Context & Considerations

This document provides a critical review of the draft bylaws made under the Health Professions and Occupations Act (HPOA), with a focus on sections governing registration, certification, equivalency, renewal, delegation, and professional accountability. At a high level, the bylaws restructure many existing processes, shifting significant discretion to the Registrar and Licence Committee, while reducing the procedural safeguards, timelines, and appeal rights that supported fairness under the Health Professions Act.

Several themes emerge across the bylaws. Applicants and licensees are repeatedly required to meet open-ended obligations without clear standards, criteria, or timelines. Discretion is concentrated in the hands of regulatory decision-makers without transparent checks, public criteria, or meaningful recourse for reconsideration. Cultural safety, equity, and non-discrimination obligations, which are explicit in the HPOA, are not consistently integrated into the bylaws, raising questions about alignment with the statute and broader commitments under DRIPA.

The section on Certified Practice illustrates these concerns most directly. Prescriptive Authority is retained as the only certification, while longstanding certifications such as IV therapy, chelation, advanced injections including prolotherapy, aesthetic procedures, ozone, and immunizations appear to disappear without explanation. It is unclear whether these practices are now prohibited, folded into general scope, or expected to be re-established later by bylaw. The absence of clarity or continuity mechanisms such as grandfathering or deemed certification creates serious regulatory ambiguity for naturopathic doctors and raises risks of disruption to patient care. Embedding such a profound change in draft bylaws, without advance discussion or substantive consultation, does not meet expected standards of transparency and accountability.

Other provisions reinforce this pattern. Requirements for equivalency determinations, reinstatement, and certification renewals grant broad powers to the Registrar or Licence Committee without transparent standards or limits. Renewal and reporting obligations place heavy burdens on licensees without proportional safeguards. Liability insurance requirements and disclosure rules are set at high thresholds without clear rationale. In combination, these provisions may create unnecessary barriers to entry or re-entry, discourage internationally trained applicants, and weaken confidence in the fairness of regulatory decision-making.

Taken together, the draft bylaws risk embedding ambiguity and concentrating discretion at a time when professions are being transitioned into a new regulatory model. Greater transparency, clear transitional protections, and meaningful consultation, particularly regarding scope and certified practice, are required to ensure that the new framework is defensible, equitable, and aligned with the principles of public protection and professional accountability.

6.0 Licensure

Classes of Licenses 6.1-6.2

Comments

- Ensure “Non-Practising” is clearly defined elsewhere in bylaws with respect to use of title, public communication, and continuing education requirements. Restrictions here could affect registrant identity and employment options.
- Sub-classification is included for Traditional Chinese Medicine but not for Naturopathic Medicine. While this reflects historical precedent, it should be flagged that sub-classification of ND licensure (e.g., IV therapy, prescriptive authority) must not be introduced post hoc without transparent consultation, especially under HPOA’s diminished consultation requirements.

Non-Practising (Legacy) Class Closure and Expiration 6.3-6.5

Comments

- Closure of the non-practising class without explanation creates uncertainty for registrants who rely on non-practising status for maternity/parental leave, disability, research, or temporary relocation. This could disproportionately affect women and those in rural or remote practice. While the class has functioned as a title-only designation in recent years, it continued to serve symbolic and transitional purposes that many registrants relied on. A rationale should be provided.

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- Eliminating the option to transfer from Full to Non-Practising restricts registrant flexibility and appears inconsistent with the principle of proportional regulation. There is no clear justification offered in the bylaw or preamble.
- No indication is given as to whether former non-practising registrants will retain access to College communications, CE opportunities, or voting rights (if restored).
- Transition window to Full licensure (until March 31, 2027) should be accompanied by explicit guidance on re-entry supports and any refresher requirements. Absence of such supports may create unnecessary barriers, especially for internationally trained or returning NDs.
- The elimination of the non-practising class raises implications for registrants' eligibility for professional association membership, which often depends on maintaining registration status. This could result in unintended professional or reputational impacts.
- Removal from the register may affect insurance coverage, particularly if policies are written on a claims-made basis rather than occurrence-based. Without guidance from the College on these impacts, registrants may unknowingly expose themselves to risk.
- The expiry date (April 1, 2027) may conflict with registrants' personal/professional planning horizons. The College should be required to give formal notice and publish clear timelines and transition protocols.

Publication of Licence and Permit Requirements 6.6

Comments

- While publication requirements support transparency, the use of "may include" weakens enforceability. The bylaw should require that all items (a) through (f) be published to ensure procedural fairness and applicant awareness.
- There is no obligation to provide timelines for appeal or reconsideration processes, which is a gap given the HPOA's removal of merit-based appeals.
- The bylaw gives broad discretion to the Registrar without reference to oversight by the Board or Superintendent, raising concerns about centralized authority and lack of accountability.
- No mention is made of culturally safe communication practices or accessibility of published materials (e.g., translation, plain language, Indigenous access), which may be necessary under HPOA s. 15 and DRIPA implementation obligations.
- The bylaw does not clarify who is responsible for setting the policies and procedures referenced, leaving ambiguity around whether authority rests with the Registrar, the Board, or the Superintendent. This lack of clarity undermines transparency and governance accountability.

Licence Applications 6.7

Comments

- The bylaw lacks detail on what constitutes a "completed application" or how the "specified form" is made available. Without further guidance or cross-reference to public policies under 6.6, applicants may face uncertainty or inconsistent processing.
- No criteria are listed for application completeness or timeliness, leaving discretion entirely with the Registrar. This could lead to arbitrary rejection or delays without recourse.
- There is no obligation to acknowledge receipt, provide a decision timeline, or advise applicants of deficiencies, all common administrative law expectations.
- The clause does not include any fairness provisions for applicants trained outside of BC or internationally, despite the HPOA's emphasis on enabling access to practice for qualified professionals (see HPOA s. 27(2)(d)).
- The bylaw fails to define a stable or comprehensive set of requirements for a "completed application," especially in light of clauses like 6.8(p) that allow for additional information to be requested later. This creates a shifting standard that may disadvantage applicants, particularly those from out-of-province or international backgrounds.

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General Eligibility Standards 6.8-6.10

Comments

- The section as a whole places significant documentation and disclosure burdens on applicants, with broad discretionary powers delegated to the Registrar and Licence Committee. Many requirements reference undefined standards or internal policies that are not publicly accessible or appealable.
- Clause (d) permits the Registrar to request "a declaration or other information" to assess good character and ethical intent without setting criteria or referencing objective indicators. This opens the door to value-based or culturally biased screening that may disproportionately affect marginalized or integrative care professionals.
- Clause (e) sets a universal $5 million per-claim liability insurance requirement without evidence or rationale. The amount appears arbitrary and may be unreasonably high for some professions or practice settings. The College should consult with each profession on risk-appropriate thresholds.
- Clause (h) imposes a three-year limit on program currency for applicants unless they are applying for a provisional licence. This poses a systemic barrier for otherwise qualified individuals returning from maternity leave, illness, caregiving, or international service. The College should offer equivalency pathways or re-entry supports.
- Clause (j) requires confirmations from every past jurisdiction in which the applicant was licensed. This imposes significant administrative burden, particularly for applicants with international experience or who practiced in jurisdictions with closed or unresponsive regulators. There is no process for handling cases where documentation is unavailable or delayed.
- Clause (p) grants open-ended authority to demand further information or records with no limiting principle. This should be narrowed to require that requests be reasonable, necessary, and proportionate to the licensure decision.
- Clause (o), which requires confirmation of "mandatory vaccinations against transmissible illnesses required by or under an enactment," must be clearly understood as a reference to compliance with external public health law only. This clause does not authorize the College to create or enforce vaccination mandates.
- The College should publish a clarifying policy stating that vaccination documentation will only be required when explicitly mandated by law or employer policy and that it will respect the rights of applicants under the Canadian Charter of Rights and Freedoms, the BC Human Rights Code, and the Code of Ethical Conduct, including access to valid medical or religious exemptions.
- Clause 6.9, which governs licensure for applicants authorized in another Canadian jurisdiction, effectively recreates most of the documentation requirements from 6.8. This undermines the principle of interprovincial mobility and may conflict with the minimal-barrier intent of the Canadian Free Trade Agreement.
- Clause 6.10 introduces further discretion by allowing the Licence Committee to assess whether international regulators meet "substantially equivalent" standards, without specifying the assessment process, evaluation criteria, or appeal rights. This lack of transparency and structure creates high exclusion risk, especially for internationally trained professionals.
- Neither 6.9 nor 6.10 make any mention of the College's duty to ensure fair, non-discriminatory licensure practices, including consideration of cultural safety and accommodation obligations. A reference to equitable access and procedural fairness should be embedded in all registration pathways.
- English language proficiency requirements in 6.9(c)(ii) and 6.10(c)(ii) are left to the Registrar's discretion where the prior regulator did not require them. This creates potential for subjective gatekeeping. Transparent, evidence-based benchmarks and exemption pathways should be publicly posted.
- Across the section, there are no timelines for decision-making, no obligation to inform applicants of deficiencies, and no internal appeal process for refusals. Without these basic procedural protections, applicants may be forced to pursue judicial review, which is costly and inaccessible for many.

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- Clause 6.8(d) should align its language with the terminology used in HPOA s. 54(4)(a)(ii) to avoid introducing undefined or alternative ethical standards. Without alignment, applicants face uncertainty about which set of standards governs licensure.
- Clause 6.8(e) imposes a $5 million insurance requirement across all applicants without assessing whether that amount is proportionate for each profession. This standard may not be appropriate for all practice types and should be supported by profession-specific consultation.
- Clause 6.8(i) lacks clarity in its reference to required examinations. Instead of delegating this to the Licence Committee without public oversight, all required exams — including jurisprudence — should be listed in a schedule appended to the bylaws to ensure transparency and proper consultation under the HPOA.
- The structure of the Licence Committee under Bylaw 3 may not ensure adequate professional representation when determining complex issues such as educational equivalency. These decisions require technical expertise that may not be met by a single representative per profession.
- Clause 6.8(j) should include a sunset clause to limit how far back jurisdictions must provide registration status confirmations. Requiring current documentation from all prior regulators, particularly within 60 days of application, places an unreasonable burden on applicants, especially for older or inactive registrations.
- Clause 6.8(k) should require all language proficiency standards to be publicly posted. Applicants should be able to view the minimum expectations in advance, and the Registrar's discretion to waive requirements in reasonable circumstances should be made explicit.
- Clause 6.8(o) effectively links registration eligibility to vaccination status for the first time. Any such requirement must be fully transparent, publicly posted, and clearly limited to compliance with existing laws. The College should not use this clause to create new vaccine mandates outside the legislative framework.
- Clause 6.8(o) risks crossing a critical legal and ethical boundary: the use of licensure powers to enforce health interventions. Even if vaccine documentation is technically "required under an enactment," the College must not act as a proxy enforcement body for public health law without explicit delegation of that role. Informed consent is not simply a clinical principle; it is a constitutional standard that must govern all regulatory decision-making involving bodily autonomy. Conditioning access to professional licensure on proof of vaccination, especially in a context where mandates are fluid, politicized, or inconsistently applied, is an inherently coercive act. If left unchecked, this clause will have a chilling effect on practitioner diversity, erode public trust in health regulation, and invite legal challenge. The College must treat vaccination status as a protected personal health matter, not a proxy for professional competence or character. If any documentation is required under 6.8(o), the College must implement strict procedural safeguards including notice, justification, appeal rights, and an explicit reaffirmation that no applicant will be denied licensure for exercising lawful rights to refuse or defer vaccination in accordance with valid exemptions and informed choice.
- Section 6.10 lacks clarity on how the Licence Committee's assessment of "substantially equivalent" credentials relates to the equivalency determination process set out in sections 6.18–6.22. It is unclear whether these are parallel or sequential processes, or whether the Licence Committee may bypass a formal equivalency determination entirely. This ambiguity risks inconsistent or opaque decision-making.

Assessment of Non-Current Education Credentials [Non-Current Graduation] 6.11-6.13

Comments

- The three-year threshold in 6.11 is arbitrary and lacks evidence or rationale. This creates barriers for qualified applicants who have been away from practice for parental leave, caregiving, illness, or international service. The College should offer alternative pathways based on experience, continuing education, or supervised practice rather than defaulting to re-assessment.
- Clause 6.11 places the burden entirely on the applicant without offering guidance on what constitutes acceptable "additional records and information." This invites inconsistency and may cause delays or refusals based on unclear expectations.
- Clause 6.12 allows the Licence Committee to delegate educational assessment to third parties without requiring transparency, independence, or recourse. There is no obligation to disclose the identity of the

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assessor, share their report, or offer applicants the opportunity to respond. This undermines procedural fairness.

- Clause 6.13 gives the Licence Committee broad discretion to impose remedial measures without defined criteria or proportionality principles. The bylaw permits open-ended requirements that may be duplicative or financially inaccessible, particularly for internationally trained or returning professionals.
- There is no reference to the rights of applicants to challenge, appeal, or request clarification of assessments or additional requirements imposed. This is a serious gap, especially given the lack of appeal mechanisms under the HPOA regime.
- The section fails to incorporate principles of cultural safety, equity, or non-discrimination in education assessment, despite statutory duties under the Human Rights Code and DRIPA. ND applicants with non-mainstream or integrative training backgrounds may be particularly affected.
- Recommend that the College be required to publish clear criteria, assessment tools, timelines, and recourse options for applicants subject to 6.11–6.13. This would promote transparency and reduce the risk of systemic exclusion.
- The term “education assessment” should be used consistently across 6.11 and 6.12 to avoid confusion. The bylaw currently switches between phrases like “assessment of education” and “education assessment” without clarification.
- The nature and scope of the education assessment should be clearly defined in a publicly available policy. Without this, applicants are left uncertain about what will be evaluated, by whom, and on what basis.
- Section 6.13 should clarify whether its remedial requirements are subject to the limits in Bylaw 6.28. Applicants should not be subject to multiple overlapping assessments or duplicative testing if similar requirements have already been satisfied through equivalency or mobility pathways.
- The breadth of clauses (a) to (c) under 6.13 creates uncertainty about what specific standards must be met. It should be clarified whether these are sufficient on their own or if additional unspecified requirements may be imposed. A published policy outlining expected competencies and assessment triggers would improve transparency and procedural fairness.

Specific Eligibility Standards by Designated Health Profession 6.14-6.15

Comments

- These clauses defer all substantive eligibility criteria to Schedule X, but there is no requirement here that Schedule X be transparent, regularly reviewed, or co-developed with the professions. Without built-in safeguards, eligibility standards could be altered without meaningful consultation or accountability.
- There is no indication that Schedule X will be subject to oversight, public posting, or policy guidance. This creates risk that eligibility standards will be applied inconsistently, changed without notice, or interpreted in ways that disadvantage NDs or applicants with non-mainstream training.
- The bylaw does not include any procedural mechanism for requesting exemption, equivalency assessment, or accommodation from specific Schedule X requirements. This undermines access to licensure for qualified applicants who meet the intent but not the exact form of prescribed standards.
- No reference is made to the College’s legal obligations under the BC Human Rights Code or Charter in applying eligibility standards. This is particularly important for Indigenous, internationally trained, or returning NDs, who may face structural barriers not addressed in Schedule X.
- Recommend that this section include a requirement for Schedule X to be:
  - public
  - reviewed in consultation with each profession
  - accompanied by policies on equivalency, exemption, and procedural fairness

This would enhance defensibility and reduce the risk of arbitrary exclusion.

Waiver and Refund of Fees 6.16-6.17

Comments

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- Clause 6.16 allows the Registrar to waive, reduce, or refund fees based on "undue hardship or other circumstances," but does not define hardship, set criteria, or establish timelines for decision-making. This creates the risk of inconsistent or opaque application of financial relief.
- Given that fees are due on specific dates, the bylaws should include a process for when and how applicants can apply for a fee waiver or reduction. Without this clarity, applicants may miss deadlines or face financial hardship due to uncertainty around timing.
- There is no requirement to provide reasons for decisions, notify applicants of their right to reapply, or offer a dispute mechanism if relief is denied. For applicants in precarious financial situations, especially new graduates, racialized practitioners, or internationally trained NDs, this may block access to licensure.
- Clause 6.17 references Published policy, but there is no requirement that such a policy exist, be publicly accessible, or include equity-focused criteria. Without this, the Registrar retains broad discretion without accountability.
- Clause 6.17 refers to a Published policy but does not define what that policy must contain. Minimum requirements should be set out in the bylaw to ensure transparency and consistency in how fee relief is administered.
- Recommend requiring the College to develop and publish a formal policy outlining:
  – eligibility criteria for hardship-based relief
  – application timelines
  – decision standards
  – appeal or re-application processes

This would support equitable access to the profession and reduce financial gatekeeping.

Recognized Credentials 6.18-6.20

Comments

- These clauses defer all recognition of credentials to Schedule X, but there is no requirement that Schedule X be public, consistently applied, or reviewed in consultation with affected professions. This creates risk that recognition decisions could be modified without notice or justification, disproportionately affecting NDs.
- There is no process for applicants to request reconsideration, review, or exemption if their credential is not listed or is later removed. For internationally trained or non-traditional ND applicants, this poses a significant barrier to licensure.
- The bylaws do not define what criteria are used to determine whether a credential is "recognized." Without published standards, this opens the door to inconsistent or exclusionary practices — especially with respect to integrative or non-Western medical programs.
- There is no reference to obligations under the BC Human Rights Code or DRIPA to ensure that recognition processes do not disproportionately disadvantage Indigenous applicants or those trained in culturally distinct systems of healing
- Clause 6.20 refers to compliance with "policy" without defining whose policy it is, how it is created, or whether it is publicly accessible. The bylaw should specify the source of the policy and require that it be formally adopted and published to ensure transparency and accountability.
- Recommend amending this section or Schedule X to:
  – require public posting of all recognized credentials
  – include a transparent application and review process for credential recognition
  – embed procedural fairness safeguards, including reasons for decisions and a right to respond

This would ensure legitimacy, consistency, and equitable access to licensure for all applicants.

Equivalency Determination of Extrajurisdictional Credentials – General 6.21

Comments

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- The clause allows the Registrar to trigger an Equivalency Determination where a Licence Applicant lacks a recognized credential, but does not set any criteria or timeline for how that determination is conducted. This leaves internationally trained NDs vulnerable to delay or rejection without clear guidance or recourse.
- It is noted that Under 53(4) of the HPOA, the Licence Committee has to give notice of the reasons for an adverse application decision.
- The bylaw lacks transparency around what constitutes "sufficient qualifications" and how equivalency is assessed. There is no obligation to consider experience, ongoing education, or supervised practice as part of the equivalency framework.
- There is no assurance that cultural or system-specific training , including Indigenous, traditional, or integrative medical education, will be evaluated without bias or through culturally competent review. This poses particular risk to non-Western ND applicants.
- The bylaw should include an obligation for the College to update and publish information on equivalency determinations as they are made. Without ongoing transparency, applicants are left in the dark about precedents or evolving recognition standards.
- The equivalency process may operate as a significant barrier to entry for internationally trained applicants. The bylaw should clarify whether the College may require an Equivalency Determination solely based on jurisdiction of education, and ensure that such decisions are evidence-based and not geographically discriminatory.
- The bylaw should clarify whether applicants educated in another jurisdiction will automatically be subject to an Equivalency Determination. Without limits or criteria, this process risks operating as a default barrier to entry for internationally trained professionals.
- It is unclear who bears the cost of the Equivalency Determination. The bylaw should specify whether fees will apply, and if so, ensure they are transparent, proportionate, and publicly posted to avoid financial deterrence.
- Recommend that the College be required to:
  - publish equivalency criteria and methodologies
  - disclose third-party assessors or committees involved
  - provide applicants with reasons, and opportunity to respond or appeal

This would increase legitimacy, reduce arbitrary gatekeeping, and support fair access to the profession.

Equivalency Determination of Extrajurisdictional Credentials – Education Programs 6.22-6.24

Comments

- These provisions give the College wide discretion to assess whether a non-Canadian education program is "substantially equivalent" to Canadian standards, but there is no reference to procedural safeguards such as disclosure of assessment results, opportunity to respond, or right to appeal. This leaves internationally trained ND applicants particularly vulnerable to opaque or exclusionary processes.
- Clause 6.22(a) relies heavily on external accreditation organizations, but there is no requirement that these organizations be culturally competent, accountable, or subject to College oversight. There is also no obligation to make the list of "recognized" assessors publicly available, which prevents applicants from knowing in advance whether their credentials will be accepted.
- Clause 6.22(a) should establish minimum standards that educational accreditation organizations must meet, including impartiality, cultural competence, and transparency. Without such benchmarks, the legitimacy of assessments may be undermined.
- If recognized accreditation organizations only operate in certain jurisdictions or languages (e.g., English-only reviews), the bylaw should require alternative, flexible pathways for applicants from other systems to demonstrate equivalency.
- Clause 6.23 should include minimum standards for any third-party assessor to ensure fair, consistent, and credible evaluations. These standards should be published and subject to periodic review.
- Clause 6.24(a) should require that any organization being relied on for equivalency judgments meet defined minimum criteria. This is critical to prevent exclusion based on the characteristics or structure of the applicant's educational institution rather than the competence of the applicant.

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- Clause 6.22(b) grants the Registrar broad authority to request unspecified information for internal assessment where no third-party assessor is recognized. There is no transparency regarding what evidence will be deemed acceptable, how it will be weighed, or who will perform the assessment.
- Clause 6.23 allows the College to delegate education assessments to a third party, but again without any requirement to share the report with the applicant or allow for procedural fairness in the outcome.
- Clause 6.24 lists broad and potentially exclusionary criteria, such as whether faculty are licensed in the profession or whether the program expresses a purpose aligned with Canadian norms. These criteria may structurally disadvantage Indigenous, traditional, or integrative programs that train competent NDs outside of dominant regulatory frameworks.
- There is no requirement that the College consider additional factors such as clinical experience, continuing education, or demonstrated patient safety outcomes when assessing equivalency. This is particularly concerning given the diversity of ND training pathways internationally.
- The clause fails to reference anti-discrimination obligations under the BC Human Rights Code or the College's Code of Ethical Conduct, nor does it reflect any alignment with the DRIPA Action Plan or cultural safety principles.
- Recommend that the College be required to:
  – publish all recognized third-party assessors and criteria for equivalency
  – disclose decisions and allow applicants to respond to concerns before denial
  – develop an internal appeal or review pathway
  – ensure all equivalency decisions are informed by principles of equity, transparency, and cultural safety

These steps would promote access, reduce gatekeeping, and build defensibility across the assessment process.

Process for Equivalency Determination 6.25-6.29

- Comments:
  This section grants broad discretion to the Licence Committee to determine whether an applicant's credentials, knowledge, or experience are "substantially equivalent" to Canadian eligibility standards, but provides no definition of "substantial equivalence" and no requirement for objective, published benchmarks.
- Clause 6.26 requires assessment of an applicant's knowledge, skills, ability, and judgment, but offers no protection against subjective or culturally biased interpretation of these terms. There is also no requirement to assess these qualities in a fair or trauma-informed manner.
- Clause 6.27 permits reliance on external accreditation or certification organizations, yet again without any requirement for transparency, independence, or disclosure. Applicants have no procedural right to view or respond to third-party assessments that may affect their eligibility.
- Clause 6.28 allows the Licence Committee to require applicants to complete testing or undergo further assessment, but does not limit how many steps can be imposed, who will conduct the assessment, what standards apply, or whether results will be shared. This could enable financially or procedurally burdensome "hoop testing" for otherwise qualified applicants.
- Clause 6.29 lists a wide and flexible set of factors for consideration, but with no hierarchy, weightings, or clear standards. Some factors ,such as differences between Canadian and non-Canadian practice (6.29(h)) , risk becoming a justification for excluding qualified applicants based on jurisdictional differences alone.
- There is no internal review or appeal mechanism if an applicant disputes the outcome of the equivalency determination. This is especially problematic under the HPOA, where judicial review is the only recourse and does not examine the merits of the decision.
- The criteria make no reference to systemic barriers, cultural safety, or human rights obligations. For ND applicants from non-Western, Indigenous, or integrative medical backgrounds, this creates risk of exclusion based on normative biases about "acceptable" training and practice.
- Clause 6.28 should specify that applicants will not be subject to multiple overlapping assessments across sections (e.g., under both 6.13 and 6.28). A single, coordinated assessment process should be clearly articulated to prevent duplicative or excessive testing.

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- Clause 6.29(c) should include cross-references to the relevant bylaw provisions that govern third-party assessments, such as 6.22(a) and 6.23. This would improve clarity and ensure applicants understand how those external evaluations factor into their equivalency determination.
- Recommend that the College:
  – adopt a written framework for assessing equivalency, including transparent rubrics
  – disclose all third-party reports or adverse findings to the applicant
  – offer a right to respond, submit additional information, or seek reconsideration
  – require assessments to reflect the principles of equity, cultural humility, and non-discrimination under the BC Human Rights Code and DRIPA

Without these protections, equivalency determinations may function as a form of indirect exclusion, particularly for internationally trained NDs and those from underrepresented systems of medicine.

Periodic Review of Measures Imposed on Extrajurisdicitonal Applicants 6.30-6.33

Comments

- This section introduces a welcome commitment to periodic review of barriers imposed on internationally trained and out-of-province applicants, but it lacks enforceable timelines or minimum frequency requirements. Without these, the review process could be infrequent or symbolic.
- Clause 6.30 contains important language — "do not substantially lower the risk of harm to the public" — which aligns with evidence-based regulation principles. However, there is no requirement to publicly report findings or to amend discriminatory or unnecessary conditions once identified.
- Clause 6.31 allows for external input, but makes consultation optional and dependent on Registrar approval. There is no requirement to include affected communities, such as internationally trained NDs, Indigenous practitioners, or applicants from non-Western systems of care, in the review process.
- Clause 6.32 incorporates the proportionality test (rational connection and minimal impairment), but does not mandate the use of data, legal analysis, or applicant feedback to inform this test. Without methodological transparency, decisions may continue to reflect institutional bias.
- Clause 6.33 requires notification of findings to the Registrar and Board, but imposes no duty on those bodies to act on the findings or to update the Eligibility Standards. This weakens the accountability mechanism.
- Recommend strengthening this section by requiring:
  – annual or biennial review cycles
  – inclusion of affected applicants and equity-deserving groups in consultation
  – publication of findings and rationale
  – a duty to amend or eliminate any requirements shown to be unjustified or exclusionary

For internationally trained or non-traditional NDs, these changes are essential to ensuring the credentialing process is fair, lawful, and aligned with evolving professional realities.

Examinations and Assessments 6.34-6.39

Comments

- 6.34 and 6.35 centralize control of exam content, administration, and outcomes in the Registrar but contain no procedural safeguards, transparency requirements, or obligation to involve profession-specific expertise.
- There is no review or appeal mechanism for failed exams or assessments, which undermines procedural fairness given the licensure consequences.
- 6.36 allows external exams to be substituted or added without any bylaw criteria for vetting the external bodies, raising consistency and accountability concerns.
- 6.37 enables the Registrar to impose penalties for "improper conduct" without defining the term or requiring independent oversight. This grants wide discretion without clear due process.
- 6.38 mandates written reasons for decisions but does not specify scope or timelines, which could limit meaningful recourse.

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- 6.39 clarifies that required rewrites do not count as failed attempts but is silent on how and when such rewrites are triggered outside misconduct scenarios.
- There is no reference to the College's legal obligation to provide exam accommodations under the BC Human Rights Code.
- Recommend including appeal rights, standards for misconduct determinations, criteria for external exam providers, and clear reference to accommodation duties.
- Clause 6.35(b) should include a definition or minimum standard for what constitutes successful completion of an exam. Without this, outcomes may be applied inconsistently or subjectively.
- Clause 6.35(c) uses the phrase "as soon as practicable" without defining a reasonable timeframe. A fixed or maximum period for providing results would enhance fairness and predictability for applicants.
- Clause 6.37(a) should include a timeline for notifying applicants of allegations or findings related to exam misconduct to ensure timely and procedurally fair responses.
- Clause 6.37(b) grants authority to impose conditions for future exam attempts but is too vague in scope. Clear criteria or examples should be included to avoid arbitrary or disproportionate restrictions.

Professional Liability Protection or Insurance 6.40-6.41

Comments

- 6.40 sets a high coverage threshold of $5 million per claim or occurrence but does not define "form satisfactory to the college," which grants broad discretion without transparent criteria. This may create uncertainty for Licensees or insurers when assessing compliance.
- In 6.40 college should be capitalized.
- The bylaw does not clarify whether the coverage must be occurrence-based or claims-made, nor whether tail or extended reporting coverage is required upon retirement or non-practising status.
- Clause 6.41 references obligations under Part 8 (Professional Responsibilities), but that section does not currently include any provisions related to insurance. This cross-reference should be revised or clarified to ensure it is meaningful and enforceable.
- The bylaw should specify whether institutional or employer-provided insurance satisfies the requirement under 6.40. Without this clarity, Licensees working in hospitals or academic settings may face unnecessary duplication or confusion.

- 6.41 appropriately links loss of coverage to compliance with Professional Responsibilities, but this is a cross-reference to a placeholder (X.X) with no current substance. Without detail, there is no clear consequence or procedural pathway tied to non-compliance.
- The bylaw does not reference exemption provisions (if any), such as for non-practising Licensees or those working in institutional settings where coverage is employer-provided.

Duty to Report Criminal Charges and Disciplinary Proceedings 6.42-6.43

Comments

- 6.42 requires disclosure of criminal charges but excludes summary conviction offences, which may be appropriate given their lower severity, though no rationale is stated. It is unclear whether hybrid offences proceeding summarily fall within scope.
- Clause 6.42 should include clear guidance on the types of offences that must be reported and specify whether the duty arises upon being charged or only upon conviction. Without this clarity, Licensees may under- or over-disclose, leading to inconsistent enforcement.
- 6.42 and 6.43 both require "immediate" disclosure but provide no definition or timeframe. Without a concrete standard (e.g., within 7 days), enforcement may be inconsistent or arbitrary.

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- 6.43 includes a wide range of regulatory proceedings but does not distinguish between initial inquiries and formal prosecutions. This could lead to over-reporting of preliminary matters not yet serious in nature.
- The discretion granted to the Registrar to request or order further information is broad and uncoupled from any relevance or proportionality requirement.
- Neither provision outlines how this information will be used, assessed, or disclosed, raising potential privacy and procedural fairness concerns for applicants under investigation but not yet found at fault.

Eligibility Standards for Provisional Licence 6.44-6.48

Comments

- 6.44 and 6.45 properly distinguish between Labour Mobility Act applicants and those undergoing equivalency determinations, but the layering of references (Act + bylaw + committee discretion) may create interpretive ambiguity for applicants unfamiliar with the framework.
- The reference in 6.44 to “Fit to Practise” is undefined in the bylaws and lacks criteria. Without clear standards or a policy cross-reference, this invites discretionary or inconsistent application.
- 6.46 establishes a three-month default term for Provisional Licences but does not state whether this term is renewable outside the one-time extension noted in 6.48. It’s also unclear whether the provisional status expires automatically or must be actively revoked.
- 6.47 grants the Licence Committee wide discretion to impose conditions, including title and scope restrictions, but without requiring the rationale to be documented or disclosed. There is no built-in right to seek reconsideration or review.
- Clause 6.47 should define “Provisional Licence” as a formal term to avoid ambiguity throughout the section and ensure consistent interpretation across College communications and policies.
- Clause 6.47(c) refers to “Supervision,” which is defined in Part 9 for delegation purposes. The same or a harmonized definition should be adopted here to prevent conflicting interpretations of oversight responsibilities.
- Clause 6.47(e) is vague in its wording and should be clarified
- Clause 6.47 includes a duplication error (“practice of practice”) which should be corrected for clarity and precision.
- 6.47(g) appears duplicative (“aspect of practice of practice”) and may need correction.
- 6.48 permits a one-time extension of two months but offers no guidance on approval criteria, potentially leaving applicants uncertain of how to ensure continuity of practice.
- Clause 6.48 does not specify when an applicant must apply for the extension in order to maintain uninterrupted licensure. Without a defined application timeline, there is a risk of unintended lapses in authority to practise.
- The section as a whole provides no indication of how provisional status interacts with public disclosure requirements (e.g., whether provisional status, limitations, or supervisors are published), which has implications for both transparency and reputational fairness.

Limitations on Provisional Licence 6.49

Comments

- This provision appropriately reinforces compliance with limits or conditions but is functionally redundant with 6.47 and offers no enforcement or monitoring mechanism. It would benefit from clarification on how the College ensures compliance (e.g., supervision verification, reporting obligations, or audit process).
- There is no reference to consequences for breaching conditions, nor is it linked to any remedial or disciplinary process. This may reduce its regulatory effect or legal defensibility if challenged.
- Clause 6.49 should reference the College’s obligation under s. 55(1)(b) of the HPOA to publish limits and conditions on the Public Registry. Without this linkage, transparency and public protection duties may be under-realized or inconsistently applied.

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Voluntary Limits and Conditions 6.50-6.51

Comments

- This provision allows Licensees to proactively seek limits and conditions, which can support professional autonomy, disability accommodation, or practice transitions, but it does not state whether these limits will be disclosed publicly. Lack of clarity on disclosure has reputational and privacy implications.
- 6.50 should explicitly acknowledge that voluntary limits and conditions are also subject to publication under s. 55(1)(b) of the HPOA. Without this clarity, Licensees may unknowingly assume such disclosures are private, creating risk of misunderstanding or reputational harm.
- 6.51 grants the Registrar broad discretion, including fee waivers and denial of the request, but does not require reasons to be provided or any right of reconsideration, which may undermine transparency and procedural fairness.
- There is no indication of whether a Licensee may later request removal or amendment of the voluntary limits, nor what process governs such a change.
- The bylaw does not explicitly distinguish between voluntary limits and those imposed for public safety reasons, which could create confusion in interpretation or enforcement.

Transfer from Non-Practising (Legacy) to Full Licensure 6.52-6.53

Comments

- 6.52 appropriately sets out the transition process from non-practising to Full licensure but links to reinstatement provisions (6.58 and 6.60) that may not have been designed with legacy class holders in mind. This risks procedural mismatch or confusion.
- There is no clarification on whether continuing education, insurance coverage, or currency of practice standards must be re-established prior to transfer, unless buried in the cross-referenced bylaws. Explicit linkage here would improve transparency and defensibility.
- 6.53 appears to be an incomplete provision and should be clarified. As written, it does not complete the thought on how the non-practising period is calculated or whether it includes time under previous (pre-HPOA) regimes.
- There is no provision indicating how limits or conditions imposed during the non-practising period (if any) affect re-entry, nor is there a statement on public notification or registrar discretion.

Licence Renewal Dates and Late Renewal 6.54-6.55

Comments

- 6.54 establishes a uniform annual renewal deadline but does not indicate whether notice will be provided to Licensees, whether a grace period applies, or what penalties or consequences apply for late or missed payments (unless addressed elsewhere). Adding a cross-reference to any late renewal or suspension provisions would enhance clarity.
- 6.55 carves out a one-time exception for Chiropractors in 2026, which appears to reflect transitional alignment due to amalgamation or regulatory calendar shifts. However, it would benefit from an explanatory note in the published policies or accompanying materials to avoid confusion for applicants or registrants unfamiliar with the rationale.
- The bylaw assumes all Licensees will follow a March 31 to March 15 annual cycle but does not address new Licensees entering partway through a year. Pro-rating or first-year adjustments should be clarified elsewhere if not here.

Expiration of Licences 6.56

Comments

- This provision sets the expiry timelines clearly and aligns with the transitional renewal structure in 6.55. The one-time August 1, 2026, expiration for Chiropractic allows for a smooth shift to the March 31 standard.

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- The bylaw does not clarify whether an expired Licence immediately renders the individual unauthorized to practise, nor does it indicate if any grace period or administrative suspension process applies. This creates uncertainty around the regulatory consequences of late renewal.
- There is no explicit cross-reference to reinstatement procedures under 6.58 or 6.60, which may result in inconsistent application or confusion for Licensees. Adding such a reference would support procedural clarity and legal defensibility.
- The bylaw is silent on how the College communicates upcoming expirations to Licensees. In the absence of statutory requirements, this should be addressed through clear policy to ensure fairness and mitigate unintended lapses.

Renewal Requirements for Licences 6.57

Comments

- The bylaw lays out comprehensive renewal obligations, including compliance declarations, insurance documentation, and legal history updates. However, the cumulative burden may be excessive without proportional risk justification, particularly for Licensees in good standing with a stable practice history.
- Subsection (g) introduces a broad obligation to report legal proceedings but does not define scope or thresholds (e.g., charges vs. allegations, settled civil matters, or regulatory cautions). Without clarification, this may capture irrelevant or prejudicial information and create privacy concerns.
- Subsection (h) refers to “currency of practice hours” but defers all standards to Schedule X. There is no indication in this section of how those hours are verified, audited, or evaluated. The lack of detail raises potential for inconsistency or error in assessing compliance.
- The provision empowers the Registrar under (i) to request “additional information” without constraint, which introduces subjectivity and could result in overreach. A requirement that such requests be “reasonable” or tied to public safety would align better with fair regulatory practices.
- Clause 6.57(i) should specify that any “additional information” requested by the Registrar must be reasonably required in relation to renewal assessment. This ensures proportionality and limits discretionary overreach.
- There is no reference to notice timelines, grace periods, or what happens if a renewal application is incomplete but submitted before the deadline. This leaves a procedural gap that could harm Licensees inadvertently.

Reinstatement – General 6.58

Comments

- Clarification if reinstatement is different from a fresh application.
- This provision establishes comprehensive requirements for reinstatement of a Former Licensee who has not been suspended or cancelled, aligning closely with the original licensure criteria. While thorough, the absence of prioritization or tiering may place an excessive burden on applicants who have only been inactive briefly.
- Subsection (e) requests detailed regulatory history from other jurisdictions but may pose administrative difficulties if the applicant’s prior regulator has dissolved, merged, or changed processes. A failsafe or alternative pathway should be included to address unavailable documentation.
- Subsection (h), which addresses legal proceedings, mirrors language in Bylaw 6.57 but again lacks threshold clarification for what constitutes a reportable event. Without refinement, it could result in disclosure of matters that are irrelevant or resolved without findings.
- Subsection (j) blends two distinct requirements, a criminal record check and a declaration of practice hours, in a way that could confuse applicants and should be separated for clarity and administrative accuracy.
- Subsection (k) permits the Registrar to request unspecified “additional information,” which introduces wide discretion without checks. Consider requiring such requests to be reasonable and relevant to licensure eligibility.
- Subsection (l) requires completion of all applicable CPD requirements “that would have applied… had they not ceased to be Licensed.” This phrasing is ambiguous and assumes the Licensee remained in a static category.

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Clearer guidance is needed on how CPD expectations are calculated retroactively, particularly across regulatory transitions.

- There is no indication in this bylaw of how long the reinstatement process typically takes, or whether the applicant may practise provisionally while under review. Including this in policy or elsewhere in the bylaws would improve procedural transparency.

Reinstatement Within Three Months of Licence Expiry 6.59

Comments

- This provision appropriately establishes a streamlined reinstatement window of three months following Licence expiry, which supports fairness and administrative efficiency. However, it is not clear whether practice is prohibited during this window or if it is treated as a lapse requiring immediate cessation. Explicit clarification is needed to protect both the public and applicants.
- The term “former Licence” in 6.59 is undefined, making it unclear whether this applies to Licensees under the former Act, current Act, or both. This ambiguity should be resolved for consistent application.
- Clause 6.59(e) is confusing as written. It is unclear why CPD compliance under former bylaws would be relevant for reinstatement under the new Act. If this section only applies to a transitional period post-HPA, that intent should be explicitly stated.
- The bylaw requires significant documentation even within this short window, including full CPD evidence and criminal record checks. This may be disproportionate for applicants who missed the deadline by a matter of days and could be made more proportional to risk.
- The continuing professional development (CPD) requirement in (e) refers again to what “would have applied… had they not ceased to be Licensed,” which remains vague and potentially open to interpretation, especially during a period of regulatory transition. Guidance or policy clarification would reduce applicant uncertainty.
- The bylaw appears silent on whether any additional fee, penalty, or late charge applies for reinstatement under this section. If such fees are intended, they should be referenced or cross-referenced to Schedule “__”. Because this Schedule has not been provided, it is not currently possible to comment on the fee framework or assess whether the financial requirements for reinstatement are proportionate or equitable.
- There is no mention of whether a Licensee reinstated under this section retains their original Licence number, title, or practice history. This has implications for public records and transparency.

Reinstatement After Three Years of Non-Licensure 6.60-6.63

Comments

- This section establishes a distinct, more rigorous process for reinstatement after a significant lapse, which is appropriate from a public safety perspective. The three-year threshold aligns with general regulatory norms; however, no rationale is provided for the time limit. Consider cross-referencing guidance or policy for how that threshold was established.
- Bylaw 6.61 gives the Licence Committee broad discretion to impose requirements, including reassessment under Bylaw 6.8 or other conditions deemed "appropriate in the circumstances." While flexibility is necessary, the lack of criteria or procedural safeguards for this discretion may lead to inconsistent or opaque decision-making. More detailed policy or guidance should be developed to support procedural fairness.
- Clause 6.61 may create a re-entry barrier for individuals returning from time away due to maternity leave, caregiving, or other valid reasons. Reinstatement requirements should allow for proportional pathways that support return to practice without undue burden.
- Clause 6.63 should clarify that only *applicable* prior limits or conditions will be reinstated. A qualifier such as “that are still applicable” would prevent automatic re-imposition of time-limited or outdated restrictions.
- Subsection 6.61(b) refers to a “competency assessment as determined by assessment policy,” but no such policy is cited or appended. Without access to this policy, it is not possible to fully assess whether the assessments will be appropriate, proportional, or uniformly applied. Clear standards or reference to Schedule X would improve transparency and defensibility of decisions.

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- Bylaw 6.62 preserves the integrity of professional class distinctions by requiring reinstatement in the same profession and class previously held. However, the bylaw does not provide a pathway for transitioning to another class of licence where scope and training overlap may support it. This may be particularly relevant for legacy or transitional licensees.
- Bylaw 6.63 appropriately reinstates any previously imposed limits or conditions. However, it references Bylaw 6.69, which has not been provided. Without access to 6.69, it is not currently possible to evaluate how new limits or conditions are determined, or whether due process is afforded.
- As with other sections, there is no reference to applicable fees, timelines for review, or whether applicants may practise provisionally during the process. These are material omissions that may impact fairness and access. Full comment will require review of the missing Schedule "__" and Bylaw 6.69.

Reinstatement Following Revocation by a Capacity Officer 6.64-6.67

Comments

- Bylaw 6.64 provides an important regulatory safeguard by requiring evidence that fitness to practise has been restored following revocation for incapacity. However, the bylaw grants the Licence Committee wide discretion without setting out procedural standards or criteria for evaluation, which could create inconsistency in decision-making. Consider referencing or developing transparent guidelines to support fairness and reduce subjectivity.
- Bylaw 6.64(b) allows for competency or capacity assessments "at the discretion" of the Licence Committee. While this is appropriate given the nature of revocation, it would benefit from cross-reference to the relevant assessment policy to ensure clarity and proportionality in application. Without this policy or Schedule X, full evaluation is not possible.
- Bylaw 6.64(c) introduces a public protection standard — that reinstatement must not pose an "undue risk" or be contrary to the public interest — but the terms are not defined and lack thresholds or evidentiary standards. Consider adding detail, referencing risk frameworks, or ensuring alignment with equivalent standards in other Colleges.
- 6.64(b): Technically, the HPOA uses the term "capacity," which links to the definition of "fit to practise" in section 39 of the HPOA. That section should be referenced directly for clarity. The discretion of the Licence Committee should also be required to be reasonable and consistent with section 39.
- 6.64(c): Section 39 of the HPOA defines "fit to practise" without referring to "undue risk" or "public interest." Those terms only come into play when a capacity officer is deciding whether a revocation is necessary. Including them here introduces additional reinstatement criteria that go beyond what the statute requires.
- 6.65(b): This would be better drafted with an added (c) that says: "a Reconsideration decision that upheld the Revocation Order."
- 6.66: This should clarify that the licence being reinstated is the same one held at the time of revocation, or a comparable licence if the class has since changed.
- Bylaw 6.65 appropriately protects the integrity of review processes by deferring reinstatement until all reconsideration processes are exhausted. This is consistent with procedural fairness and administrative law principles.
- Bylaw 6.66 maintains continuity and scope protection by limiting reinstatement to the same licence class previously held. However, the bylaw does not address scenarios where a new class of licence may be more appropriate post-reinstatement, for example, in the context of gradual re-entry or professional re-training.
- Bylaw 6.67 reiterates the continuity of limits and conditions imposed prior to revocation, and introduces the possibility of new limits under Bylaw 6.69. As Bylaw 6.69 has not yet been provided, the process for imposing additional limits remains unclear and should be reviewed once available.
- The bylaw does not specify any timelines for the College's response to applications under this section, nor does it address whether the applicant may request reconsideration or appeal. This could affect access to reinstatement and should be considered in accompanying policies or procedural documents.

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- There is no mention of fees or cost recovery for assessments, which are likely to be substantial in cases involving capacity and fitness evaluations. Reference to Schedule "__" would allow for more complete evaluation.

Registrar Authorized to Issue, Vary, Renew and Reinstate Licences 6.68

Comments

- Bylaw 6.68 enables the Registrar to exercise the authority granted under HPOA s. 43(1), subject to s. 43(2), which limits that authority where there is a need for referral to the Licence Committee (e.g., due to complexity, public interest concerns, or failure to meet standards).
- This delegation is consistent with efficient administrative practice but would benefit from clarification on when the Registrar must refer to the Licence Committee, particularly in complex cases (e.g., reinstatement after revocation or unclear equivalency). Without this clarity, there is a risk of inconsistent referrals and potential procedural unfairness.
- As this bylaw simply restates legislative authority without elaboration, its effectiveness depends on internal College policies or procedures outlining how the Registrar will apply this power. These supporting instruments should be transparent and accessible to applicants.
- Consider confirming in accompanying policy that all decisions under this authority remain subject to reconsideration or appeal under s. 59 of the HPOA to protect applicant rights.

Imposition of Limits or Conditions by Registrar or Licence Committee 6.69-6.71

Comments

- The Registrar does not inherently have authority under the HPOA to impose limits or conditions on licences. Consider whether it is appropriate for a non-licensee (Registrar) to exercise this power without oversight or restriction.
- Both the Registrar and the Licence Committee should be required to exercise this authority reasonably. A reasonableness standard should be added to the bylaw to ensure defensibility and fairness.
- The final sentence of 6.69 contains a typographical error — "no" should read "not."
- For transparency and procedural consistency, Bylaw 6.70 should set out clear timelines: e.g., notice should be provided within 7 days, and the registrant should be given at least 30 days to respond or be heard.
- Bylaw 6.71(a) should also include a clear timeline for the registrant's right to respond — e.g., 30 days — to avoid ambiguity and ensure procedural fairness.
- Bylaw 6.69 grants the Registrar or Licence Committee significant discretion to impose limits or conditions, even in non-disciplinary contexts. While this supports risk-based regulation, the breadth of discretion would benefit from policy guidance or defined criteria to ensure transparent, fair, and consistent application across professions.
- The bylaw appropriately includes cultural safety, humility, and Indigenous-specific anti-racism approaches in clause (d), aligning with HPOA s. 15 and DRIPA commitments. However, clarity is needed on how these educational or training measures will be operationalized, assessed, and whether they are uniformly required or triggered by specific findings.
- Clause (e) authorizes random or periodic audits but lacks specificity regarding frequency, scope, or triggers. This may raise fairness concerns if audits are perceived as arbitrary. Consider including in policy whether certain conditions (e.g., practice gaps) justify increased audit likelihood.
- Bylaw 6.70 ensures procedural fairness by requiring notice and an opportunity to respond before conditions are imposed, which is consistent with natural justice principles. This is a strong safeguard and should be maintained.

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- Bylaw 6.71 establishes a deemed condition allowing the Licence Committee to act on material misrepresentations. This is standard in regulatory frameworks and appropriately allows revocation or variation. The clause also includes a fairness clause requiring a right to be heard and sets out relevant factors, including intent and impact.
- Consider whether "material misrepresentation" includes unintentional omissions or only deliberate acts. The test may benefit from clarification in guidance materials to avoid chilling effects on applicants who make good faith errors.
- As the imposition of limits may have significant professional consequences, it would be beneficial for applicants and Licensees to be made aware (in policy or guidance) of their right to seek reconsideration or appeal of such decisions under s. 59 of the HPOA.

Notice of Right to Apply for Reconsideration of Administrative Refusal by the Registrar 6.72

Comments

- This provision reflects a fundamental procedural fairness requirement and is a necessary component of the regulatory framework under the HPOA. Ensuring that applicants are explicitly informed of their right to request reconsideration strengthens transparency and supports trust in the administrative process.
- The bylaw would benefit from a reference to the relevant reconsideration process or section of the HPOA or bylaws that governs timelines, form, or manner of applying. Without this, applicants may not be aware of procedural obligations or deadlines associated with seeking review.
- It may be useful to clarify whether this requirement applies only to final decisions or also to preliminary refusals that could be resolved through clarification or additional documentation.
- Consider explicitly requiring that this notice be in plain language to support accessibility and compliance with equity, diversity, and inclusion principles, especially for applicants from diverse linguistic or educational backgrounds.

Request for Reconsideration by the Registrar 6.73

Comments

- This provision ensures that applicants and licensees have recourse to challenge an Adverse Application Decision, supporting procedural fairness and natural justice.
- The 30-day timeline aligns with typical administrative standards; however, the bylaw does not specify whether the Registrar has discretion to extend the deadline under exceptional circumstances (e.g., illness, postal delay). Consider clarifying this to avoid procedural rigidity.
- It is unclear whether the request for reconsideration must include new information or grounds for review. Consider specifying if the applicant must include rationale or evidence to support the request.
- The form referenced should be published and accessible to all applicants. There may also be value in requiring the Registrar to acknowledge receipt of the request within a set timeframe to avoid uncertainty about procedural status.

Reconsideration Hearing Process 6.74-6.75

Comments

- Bylaw 6.74 appropriately establishes that reconsideration hearings will be conducted by written submissions, promoting efficiency and administrative fairness. However, the term "exceptional circumstances" is undefined, which could lead to inconsistent application. Consider providing examples (e.g., procedural irregularities, complex factual disputes) or referring to a policy guiding this determination.

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- There is no indication of whether the Licensee or Applicant may request an oral hearing or submit evidence to support a claim that exceptional circumstances exist. Including a mechanism to request an oral hearing could strengthen procedural fairness.
- Bylaw 6.74 may overly restrict access to oral hearings by defaulting to written submissions. Parameters should be added to clarify when oral hearings may be granted, such as where credibility is at issue or where there are complex evidentiary disputes.
- Bylaw 6.75 should set a clear outer time limit for issuing written reasons — e.g., "within 7 days" — to promote transparency and certainty for applicants and Licensees.

Notice of Adverse Decision by the Licence Committee 6.76

Comments

- This bylaw appropriately affirms the duty to provide written notice of an Adverse Application Decision and supports transparency and procedural fairness. However, to align with best administrative practices, the phrase "within 30 days" should clarify whether this refers to calendar or business days.
- The bylaw references section 53(4)(b) of the Act for the right of review but does not clarify who conducts the review (e.g., Registration Review Committee) or how the applicant can initiate it. A cross-reference to a College policy or procedure could make the right more accessible.
- The bylaw does not specify whether this applies only to new applications or includes renewals, reinstatements, and provisional licence requests. Consider clarifying the scope of "Adverse Application Decision" for consistent interpretation.

When the Registrar May Revoke Licence 6.77

Comments

- Clause (a) provides for voluntary revocation with consent, which supports professional autonomy. However, best practice would include a procedural safeguard requiring the College to verify whether any complaints, investigations, or proceedings are pending before allowing revocation, to avoid misuse as an exit strategy from regulatory scrutiny.
- Clause (b) permits revocation for non-payment, but the bylaw does not specify any grace period, notice requirement, or opportunity to remedy the default. Absent such procedural fairness, automatic revocation could be challenged. A cross-reference to a policy on fees or late payments would improve transparency.
- Clause (c) allows revocation upon death, which is appropriate. Still, the phrase "in a form satisfactory to the Registrar" is vague and could benefit from clarification—e.g., specifying acceptable forms of notification such as a death certificate or coroner's report.
- This bylaw does not clarify whether the Registrar must give written notice of revocation to the Licensee or their estate (where applicable). Even in cases of non-payment or consent, notification of revocation is important for recordkeeping and due process.
- 6.77(b) The authority to revoke a licence for non-payment should be limited to mandatory fees such as annual renewal fees and should not apply to optional or ancillary payments like fees for voluntary limits. Without this clarification, the provision risks disproportionate enforcement.
- The bylaw should include notice and grace period requirements before revocation for non-payment can occur. This ensures procedural fairness and gives Licensees an opportunity to remedy inadvertent defaults.

Authority to Investigate Before Decision 6.78-6.79

Comments

- Bylaw 6.78 affirms the authority of the Registrar, Licence Committee, and Permit Committee to investigate matters before rendering a decision, which is appropriate. However, it lacks detail on scope, methods, timelines, or procedural safeguards (e.g., right to respond to findings), which could lead to inconsistency or perceptions of arbitrariness in decision-making.

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- It is unclear whether the applicant will be informed that an investigation is underway or have access to the information being gathered. This could raise concerns around procedural fairness, particularly if the investigation influences an adverse decision.
- Bylaw 6.79 places the full onus on the applicant to demonstrate eligibility, which is standard. However, given the potential burden for internationally trained applicants or those from unregulated jurisdictions, the College may wish to publish guidance on evidentiary expectations to avoid confusion or inequity.
- The absence of any reference to timeliness or transparency obligations on the part of the College in conducting investigations may be seen as a gap, especially where delays could impact the applicant's ability to practise.

Hearing Process 6.80-6.82

Comments

- Bylaw 6.80 appropriately allows flexibility in hearing format (in person, electronic, written), aligning with modern regulatory practices. However, clarification would be helpful regarding criteria for determining format—particularly when an applicant requests an in-person hearing. The lack of applicant input in determining format could raise fairness concerns in more complex or high-stakes matters.
- The bylaw also references the possibility of witness examination under oath or affirmation, which is appropriate where factual disputes exist. The College may wish to confirm whether formal procedural rules (e.g., evidentiary rules, rights to cross-examine) will be published or otherwise available to parties for transparency.
- Bylaws 6.81 and 6.82 properly affirm the College's ability to retain legal counsel and participate as a party (although the wording is awkward), which supports public interest representation. However, it would be helpful to clarify whether the Licence Applicant will also be entitled to legal representation and whether the College provides procedural guidance or assistance to self-represented applicants. This is especially important for fairness and accessibility, particularly for individuals from marginalized or international backgrounds.
- 6.82 requires clarification if this is separate representation from the Licence Committee.

Certified Practice: Naturopathic Medicine 6.83-6.86

Questions:

- Is the apparent removal of all existing certifications (except Prescriptive Authority) an intentional repeal of clinical authorizations such as IV therapy, chelation, ozone, aesthetic procedures, immunizations, or prolotherapy?
- If these procedures are no longer subject to certification, does that mean all NDs can now perform them without additional regulatory approval? If so, where is that made explicit?
- If certification is no longer required, what mechanisms will the College use to ensure competence and public safety for previously certified practices?
- Is the College planning to reintroduce these certifications by future bylaw? If yes, what is the timeline and transitional approach? If no, why was this not transparently disclosed as a major scope change?
- Why is there no grandfathering clause or deemed certification mechanism to preserve current licensee authorizations post-transition?
- How will this affect delegation rules, given that certified practices could not previously be delegated, and that limitation appears to have been removed?
- Does the College intend to manage previously certified practices through individual limits and conditions on licensure instead? If so, what is the process and how will this be made transparent?
- What consultation occurred to support such a significant structural shift in certification, and why has there been no explanatory guidance issued?
- How does the current drafting meet the College's obligations to ensure transparency, fairness, and clarity in defining professional scope?

Comments:

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- There has been no advance discussion or substantive consultation regarding this. Embedding such a fundamental shift within draft bylaws framed as general governance or regulatory updates falls far short of what would constitute meaningful consultation. It is not procedurally adequate, nor does it meet the standard expected for potentially significant changes.
- Bylaw 6.84 appropriately preserves the certification of licensees who held Prescriptive Authority prior to the In-Force Date. However, it is unclear whether this deemed certification will be considered equivalent on an ongoing basis or whether these licensees will be subject to future recertification, continuing education, or regulatory revalidation under Bylaw 6.86. Without clarification, this introduces regulatory uncertainty for currently certified naturopathic doctors.
- Bylaw 6.85 states that certifications held under the Health Professions Act expire on the In-Force Date unless preserved under Bylaw 6.84. This provision risks unintended decertification, particularly for returning or recently graduated licensees whose certification records may be incomplete or out-of-province. There is no grace period, case review process, or opportunity for reconsideration. Consideration should be given to transitional fairness, especially given the administrative changes underway.
- 6.86 provides no definition for 'Prescriptive Authority'.
- Bylaw 6.86 gives the Licence Committee full discretion to set education, training, and additional requirements for certification. This departs from the current in-use Prescriptive Authority Standard, which includes defined and publicly available criteria. There is no requirement under the draft bylaw for transparency, consultation, or notice when changes to the certification pathway are made. This raises concerns about fairness, access, and regulatory predictability, particularly for internationally trained naturopathic doctors or those re-entering practice. Registrants would benefit from clarity on whether previously approved programs remain acceptable, and whether timelines between training and application will be strictly enforced. It would also be helpful to clarify whether applicants will have access to procedural recourse if their application is denied.

Certification Applications and Renewals 6.87-6.89

Comments

- Bylaw 6.87 sets out a basic application process for Prescriptive Authority certification but grants broad discretion to the Registrar to determine the form of the application and request additional information. While flexibility is appropriate, the absence of clear criteria or timelines raises concerns about consistency and transparency. It is unclear whether prior completion of a certification program under Bylaw 6.86 guarantees approval or whether the Registrar may apply additional subjective standards when assessing documentation.
- Bylaw 6.88 allows for annual renewal of Prescriptive Authority certification but does not specify whether any ongoing education, competency assessments, or continuing practice requirements will be imposed as part of the renewal process. If such conditions are intended, they should be stated clearly in either the bylaw or the referenced certification program. As drafted, the renewal process appears administrative, but the lack of definition leaves room for variation or escalation without notice.
- 6.88: This could allow the Registrar to require additional qualifications to be met on a year-over-year basis
- Bylaw 6.89 establishes March 31 as the uniform expiry date for all Prescriptive Authority certifications. This centralized expiry approach is administratively simple but may disadvantage licensees who complete certification later in the registration year. For example, a licensee certified in February would need to renew one month later. Consideration should be given to a pro-rated fee or rolling renewal window to avoid disincentivizing new applicants or mid-year certifications.

Issuance and Reconsideration of Certifications 6.90-6.91

Comments

- 6.90: The word "me" should be "met".
- There is no reconsideration process mentioned in this bylaw, and certification decisions are not among those that carry a statutory right of reconsideration under the HPOA. This creates a gap in procedural fairness.
- Bylaw 6.90 obliges the Licence Committee to direct issuance of a certification where bylaw requirements have been met, which supports fairness and consistency. However, there is no mention of a right to reconsideration

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or review if an applicant is denied certification. This omission is notable, particularly given the discretionary authority granted to both the Licence Committee (under Bylaw 6.86) and the Registrar (under Bylaw 6.87) in determining application completeness. Without a clear reconsideration or appeal mechanism, applicants denied certification may be left without recourse.

- Bylaw 6.91 sets out the minimum content and form of the certification, which is reasonable. However, it may be helpful to clarify whether the Licence Committee-approved form must include any limitations or conditions (e.g., restricted drug classes or scope) if imposed, and whether licensees will have the opportunity to challenge or seek clarification of such conditions prior to issuance. As drafted, there is no indication of whether partial or conditional certifications are contemplated.

Notation on Registry 6.92-6.94

Comments

- Bylaw 6.92 requires the Registrar to note Prescriptive Authority certification in the Registry, which aligns with transparency and public access to licensure information. However, it would be helpful to clarify whether the Registry entry will include additional details such as certification status (active, expired, revoked), date of issuance, or any conditions or limitations, especially for employers or members of the public seeking verification.
- Bylaw 6.93 sets out conditions under which the Registrar must remove a certification from the Registry. While failure to renew or maintain requirements is standard, clause (b) raises concerns due to the open-ended reference to Bylaw 6.86. Because 6.86 allows the Licence Committee to establish undefined or evolving requirements, it is unclear how licensees will be notified of non-compliance or given an opportunity to remediate before removal. A process for notice and response prior to removal would strengthen procedural fairness.
- 6.93(b) The Registrar should only be permitted to remove certification for non-compliance with updated requirements when the licensee is reapplying or renewing, not retroactively or without prior notice.
- Bylaw 6.94 provides for automatic revocation of Prescriptive Authority certification if a licensee no longer holds a Full Licence in Naturopathic Medicine. This is appropriate in principle, but the bylaw does not distinguish between voluntary resignation, administrative suspension, or temporary leave (e.g., medical or parental). Without such distinctions, there is a risk of disproportionately penalizing licensees in good standing who step away from active practice temporarily. Clarification on reinstatement procedures or protections for temporary non-practice would be beneficial.

Schedule X: Specific Eligibility Standards by Designated Health Profession; Part 3- Naturopathic Medicine

7.0 Naturopathic Medicine: Full – Conditions and Requirements for Licensure

Comments

- The core requirements for initial licensure remain consistent with the current June 2024 CCHPBC bylaws. Graduation from a recognized education program, successful examination completion, and life support certification continue to form the basis of eligibility. No material changes are made to the recognized institutions or the content of CPR and NALS requirements. This continuity is appropriate and stabilizing for students, educators, and licensing pathways.
- The limit of three attempts for licensing examinations aligns with the current bylaw framework. However, all authority to grant additional examination attempts now rests entirely with the Licence Committee under a discretionary “opinion of the committee” standard. This standard is not defined, and there is no requirement that decisions be published, justified, or subject to independent appeal. NDs facing exceptional circumstances may have limited recourse under this structure.
- Under the HPOA, decisions of the Licence Committee are no longer appealable on the merits. Judicial review is the only pathway, which is narrow, costly, and rarely overturns discretionary outcomes. This reduces procedural fairness in cases where access to licensure is denied based on subjective assessments of exam eligibility.
- The bylaw allows the Licence Committee to approve “other equivalent certifications” for life support training, but does not define what constitutes equivalency or who may request recognition of alternative credentials. This

could lead to inconsistent or delayed recognition of legitimate qualifications, particularly for internationally trained applicants or those with military or non-traditional health backgrounds.

- The requirement that certification be "current" is appropriate, but no grace period or renewal window is defined. There is a risk that administrative gaps, such as a brief lapse in CPR renewal, could result in disproportionate application delays unless the College adopts a flexible policy.
- There is no explicit recognition of remote or online life support training options, which may disadvantage rural or remote applicants. In a post-COVID landscape, the bylaw could be strengthened by explicitly allowing blended or virtual certifications if delivered by approved organizations.
- The new bylaw framework centralizes control over licensure in the hands of the Licence Committee without guaranteeing registrant input into its policies, criteria, or interpretations. Under HPOA, committees are appointed, not elected, there may be only ONE ND representative, and consultation is not required. This could lead to shifting eligibility standards in the absence of transparent policy development or profession-led governance.
- While the current draft replicates existing standards, it operates in a new legal context where discretion is broader, procedural protections are weaker, and regulatory decisions are less accessible to challenge. Safeguards such as written reasons, timelines for decision-making, and review processes should be included to maintain fairness in licensure access.

Table 3: Recognized Education Program: Naturopathic Medicine

Comments

- The list of recognized education programs for naturopathic medicine remains consistent with the June 2024 CCHPBC bylaws. This continuity is welcome. It preserves stability in licensure pathways, supports interjurisdictional mobility, and avoids disruption for students and educators. However, under the HPOA, decisions about education program recognition fall under the authority of minister-appointed boards. There is no registrant vote or requirement for profession-led review. This creates a future risk that recognition criteria or institutional status could be changed unilaterally, without notice or transparent evaluation. Safeguards should be considered to ensure that any future changes are evidence-based, procedurally fair, and aligned with the public interest in qualified, accessible naturopathic care.

9.0 Delegation

Authority to Delegate 9.1-9.2

Comments:

- Bylaw 9.1 establishes general authority to delegate but fails to define key terms like "Aspect of Practice" or "Restricted Activity," creating ambiguity about what may actually be delegated. This could result in inconsistent application or enforcement.
- The clause allows delegation "subject to the Act and Regulations," but does not cite specific sections. Without clear cross-referencing (e.g., to HPOA s. 74), Licensees cannot be certain of the legal boundaries of delegation.
- There is no procedural requirement to document delegation, notify the College, or confirm acceptance by the delegatee. This raises concerns about accountability and traceability — especially if harm results.Bylaw 9.2(a)–(d) is structured to prevent delegation beyond scope, but relies on self-assessment by the Licensee. There is no built-in safeguard (e.g., oversight mechanism or audit standard) to verify compliance, potentially exposing patients to risk.
- The bylaw omits any reference to cultural safety, patient consent, or anti-discrimination duties in the delegation process. Given HPOA s. 15 and the DRIPA action plan, this is a missed opportunity to embed safeguards for Indigenous patients and other equity-deserving groups.
- There is no requirement that the person receiving the delegation (the "Delegatee") be identified or qualified in a verifiable way. Without such a condition, delegation could occur to unregulated or poorly trained individuals.

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- The absence of any prohibition on chain delegation (i.e., re-delegation by the delegatee) could allow tasks to pass through multiple hands without oversight.
- Under the HPA, colleges exercised more direct control over delegation through clear bylaws and programmatic guidance. The HPOA shifts this responsibility to minister-appointed boards, making it more important that bylaws clearly define and constrain delegation authority.

General Requirements for Delegation 9.3

Comments

- The bylaw places responsibility on the Licensee to ensure standards are met, but offers no criteria or process for assessing whether a delegatee is competent. This opens the door to highly subjective or inconsistent delegation decisions.
- Requiring that delegation be "noted in the applicable clinical record" is appropriate, but there is no direction on what information must be recorded. Without a minimum documentation standard (e.g., identity of delegatee, scope of task, supervision plan), this requirement may be meaningless in practice.
- The reference to "standards of practice applicable to the Licensee" assumes those standards are well-defined and accessible, but the bylaws don't link to or incorporate those standards by reference. This undermines enforceability and fairness.
- There is no requirement for the delegatee to acknowledge or accept the delegation, which raises liability concerns if tasks are improperly performed or misunderstood.
- The bylaw relies heavily on Licensee discretion without parallel obligations on the College to audit, monitor, or support safe delegation practices. This creates a regulatory blind spot, especially in team-based or high-volume environments.
- The bylaw fails to specify what information must be recorded when noting a delegation in the clinical record. At minimum, the record should include the delegatee's name, the date, the task delegated, the supervision plan, and what the delegatee did. Without this, the documentation requirement lacks enforceability and clinical utility.
- No safeguards are included for ensuring that delegated acts respect cultural safety, informed consent, or anti-discrimination principles. This is especially concerning given the broad authority to delegate and HPOA's emphasis on equity (s. 15) and Indigenous health protections (s. 467).
- The bylaw assumes compliance with section 74(2) of the Act, but does not explain what that entails. Most Licensees will not cross-reference the statute unless explicitly guided to do so.

Revocation of Delegation 9.4

Comments

- Revocation is permitted at the Licensee's discretion but no procedure is specified, leaving uncertainty around how and when a delegation is considered officially revoked.
- There is no requirement to document the revocation in the clinical record, which could undermine accountability if questions arise about who was authorized to perform a restricted activity.
- The bylaw does not require notifying the delegatee, the patient, or the College, even in cases where the revocation is due to competence or safety concerns. This may allow unsafe delegation to continue due to lack of communication.
- There is no mention of whether revocation must occur in cases where the delegatee breaches standards, poses a risk to the patient, or acts outside the delegated authority. Leaving this discretionary could create public protection gaps.
- Without mandatory reporting or tracking of revoked delegations, the College may be unable to detect patterns of unsafe delegation or repeated revocation involving the same delegatee.
- Compared to the HPA, which emphasized structured delegation and oversight through bylaws and policies, this provision under the HPOA feels underdeveloped and overly permissive.

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Responsibility for Delegated Services 9.5

Comments

- The bylaw affirms Licensee responsibility but offers no standard for how oversight must be exercised after delegation.
- There is no requirement to monitor or reassess the delegatee's performance, which undermines the enforceability of this obligation.
- The clause does not clarify how responsibility is shared or retained in team-based or institutional settings, creating ambiguity.
- Without documentation or review requirements, a Licensee could be held responsible for actions they did not reasonably control.
- The bylaw should link this responsibility to specific supervision or quality assurance duties elsewhere in the bylaws to give it operational meaning.

Conditions for Delegation Other Than Delegation to a Student 9.6

Comments

- The bylaw allows delegation only within an employment or contractual relationship, which creates a clear accountability link but may exclude legitimate team-based care models where no direct contractual link exists.
- The requirement for the Licensee to be "satisfied" with the delegatee's qualifications relies entirely on subjective assessment, without requiring evidence or documentation to support the decision.
- There is no obligation to verify qualifications through objective criteria such as credentials, references, or regulatory history, weakening public protection.
- The phrase "reasonable assessment" is undefined and risks inconsistent application across Licensees with varying levels of experience or risk tolerance.
- There is no requirement for College oversight, audit, or reporting of delegation decisions, even though this bylaw opens the door to delegation of regulated activities to unregulated personnel.
- The bylaw limits delegation to specific activities listed in later sections, but those sections are not included or summarized here, requiring the reader to cross-reference multiple pages just to understand what is permitted.
- There is no reference to anti-discrimination or cultural safety obligations in the assessment of the delegatee's qualifications or in the performance of the delegated activity, despite these being statutory duties under the HPOA.
- The bylaw does not require patient consent or disclosure that care will be delivered by someone other than the Licensee, which may undermine informed consent and trust.
- The bylaw should require delegatees to explicitly identify that they are not Licensees when interacting with patients or the public. This is a basic safeguard against confusion or misrepresentation of qualifications, similar to requirements in legal and financial professions.
- The phrase "or the legal entity through which the Licensee provides Health Services" is unclear. If the intent is to refer to Health Profession Corporations, that should be specified. If other arrangements are intended, such as joint ventures or shared practices, the bylaw should clarify how delegation authority applies in those contexts.
- Including certain activities as delegatable assumes they are low-risk and do not require specialized knowledge, but this may not be accurate for all listed activities. Some may involve higher risk and should either be excluded from delegation or subject to stricter oversight and accountability requirements.
- Listing these activities as delegatable may unintentionally weaken the protected scope of practice by creating a precedent for non-licensees or other health professions to perform them in the future. This could lead to scope encroachment and erosion of professional boundaries over time.

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Aspects of Practice That May Be Delegated – Naturopathic Medicine 9.9- 9.10

Comments

- This bylaw introduces a formal delegation regime for NDs that did not exist in the June 2024 bylaws. Delegation was previously governed by general professional discretion, not task-specific regulation. The shift to codified delegation reflects a structural change in regulatory oversight.
- Mixing, compounding, and dispensing of herbs and tinctures were not previously regulated as delegable tasks. By introducing these activities into a formal delegation list without setting training thresholds, credential checks, or oversight mechanisms, the bylaw shifts clinical and legal risk onto the ND without regulatory support or clarity.
- Taking and documenting vital signs is reframed as a delegable task, which formalizes a practice that was previously managed under general supervision. The bylaw does not specify accuracy standards, equipment requirements, or follow-up obligations, leaving NDs accountable for clinical data without assurance of how or by whom it was collected.
- Application of hot and cold therapy is permitted without reference to contraindications, risk screening, or patient tolerance. The bylaw allows delegation of this physically therapeutic activity without requiring that the delegatee be trained or assessed for safety competence, which places procedural liability on the ND without defining enforceable safeguards.
- Explanation of diet recommendations introduces a blurred boundary between administrative support and individualized clinical communication. The bylaw does not define the limits of this task or provide clarity on when delegatees must defer back to the ND, which increases the risk of patient miscommunication and unregulated practice under the ND's authority.
- Preparation of equipment or patients for examination is a routine support role, but its inclusion as a regulated delegation task formalizes an obligation that was not previously subject to documentation or compliance. No standards for hygiene, cultural sensitivity, or patient readiness are provided, increasing the ND's exposure in case of error or complaint.
- The requirement to provide supervision under Bylaw 9.10 is not supported by any definition of what level or form of supervision is required. Without specifying direct, indirect, or retrospective oversight, the bylaw introduces ambiguity that can be enforced inconsistently and retrospectively against the ND.
- The bylaw includes no requirement to document the delegation process, assess or record delegatee qualifications, or disclose delegation to patients. These omissions conflict with HPOA obligations related to informed consent, anti-discrimination, and culturally safe care, yet the bylaw offers no guidance on how these statutory duties are to be upheld when care is delivered by unregulated staff.
- Patient notification and the right to refuse delegated care are not addressed. Tasks that involve dispensing, applying therapy, or communicating diet instructions have direct impact on patient experience and autonomy. The bylaw does not require transparency around who is providing care on behalf of the ND.
- Under the HPA, changes to delegation frameworks were shaped by registrant-informed bylaw development and elected board oversight. Under HPOA, delegation lists can be amended unilaterally by a minister-appointed board without registrant vote or profession-led review, weakening democratic control over clinical responsibilities.
- Delegation is redefined in this bylaw as a formal compliance function rather than a matter of professional discretion. This shifts risk onto NDs while providing no operational tools, decision-making frameworks, or audit protections to support safe implementation.

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Restricted Activities that May Be Delegated – Naturopathic Medicine 9.11-9.12

Comments

- Delegation of restricted activities was not permitted or contemplated in the June 20, 2024 CCHPBC bylaws. This bylaw introduces a new authority without parallel changes to the regulatory framework to support safe implementation or mitigate risk to the ND.
- The placement and removal of a nebulizer for the purpose of administering a substance is a restricted activity involving controlled equipment, therapeutic substances, and direct patient contact. The bylaw authorizes delegation of this task without specifying the training, competence, or supervision requirements necessary to ensure safety and regulatory compliance.
- No supporting provisions exist in the current bylaws to define minimum qualifications for delegatees who carry out restricted activities. The bylaw creates enforceable risk exposure for the ND but does not offer accompanying certification standards, documentation protocols, or tools for clinical oversight.
- Supervision is required under Bylaw 9.12 but is not defined. The absence of clarity regarding whether supervision must be direct, indirect, real-time, or retrospective creates ambiguity that undermines defensibility. NDs are placed in a position of post-hoc accountability without knowing what standard applies.
- There is no requirement for NDs to document the delegation of a restricted activity, assess or record the qualifications of the delegatee, or obtain informed consent from the patient. In the absence of these protections, NDs bear full responsibility for the outcome of care they did not personally deliver.
- The bylaw does not distinguish between low-risk and high-risk patient contexts or offer criteria to guide when delegation may be appropriate. Without limitations based on patient acuity, age, or comorbidity, NDs must absorb all clinical and regulatory consequences associated with the decision to delegate.
- Under the current bylaws, no regulatory infrastructure exists to support delegation of restricted activities by NDs. This includes the absence of certification pathways for unregulated assistants, no guidelines for training or clinical readiness, and no regulatory mechanism for revocation or audit. The bylaw authorizes delegation in a vacuum, with the burden placed entirely on the ND.
- Delegation of a restricted activity without transparency or patient disclosure risks eroding informed consent. Patients may reasonably assume the ND is performing the task unless told otherwise. Without regulatory requirements for communication or consent, responsibility falls solely on the ND.
- The bylaw fails to reference cultural safety, trauma-informed practice, or the statutory duties in HPOA related to non-discrimination and equitable care. Delegated care involving respiratory support may trigger trauma responses or patient safety concerns if not delivered with appropriate skill and cultural awareness.
- Under HPOA, minister-appointed boards have full authority to amend or expand the list of delegable restricted activities without registrant vote. The delegation framework can be altered without ND participation, increasing the risk of scope expansion without adequate consultation or profession-led oversight.
- The delegation of a restricted activity without an enabling infrastructure or clear safeguards creates a one-sided regulatory model. NDs are placed at elevated risk for professional liability, College investigation, and reputational harm without the tools necessary to delegate safely or defensibly.

Delegation to Students 9.15-9.16

Comments

- Delegation to students was not addressed in the June 2024 CCHPBC bylaws. This bylaw introduces a new framework for student involvement in restricted activities and aspects of practice, without defining the regulatory standards that would guide such involvement from a College perspective.
- The bylaw permits delegation of any restricted activity to a student, provided the activity occurs within the context of a recognized education program. This grants broad discretion to educational institutions to set the limits and conditions of delegation, while placing legal and professional accountability on the supervising ND.
- NDs are required to make a reasonable assessment of a student's capacity to perform a delegated activity safely, but the bylaw provides no regulatory tools, minimum benchmarks, or risk-based delegation criteria to

support this assessment. In the event of patient harm or complaint, the ND remains accountable despite limited control over curriculum content or student placement quality.

- Supervision requirements are described in general terms but remain undefined. The bylaw permits "such other form of oversight or monitoring" in lieu of supervision, based on factors including the nature of the activity and institutional guidelines. This creates significant ambiguity and may undermine defensibility for NDs in settings where multiple preceptors or external providers are involved.
- The bylaw authorizes delegation to occur in preceptorship or externship settings, including private clinics. These environments may lack the infrastructure, staff, or safeguards of institutional premises. The responsibility for ensuring appropriateness of the site and the scope of the student's activity rests with the ND, but there is no formal mechanism to evaluate these environments or determine their compliance.
- The requirement that students carry professional liability protection is appropriate in principle but not operationalized. The bylaw does not require NDs to verify the existence, scope, or adequacy of coverage. In the absence of such requirements, NDs may become the default point of liability even when a student is at fault.
- By assigning the authority to set delegation conditions to the recognized education program, the College relinquishes regulatory control over how restricted activities are accessed by unlicensed individuals. This creates a structure in which the ND is regulated but the education provider is not, leading to asymmetrical accountability.
- The bylaw does not address how delegation to students intersects with HPOA obligations related to cultural safety, trauma-informed care, or non-discrimination. These responsibilities apply to all individuals delivering patient-facing care, including students, yet there is no reference to how NDs are to ensure compliance when oversight is shared with external institutions.
- No requirements are included for documentation of delegated student activity in the patient record or for disclosure to the patient that care is being provided by a student. This omission risks undermining informed consent and transparency, particularly in private practice settings.
- The delegation framework for students introduces enforceable responsibilities for NDs that are not balanced by regulatory supports. In practice, the ND bears responsibility for clinical supervision, institutional coordination, risk assessment, and patient protection, without guidance on how to meet these duties or mitigate exposure.
- There is no requirement for the delegation to be documented in the clinical record, which undermines traceability and weakens accountability in both educational and clinical settings.
- Section 9.16(c) lacks clarity by allowing supervision to be substituted with unspecified "other forms of oversight or monitoring." This dilutes the ND's accountability, especially when supervision is delegated to third parties. Clause (c)(iii) introduces vague language without defining what qualifies as "others overseeing," creating regulatory ambiguity.

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