. 391—pregnancy and maternal obesity part 1: pre-conception and prenatal care. *J Obstet Gynaecol Can*. 2019;41(11):1623-1640. https://doi.org/10.1016/j.jogc.2019.03.026
8. Jevitt CM, Ketchum K. Pairing evidence-based strategies with motivational interviewing to support optimal nutrition and weight gain in pregnancy. *J Perinat Neonatal Nurs*. 2024;38(1):25-36. https://doi.org/10.1097/jpn.0000000000000792
9. Obesity in pregnancy: ACOG practice bulletin, number 230. *Obstet Gynecol*. 2021;137(6):e128-e144. https://doi.org/10.1097/AOG.0000000000004395
10. National Institute for Health and Care Excellence (NICE). Optimum vitamin D dose during pregnancy for those medically classified as being in the overweight or obesity weight categories. 2023. https://www.nice.org.uk/guidance/ng247
11. Mashayekh-Amiri S, Mohammad-Alizadeh-Charandabi S, Abdolalipour S, Mirghafourvand M. Myo-inositol supplementation for prevention of gestational diabetes mellitus in overweight and obese pregnant women: a systematic review and meta-analysis. *Diabetol Metabol Syndr*. 2022;14(1):93.
12. Louis JM, Mogos MF, Salemi JL, et al. Obstructive sleep apnea and severe maternal–infant morbidity/mortality in the United States, 1998–2009. *Sleep* 2014;37:843-849.
13. Mead L, Mitchell M, Deussen AR, Dodd JM. Motivational interviewing in the preconception period for women with overweight or obesity. *Obes Res Clin Pract*. 2024;18(5):S46.
14. Karlsen K, Humaidan P, Sørensen LH, Alsbjerg B, Ravn P. Motivational interviewing: a part of the weight loss program for overweight and obese women prior to fertility treatment. *Gynecol Endocrinol*. 2013;29(9):839-842. https://doi.org/10.3109/09513590.2013.808326
15. Malhotra N, Jevitt CM, Stoll K, Phillips-Beck W, Vedam S, RESPCCT Study Team. Weight-based disparities in perinatal care: quantitative findings of respect, autonomy, mistreatment, and body mass index in a national Canadian survey. *BMC Pregnancy Childbirth*. 2024;24(1):737. https://doi.org/10.1186/s12884-024-06928-8
16. Alberga AS, McLaren L, Russell-Mayhew S, von Ranson KM. Canadian senate report on obesity: focusing on individual behaviours versus social determinants of health may promote weight stigma. *J Obes*. 2018;2018(1):8645694. https://doi.org/10.1155/2018/8645694
17. Poniedziałek-Czajkowska E, Mierzyński R, Leszczyńska-Gorzelak B. Preeclampsia and obesity—the preventive role of exercise. *Int J Environ Res Public Heal*. 2023;20(2):1267. https://doi.org/10.3390/ijerph20021267
18. Institute of Medicine. *Weight gain during pregnancy: reexamining the guidelines*. National Academies Press; 2009.
19. Dalfra' MG, Burlina S, Lapolla A. Weight gain during pregnancy: a narrative review on the recent evidences. *Diabetes Res Clin Pract*. 2022;188:109913. https://doi.org/10.1016/j.diabres.2022.109913
20. Martínez-Hortelano JA, Cavero-Redondo I, Álvarez-Bueno C, Sanabria-Martínez G, Poyatos-León R, Martínez-Vizcaíno V. Interpregnancy weight change and hypertension during pregnancy: a systematic review and meta-analysis. *Obstet Gynecol*. 2020;135(1):68-79. https://doi.org/10.1097/aog.0000000000003573
21. Maxwell C, Gaudet L, Cassir G, et al. Guideline no. 392—Pregnancy and maternal obesity part 2: team planning for delivery and postpartum care. *J Obstet Gynaecol Can*. 2019;41(11):1660-1675. https://doi.org/10.1016/j.jogc.2019.03.027
22. Catalano PM, Shankar K. Obesity and pregnancy: mechanisms of short-term and long-term adverse consequences for mother and child. *BMJ*. 2017;356:j1. https://doi.org/10.1136/bmj.j1
23. Fox R, Kitt J, Leeson P, Aye CYL, Lewandowski AJ. Preeclampsia: risk factors, diagnosis, management, and the cardiovascular impact on the offspring. *J Clin Med*. 2019;8(10):1625. https://doi.org/10.3390/jcm8101625
24. Croke L. Gestational hypertension and preeclampsia: a practice bulletin from ACOG. *Am Fam Physician*. 2019;100(10):649-650.
25. Bartsch E, Medcalf KE, Park AL, Ray JG, High Risk of Pre-eclampsia Identification Group. Clinical risk factors for pre-eclampsia determined in early pregnancy: systematic review and meta-analysis of large cohort studies. *BMJ*. 2016;353:i1753. https://doi.org/10.1136/bmj.i1753
26. Magee LA, Smith GN, Bloch C, et al. Guideline no. 426: hypertensive disorders of pregnancy: diagnosis, prediction, prevention, and management. *J Obstet Gynaecol Can*. 2022;44(5):547-571.e1. https://doi.org/10.1016/j.jogc.2022.03.002

27. Chen WY, Sun SF. Clinical efficacy of low-dose aspirin combined with calcium in preventing preeclampsia: a systematic review and meta-analysis. *Medicine*. 2023;102(34):e34620. https://doi.org/10.1097/md.0000000000034620

28. AlSubai A, Baqai MH, Agha H, et al. Vitamin D and preeclampsia: a systematic review and meta-analysis. *SAGE Open Med*. 2023;11:20503121231212092. https://doi.org/10.1177/20503121231212093

29. World Health Organization. Vitamin D supplementation in pregnant women: guidelines. 2012. http://www.who.int/publications/i/item/9789241500275

30. Government of Canada. Diabetes. Public Health Agency of Canada. 2025. https://www.canada.ca/en/public-health/services/chronic-diseases/diabetes.html

31. Sweeting A, Wong J, Murphy HR, Ross GP. A clinical update on gestational diabetes mellitus. *Endocr Rev*. 2022;43(5):763-793. https://doi.org/10.1210/endrev/bnac003

32. Berger H, Gagnon R, Sermer M. Guideline no. 393—diabetes in pregnancy. *J Obstet Gynaecol Can*. 2019;41(12):1814-1825.e1. https://doi.org/10.1016/j.jogc.2019.03.008

33. Griffith RJ, Alsweiler J, Moore AE, et al. Interventions to prevent women from developing gestational diabetes mellitus: an overview of Cochrane Reviews. *Cochrane Database Syst Rev*. 2020;6(6):CD012394. https://doi.org/10.1002/14651858.CD012394.pub3

34. Factor PA, Corpuz H. The efficacy and safety of myo-inositol supplementation for the prevention of gestational diabetes mellitus in overweight and obese pregnant women: a systematic review and meta-analysis. *J ASEAN Fed Endocr Soc*. 2023;38(2):102-112. https://doi.org/10.15605/jafes.038.02.11

35. Pakmehr A, Ejtahed HS, Shirzad N, Hemmatabadi M, Farhat S, Larijani B. Preventive effect of probiotics supplementation on occurrence of gestational diabetes mellitus: a systematic review and meta-analysis of randomized controlled trials. *Front Med*. 2022;9:1031915. https://doi.org/10.3389/fmed.2022.1031915

36. Kurnaz D, Karaçam Z. The effect of methods used in the management of maternal obesity on pregnancy and birth outcomes: a systematic review with meta-analysis. *Int J Obes*. 2025;49(6):1013-1023. https://doi.org/10.1038/s41366-025-01748-y

37. Kapadia MZ, Park CK, Beyene J, Giglia L, Maxwell C, McDonald SD. Weight loss instead of weight gain within the guidelines in obese women during pregnancy: a systematic review and meta-analyses of maternal and infant outcomes. *PLoS ONE*. 2015;10(7):e0132650. https://doi.org/10.1371/journal.pone.0132650

38. Hart TL, Petersen KS, Kris-Etherton PM. Nutrition recommendations for a healthy pregnancy and lactation in women with overweight and obesity—strategies for weight loss before and after pregnancy. *Fertil Steril*. 2022;118(3):434-446. https://doi.org/10.1016/j.fertnstert.2022.07.027

39. Minhas AS, Duvall C, Michos ED. Diet as a lifestyle intervention to lower preeclampsia risk. *J Am Hear Assoc*. 2024;13(5):e032551. https://doi.org/10.1161/jaha.123.032551

40. Liu L, Zhou Y, He L. Mediterranean diet for the prevention of gestational diabetes: a meta-analysis of randomized controlled trials. *J Matern-Fetal Neonatal Med*. 2022;35(26):10247-10252. https://doi.org/10.1080/14767058.2021.1966764

41. Seneviratne SN, McCowan LME, Cutfield WS, Derraik JGB, Hofman PL. Exercise in pregnancies complicated by obesity: achieving benefits and overcoming barriers. *Am J Obstet Gynecol*. 2015;212(4):442-449. https://doi.org/10.1016/j.ajog.2014.06.009

42. Mottola MF, Davenport MH, Ruchat SM, et al. 2019 Canadian guideline for physical activity throughout pregnancy. *Br J Sports Med*. 2018;52(21):1339. https://doi.org/10.1136/bjsports-2018-100056

43. Martínez-Vizcaíno V, Sanabria-Martínez G, Fernández-Rodríguez R, et al. Exercise during pregnancy for preventing gestational diabetes mellitus and hypertensive disorders: an umbrella review of randomised controlled trials and an updated meta-analysis. *BJOG*. 2023;130(3):264-275. https://doi.org/10.1111/1471-0528.17304

44. Xie W, Zhang L, Cheng J, Wang Y, Kang H, Gao Y. Physical activity during pregnancy and the risk of gestational diabetes mellitus: a systematic review and dose–response meta-analysis. *BMC Public Health*. 2024;24(1):594. https://doi.org/10.1186/s12889-024-18131-7

45. Endres LK, Straub H, McKinney C, et al. Postpartum weight retention risk factors and relationship to obesity at 1 year. *Obstet Gynecol*. 2015;125(1):144-152. https://doi.org/10.1097/AOG.0000000000000585

46. Blomberg M. Maternal and neonatal outcomes among obese women with weight gain below the new Institute of Medicine recommendations. *Obstet Gynecol*. 2011;117(5):1065-1070. https://doi.org/10.1097/aog.0b013e318214f1d1

47. Ruhstaller KE, Elovitz MA, Stringer M, Epperson CN, Durnwald CP. Obesity and the association with maternal mental health symptoms. *J Matern Fetal Neonatal Med*. 2017;30(16):1897-1901. https://doi.org/10.1080/14767058.2016.1229766

48. Bijlholt M, Ameye L, van Uytsel H, Devlieger R, Bogaerts A. Evolution of postpartum weight and body composition after excessive gestational weight gain: the role of lifestyle behaviours—data from the INTER-ACT control group. *Int J Environ Res Public Health*. 2021;18(12):6344. https://doi.org/10.3390/ijerph18126344

49. Moussa HN, Alrais MA, Leon MG, Abbas EL, Sibai BM. Obesity epidemic: impact from preconception to postpartum. *Future Sci OA*. 2016;2(3):FSO137. https://doi.org/10.4155/fsoa-2016-0035

50. Mogren IM. BMI, pain and hyper-mobility are determinants of long-term outcome for women with low back pain and pelvic pain during pregnancy. *Eur Spine J*. 2006;15(7):1093-1102. https://doi.org/10.1007/s00586-005-0004-9

51. Lubrano C, Locati F, Parisi F, et al. Gestational weight gain as a modifiable risk factor in women with extreme pregestational BMI. *Nutrients*. 2025;17(4):736. https://doi.org/10.3390/nu17040736

52. Dever M, Skouteris H, Rodriguez ACI, et al. Weight stigma in the preconception, pregnancy, and postpartum periods: a systematic review of women's perspectives. *Obes Rev*. 2025;26(5):e13891. https://doi.org/10.1111/obr.13891

53. Gunderson EP, Greenberg M, Najem M, et al. Severe maternal morbidity associated with chronic hypertension, preeclampsia, and gestational hypertension. *JAMA Netw Open*. 2025;8(1):e2451406. https://doi.org/10.1001/jamanetworkopen.2024.51406

54. Siu SC, Lee DS, Rashid M, Fang J, Austin PC, Silversides CK. Long-term cardiovascular outcomes after pregnancy in women with heart disease. *J Am Heart Assoc*. 2021;10(11):e020584. https://doi.org/10.1161/JAHA.120.020584

55. Lewey J, Beckie TM, Brown HL, et al. Opportunities in the postpartum period to reduce cardiovascular disease risk after adverse pregnancy outcomes: a scientific statement from the American Heart Association. *Circulation*. 2024;149(7):e330-e346. https://doi.org/10.1161/CIR.0000000000001212

56. Kosinski C, Rossel JB, Gross J, et al. Adverse metabolic outcomes in the early and late postpartum after gestational diabetes are broader than glucose control. *BMJ Open Diabetes Res Care*. 2021;9(1):e002382. https://doi.org/10.1136/bmjdrc-2021-002382

57. Staff AC, Costa ML, Dechend R, Jacobsen DP, Sugulle M. Hypertensive disorders of pregnancy and long-term maternal cardiovascular risk: bridging epidemiological knowledge into personalized postpartum care and follow-up. *Pregnancy Hypertens*. 2024;36:101127. https://doi.org/10.1016/j.preghy.2024.101127

58. Van Uytsel H, Ameye L, Devlieger R, et al. Mental health during the interpregnancy period and the association with pre-pregnancy body mass index and body composition: data from the INTER-ACT randomized controlled trial. *Nutrients*. 2023;15(14):3152. https://doi.org/10.3390/nu15143152

59. Waring ME, Pagoto SL, Simas TAM, et al. Delivering a postpartum weight loss intervention via Facebook or in-person groups: results from a randomized pilot feasibility trial. *JMIR Mhealth Uhealth*. 2023;11:e41545. https://doi.org/10.2196/41545

60. Makama M, Skouteris H, Moran LJ, et al. Co-designing a community lifestyle intervention program to reduce postpartum weight retention. *Health Expect*. 2024;27(1):e13905. https://doi.org/10.1111/hex.13905

Bridging Gaps in Care: Naturopathic Doctors' Role in Optimizing Queer and Transgender Health

Stevie Inghram, MS

At a time when there are insurmountable gaps in care among those that are gender and sexually expansive (GSE), 2SLGBTQIA+, one of the biggest questions I have as a soon-to-be graduate of Naturopathic Medical School is, what role will the field of naturopathic medicine play in alleviating some of these current gaps in care?

As was outlined in a 2024 article on LGBTQ+ health education for medical students in the United States, authors Tess I. Jewell and Elizabeth M. Petty reported that 175 out of 176 medical schools in the United States and Canada found that 76% of osteopathic medicine (DO) students and 65% of allopathic medicine (MD) students described their medical schools' GSE curriculum as fair, poor, or very poor. Additionally, 40% of medical students, residents, and fellows expressed not having adequate training in this area; 50% of whom stated that they had minimal interactions with GSE patients.[1]

Given the lack of data existing on these topics within the naturopathic profession, one wonders how our profession fares against these concerning numbers within the world of conventional medicine. This lack of inadequate data does not negate our need and duty as a profession to be more culturally informed and responsive with the care we provide to GSE patients. These reforms should occur whether or not naturopathic doctors (NDs) have a full scope of practice according to the various state/provincial laws and regulations within North America.

In a 2022 article published in *Yoga Therapy Today*, I argued that yoga therapy, as an emergent healthcare profession, has the opportunity to lead bold and progressive changes to upend the status quo that perpetuates long-enduring injustices against not only black, brown, and indigenous communities but also against those of 2SLGBTQIA+ experience.[2] I believe naturopathic medicine has this same opportunity, as does the broader community of Complementary and Integrative Health (CIH) professions.

Not only are the aforementioned statistics alarming to me as a soon-to-be ND graduate, but they are also concerning to me as a queer and trans feminine person who has directly experienced the harms and inequities of our existing medical system. In 2020 upon starting ND school and seeking the care of a new primary care physician, I experienced none other than medical discrimination from a DO, in Arizona at the time. During my initial appointment with this doctor as he reviewed my medical history and current medications, not only was he unaware of pre-exposure prophylaxis (PrEP) medication, an HIV preventive medication, he became visibly uncomfortable in my presence as I explained the reasoning for taking this medication. His discomfort became so palpable that as the conversation progressed, he began opening the door to the patient room and shouting from the opposite end of the hallway that he could no longer treat me. I left that doctor's office in utter shock and disbelief with no referral to another physician nor a prescription to renew my medications at the time. Such behaviour is illegal among licensed physicians. However, even though I submitted a complaint to the Arizona state medical board about his unethical behaviour, nothing was done and he experienced no consequence.

I would like to think that this kind of behaviour is unbecoming of those within the ND profession, but I'm keenly aware that we receive abysmal training in caring for those who are GSE throughout the tenure of Naturopathic Medical School.

Whereas some within our profession may see the integration of 2SLGBTQIA+ competencies within naturopathic medical education as promoting a certain political agenda, this view discounts the active and persistent marginalized stressors that GSE patients face in their daily lives. As NDs, we cannot truly serve within our role of health promotion and health optimization if we do not understand the realities this community faces.

Here are some noteworthy statistics to frame GSE marginalized stressors:

- Black transgender women in the Americas have a life expectancy of 30 to 35 years.[3]
- 40% of transgender adults have actively made a suicide attempt; 92% of these occurred before the age of 25.[4]
- Lesbian, gay, and bisexual (LGB) youth contemplate suicide at a rate 3 times higher than that of their heterosexual peers.[4]

Correspondence to: Stevie Inghram. **E-mail:** inghramjs@gmail.com

To cite: Inghram S. Bridging gaps in care: naturopathic doctors' role in optimizing queer and transgender health. *CAND Journal*. 2025;32(3):11-12. https://doi.org/10.54434/candj.215

Published by the **Canadian Association of Naturopathic Doctors.**

- Transgender adults 65 years of age and older account for 17% of all fatal suicides within the general population.[5]
- Transfeminine populations face a 6-times higher rate of intimate partner violence than their cisgender female counterparts.[6]
- A 2015 report of over 27,000 queer and transgender people found that nearly 30% of respondents were living in poverty compared with approximately 15% of the general population.[6]
- A 2016 transgender discrimination survey found that 1 in 4 participants experienced insurance coverage obstacles; 55% were outright denied coverage for transition-related surgeries; 25% were denied coverage for gender-congruent hormones; and one third overall had at least one negative interaction with a healthcare professional such as being refused care, being verbally harassed; or having to teach healthcare professionals about their identity.[6]

While these statistics are truly alarming, they do not begin to scratch the surface of harms that 2SLGBTQIA+ people face in society and in medicine, many of which are underreported or inaccurately represented due to fears of legal ramifications or further societal stigma for speaking up. What is well documented across the scientific literature, however, is that GSE patients face a heightened risk of mental health conditions, cardiovascular disease, hormonal and autoimmune disorders, obesity, pulmonary pathology, higher exposure to environmental toxicants, substance abuse, and many other conditions, which heightens their overall physiological and psychological disease burden beyond that of their cisgender heterosexual peers.

Through appropriate education, training, and trauma-informed care, naturopathic doctors are well equipped to confront the extensive health burdens that 2SLGBTQIA+ individuals face by not only promoting hormonal and sexual health but also addressing the very determinants of health that are vastly compromised within this community.

Due to politicized media bias and talking points, some within our profession may perceive that providing queer- and trans-affirming care simply means prescribing cross-sex hormones to those wishing to undergo gender transition; whereas this is a component, there is a much more fundamental aspect of providing care that involves the art of medicine. In this case, it involves holding a heart-centred space that allows them to show up just as they are without burdensome questions, without questioning the existence or validity of their identity, and without repeating harmful political narratives.

In short, providing an *affirming* environment for queer and trans people is about stopping the perpetual cycle of extensive injustice that the GSE community faces within dominant society and within medicine. We can consciously choose to not allow these issues to be perpetuated within our practice and the therapeutic space we provide as NDs. Isn't an affirming environment exactly why patients seek out NDs in the first place?

One of the major narratives we hear regarding patients seeking out naturopathic care is that they appreciate our deep listening skills; they often feel heard and *affirmed* simply because we show up with an open mind and heart. In other words, we *believe* patients when they express particular symptoms or experiences, as they are the experts of their own life. As clinicians, we may not fully understand those experiences, but, nonetheless, we accept and affirm the validity of their symptoms and who they are as a person. This level of awareness and care is sadly missing for all too many 2SLGBTQIA+ individuals, and that is all we were ever asking for.

Ultimately, providing queer and transgender care does not need to be complicated, nor should it continue to be politicized. My hope is that, as a profession and as individual clinicians, despite our lack of education in this area, we can appropriately discern how to navigate the care of a community that is not only desperately in need of active allies but in search of people willing to rise above all of the debates over our existence and treat us as any other human being worthy of dignity, respect, and access to medical care. As a profession, we must rise to this challenge.

AUTHOR AFFILIATIONS
National University of Health Sciences, Lombard, IL, 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. Jewell TI, Petty EM. LGBTQ+ health education for medical students in the United States: a narrative literature review. *Med Edu Online*. 2024;29(1):2312716. https://doi.org/10.1080/10872981.2024.2312716
2. Inghram, S. An opportunity to lead: caring for gender & sexually expansive communities (LGBTQIA+). *Yoga Therapy Today*. 2022.
3. Inter-American Commission on Human Rights. (2014). An overview of violence against LGBTI persons (No. 153/14). www.oas.org/en/iachr/lgtbi/docs/annex-registry-violence-lgbti.pdf
4. The Trevor Project. (2021). Facts about suicide. www.thetrevorproject.org/resources/article/facts-about-suicide/
5. National LGBT Health Education Center. Suicide risk and prevention for LGBTQ people. The Fenway Institute; 2018. www.lgbtqiahealtheducation.org/wp-content/uploads/2018/10/Suicide-Risk-and-Prevention-for-LGBTQ-Patients-Brief.pdf
6. American College of Obstetrics and Gynecology. Healthcare for transgender and gender diverse individuals: ACOG committee opinion no. 823. *Obstet Gynecol.* 2021;137(3):e75-e88. https://doi.org/10.1097/AOG.0000000000004294

PrEP and the Prevention Revolution: Why Naturopathic Doctors Must Lead in Expanding HIV Prevention

Jeffrey R. Martineau,[1] ND

Human immunodeficiency virus (HIV) continues to pose a global public health challenge, despite decades of progress in treatment and prevention. In Canada, the HIV incidence rate remains concerning, with gay, bisexual, and other men who have sex with men (MSM) constituting the highest proportion of new infections. Pre-exposure prophylaxis (PrEP) is a powerful tool for reducing HIV transmission risk. It involves the use of antiretroviral medications in HIV-negative individuals. Health Canada approved daily oral PrEP using tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) in February 2016, marking a transformative moment in the nation's HIV prevention strategy. This article argues for a stronger role for naturopathic doctors in the national PrEP landscape to advance equity, public health, and clinical integration.

The cost of managing a single HIV infection across a patient's lifetime is considerable; this includes direct healthcare expenses such as medication, physician services, and hospitalizations, as well as indirect costs from loss of productivity and employment disruptions. These costs range between CAD448,000 and CAD690,000 per person[1]. In contrast, the annual cost of PrEP per participant in Canada was estimated at CAD12,001, with each infection averted costing about CAD621,390.[1] This cost may initially seem high but is dwarfed by the lifetime cost of HIV treatment. PrEP becomes cost-saving or highly cost-effective, depending on model and adherence. The societal benefits of PrEP extend beyond direct financial savings. As Lachowsky et al. (2019) found in a Vancouver-based study, PrEP not only protects individuals but may also reduce stigmatization and anxiety associated with HIV, especially in communities such as MSM where HIV burden remains disproportionately high.[2] This psychosocial advantage can facilitate engagement in health care and reduce the long-term burden of mental health comorbidities.

Despite its efficacy, PrEP uptake remains far below optimal levels. Comer and Fernández (2022) highlight that public health systems in the United States have not fully capitalized on PrEP's preventive potential, citing underfunded programs and systemic barriers such as racism, geographic inequities, and lack of provider awareness.[3] In the United States, PrEP is indicated for more than 1.2 million Americans, yet fewer than 25% are actually using it. In Canada, data are sparse but consistent with similarly low uptake. Studies in Ontario and British Columbia suggest that stigma, lack of provider knowledge, and systemic barriers impede widespread PrEP access.[4] Disparities persist along racial, economic, and geographic lines. According to Sun et al. (2022), PrEP awareness and willingness to use PrEP among MSM vary significantly by region and income level[5]. While awareness has improved in high-income countries (HICs), actual access is still hampered by cost, cultural stigmatization, and insufficient public health infrastructure. In the United States , the "Ending the HIV Epidemic" (EHE) initiative positions PrEP as a linchpin in HIV prevention. However, as Comer and Fernández (2022) argue, public health departments have struggled to mount an equitable and coordinated PrEP rollout, particularly for communities of colour and rural populations.[3]

Canada faces similar shortcomings. Lachowsky et al. (2019) found that even in British Columbia—where PrEP is publicly funded—many MSM remain unaware of their eligibility or face difficulty accessing culturally safe primary care[2]. Despite the promise of PrEP, affordability remains a core issue. Without public healthcare coverage, TDF/FTC can cost CAD1,700 to CAD3,500 CAD per month. Even though a generic TDF/FTC is available at roughly $26 per month in the United States, Canada's access remains inconsistent.[3] Economic evaluations consistently show that universal PrEP programs are cost-effective when targeted at high-risk populations. Yet public health delivery mechanisms have not kept pace with need. Rural, racialized, and 2SLGBTQIA+ populations remain underrepresented in PrEP programs due to systemic inequities and limited reach of traditional healthcare systems.[2,4]

PrEP involves nucleoside analogue antiretroviral medications that inhibit viral reverse transcriptase, thus preventing HIV replication in the host. The two most common regimens are:

- **TDF/FTC (tenofovir disoproxil fumarate/emtricitabine)** – the standard, most thoroughly studied oral PrEP option.

Correspondence to: Dr. Jeffrey R Martineau, ND, #603-625 Fifth Avenue, New Westminster, BC V3M 1X4, Canada. **E-mail:** drjeffmartineau@gmail.com

To cite: Martineau JR. PrEP and the prevention revolution: why naturopathic doctors must lead in expanding HIV prevention. *CAND Journal*. 2025;32(3):13-15. https://doi.org/10.54434/candj.219

Published by the **Canadian Association of Naturopathic Doctors.**

- **TAF/FTC (tenofovir alafenamide/emtricitabine)** – a newer formulation with a better renal and bone safety profile.

Additionally, **cabotegravir long-acting injectable (CAB-LA)** has been FDA-approved and is expected to become available in Canada. CAB-LA is injected every 2 months, improving adherence over daily pills, which is an important benefit since efficacy studies using oral routes show greater than 90% reduction in HIV transmission with proper adherence.

Short-term side effects of PrEP include nausea, headaches, and gastrointestinal upset, which are generally mild and transient. Long-term risks, with TDF especially, include:

- **Renal dysfunction**: necessitating quarterly creatinine/eGFR monitoring. Tenofovir is entirely eliminated via the kidney without hepatic metabolism or elimination, and studies have shown that over time eGFR can decrease somewhat with longer-term use. Use of recreational drugs, a high protein diet, or protein supplements while using tenofovir can also decrease eGFR.
- **Decreased bone mineral density**: particularly concerning for those with osteoporosis or risk factors. Tenofovir is associated with small decreases in bone mineral density with longer-term use, though these decreases are quite limited.

A recent meta-analysis that included 15,678 participants across 13 RCTs found no difference in severe adverse effects between PrEP and placebo arms, with a small but nonsignificant increase over placebo with respect to fractures and creatinine elevations.[6] A large retrospective cohort study in the United Kingdom observing PrEP users found that 114/14,000 experienced decreases/low eGFR; a large proportion of these could improve eGFR by decreasing protein supplementation or discontinuing recreational drug use.[7] TAF has a better renal and bone side effect profile but can be associated with hyperlipidemia, and serum lipids should be monitored yearly.[8] On-demand or "2-1-1" PrEP (taking doses around sexual activity rather than daily) has also proven effective, particularly among MSM. However, it is not recommended for all populations and requires thorough patient education. Individuals with comorbidities (e.g., diabetes, hypertension) may require careful risk–benefit analysis. Regular monitoring (renal panels, HIV testing, sexually transmitted infection [STI] screening) every 3 months is critical to safe, effective PrEP use. Persons with hepatitis B can also experience severe hepatitis flares if PrEP is ceased and hepatitis B is not treated.[7]

Naturopathic doctors, with their holistic, preventive approach and emphasis on patient-centred care, are uniquely positioned to fill gaps in PrEP access, support adherence, manage side effects, and advocate for marginalized communities. Naturopathic doctors could help bridge these gaps in access, particularly in provinces where NDs are regulated to provide primary care services. They often practice in underserved regions and have strong community ties. NDs, with their expertise in preventive and supportive care, can also play an essential co-management role.

Naturopathic medicine is regulated in six Canadian provinces, with varying scopes of practice. While NDs can't currently prescribe PrEP directly, they can:

- **Screen** patients using risk indices like the HIRI-MSM.
- **Refer** to prescribing physicians and sexual health clinics.
- **Monitor** side effects and lab results.
- **Support** adherence using integrative tools.

Culturally competent, trauma-informed care is a hallmark of naturopathic training, which is especially relevant for marginalized groups such as MSM, trans individuals, and racial minorities. By embedding PrEP education and risk assessment into routine care, NDs can become vital access points. Adherence remains a critical determinant of PrEP effectiveness. NDs can enhance outcomes by:

- **Nutritional strategies**: Support for renal (hydration, antioxidant-rich foods), bone (vitamin D, calcium), and gut health (probiotics).
- **Herbal therapies**: Ginger, peppermint, and chamomile for gastrointestinal (GI) tolerance.
- **Lifestyle modifications**: Sleep hygiene, stress management, and sexual health counseling.
- **Educational tools**: Pill packs, mobile reminders, and check-in systems tailored to patient preferences.

Importantly, NDs can also help dismantle stigma and misinformation around PrEP in holistic care settings, offering a judgment-free, affirming space for patients to explore prevention. PrEP represents a seismic shift in HIV prevention—one that is underutilized, especially in Canada. Naturopathic doctors, with their commitment to patient-centred, preventive, and holistic care, are well-positioned to lead a new frontier in PrEP delivery and advocacy. Their involvement could address barriers in education, stigma, adherence, and accessibility. As Canada works to end the HIV epidemic, integrating naturopathic care into PrEP pathways is both an ethical imperative and a practical solution.

Resources:

- https://smartsexresource.com/resources/hiv-prep-toolkit-for-clinicians/
- https://smartsexresource.com/resources/hiv-incidence-risk-index-for-msm-hiri-msm/
- https://smartsexresource.com/sexually-transmitted-infections/sti-basics/prep/

AUTHOR AFFILIATIONS
Port Moody Health, Vancouver, BC, 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.

REFERENCES

1. Ouellet E, Durand M, Guertin JR, LeLorier J, Tremblay CL. Cost-effectiveness of 'on demand' HIV pre-exposure prophylaxis for non-injection drug-using men who have sex with men in Canada. *Can J Infect Dis Med Microbiol*. 2015;26(1):23-29. https://doi.org/10.1155/2015/964512
2. Lachowsky N, Tattersall T, Sereda P, Wang C, Edwards J, Hull M. Community awareness of, use of and attitudes towards HIV pre-exposure prophylaxis (PrEP) among MSM in Vancouver, Canada. *Sex Health*. 2019;16(2):180-186. https://doi.org/10.1071/SH18115
3. Comer C, Fernández R. Health departments and PrEP: a missed opportunity for public health. *J Law Med Ethics*. 2022;50(S1):64-68. https://doi.org/10.1017/jme.2022.39
4. Pico-Espinosa OJ, Hull M, MacPherson P, et al. (2022). PrEP-related stigma and PrEP use among gay, bisexual and other men who have sex with men in Ontario and British Columbia, Canada. *AIDS Res Ther*. 2022;19:49. https://doi.org/10.1186/s12981-022-00473-0
5. Sun Z, Gu Q, Dai Y, et al. Increasing awareness of HIV pre-exposure prophylaxis (PrEP) and willingness to use HIV PrEP among men who have sex with men: a systematic review and meta-analysis. *J Int AIDS Soc*. 2022;25:e25883. https://doi.org/10.1002/jia2.25883
6. Pilkington V, Hill A, Hughes S, Nwokolo N, Pozniak A. How safe is TDF/FTC as PrEP? A systematic review and meta-analysis of the risk of adverse events in 13 randomised trials of PrEP. *J Virus Erad*. 2018;4(4):215-224. https://doi.org/10.1016/S2055-6640(20)30312-5
7. Tittle V, Dalton R, Nugent D, et al. Complex PrEP: the factors requiring consultant-led review of PrEP users. *Sex Transm Infect*. 2022;98(8):595-598. https://doi.org/10.1136/sextrans-2021-055277
8. Hempel A, Biondi MJ, Baril JG, Tan DHS. Pre-exposure prophylaxis for HIV: effective and underused. *CMAJ*. 2022;194(34):E1164-E1170. https://doi.org/10.1503/cmaj.220645

We Are More Than Our Tools: The Value of Presence in the Physician-Patient Relationship

Vanessa Lindsay, BSc (hons), ND

The changes to the healthcare landscape over the past several years—shifts in resource management and access to treatment—have increased the complexity of patient care in my practice. I often find myself striving for advanced treatments that will address patients' needs. A recent patient experience reminded me that even the most sophisticated treatment plan with the most modern or innovative protocol always needs to be interwoven with an authentic, heart-based connection.

Many patients bring challenging health concerns. My caseload is full of patients with confusing symptoms and no definitive diagnosis. However, this patient's etiology was more elusive than most and her symptoms ever-changing and ever-confusing. I would often ruminate in an attempt to piece together the puzzle that was her case. I carefully considered her medical history, attended continuing education (CE) webinars, completed lengthy PubMed searches, delved into UpToDate, and consulted mentors and colleagues. Despite applying all that I had learned, no real improvement was noted. She declined referrals to other providers that I felt could illuminate and move the needle. She continued to book appointments with me despite no real change in her condition. I wondered, "why." A short time later, I got my answer. In a card she gave me, she shared her deep gratitude for my time and energy and thanked me for my commitment to her healing. She also expressed how much it meant to her that I believed in her health struggles and that I patiently listened to her concerns. She felt validated and honoured—this was the medicine. In that moment, I realized that I had provided her an opportunity to tune into her own inner knowing and heal on a deeper level than could be accessed by an injection or herbal extract.

As naturopathic doctors, we are more than our tools, and it is the relationship we craft with our patients that builds the foundation for incorporating the material treatments. Continued learning is absolutely essential. But that learning must focus on more than technical skills—it must facilitate and improve our capacity to be fully present with our patients. There will always be cases that require us to step away from the latest innovation and simply hold a therapeutic space where we relate to our patients from a place of respect and genuine, heart-centred connection.

Patients may not remember what medicine or tincture we dispensed, but they will remember how it felt to be validated and heard.

AUTHOR AFFILIATION
BCND president, Vancouver, BC, 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: Dr Vanessa Lindsay, 1308 W 8th Ave, Vancouver, BC V6H 4A6, Canada. **E-mail:** info@vannatclinic.ca

To cite: Lindsay V. We are more than our tools: the value of presence in the physician-patient relationship. *CAND Journal*. 2025;32(3):16. https://doi.org/10.54434/candj.220

Published by the **Canadian Association of Naturopathic Doctors.**