ABORIGINAL ADMINISTRATIVE LAW CONFERENCE
PAPER 5.1

Intersections between Professional Regulation and Aboriginal Interests

These materials were prepared by Lisa C. Fong of Ng Ariss Fong, Lawyers, Vancouver, BC, for the Continuing Legal Education Society of British Columbia, June 2015.

INTERSECTIONS BETWEEN PROFESSIONAL REGULATION AND ABORIGINAL INTERESTS[1]

I. Introduction

The discussion around improving Aboriginal health care is often centred around increasing health care services to Aboriginal communities. In recent years, the discussion has led to the formation of the First Nations Health Council to consider the development of a First Nations Health Authority, to increase access and quality of care within Aboriginal communities. An aspect of Aboriginal health care that needs more attention is the role of traditional Aboriginal healing practices and practitioners in relation to Western regulated health professions.

In Canada, the provinces regulate the licensing of health care professionals, and the scopes of their health care practices. If we take seriously the desire for Aboriginal healing practices and practitioners to be integrated into the mainstream Canadian health care system, then careful consideration is needed about regulatory issues, such as who controls the licensing of Aboriginal healers, what standards should apply to Aboriginal healing practices, and what is or is not an Aboriginal healing practice.

The time to talk intensively about these considerations is now.

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1 I gratefully acknowledge the assistance of Michael Ng, Kate Parisotto, and Julia Hincks of my firm for their research, comments, and other contributions to the creation of this paper.

On June 1, 2015 the Truth and Reconciliation Commission released its report on the Indian residential school system and its impact on Aboriginal peoples (the "Report").[2] The Report set out 94 action items directed at building mutual recognition and respect between Aboriginal and Non-Aboriginal Canadians. Under the heading "Health," the Report recognized the importance of changing Canada's health-care system to integrate Aboriginal healing practices and incorporate Aboriginal health-care professionals. Specifically, **action item #22** called upon the Canadian health-care system "to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients."

Related to that discussion is **action item #23**, which called upon governments to increase the number of Aboriginal health-care professionals, ensure the retention of Aboriginal health-care providers in Aboriginal communities, and to provide cultural competency training for all health-care professionals.

I invite you to think about how you would model a system for the regulation of traditional Aboriginal healing practitioners, given the components of the Western professional regulatory model, and what that model offers in terms of benefits or disadvantages.

The paper begins with an introduction to Western professional regulation. Then I discuss the outcomes of our firm's survey of health professional regulators and the intersections where they engage with Aboriginal interests. Finally, I come back to my invitation to you to consider the role of Western professional regulation models in regulating traditional Aboriginal healing practices.

II. Introduction to Professional Regulation

In Canada, to practice certain professions, a person must be licensed with a professional regulatory body. In health-care, professions including doctors, midwifes, social workers, pharmacists, psychologists, dentists, nurses, and naturopathic physicians, are regulated by provincial regulatory bodies. This means that a person who wishes to be a doctor in BC, for example, must be licensed with the College of Physicians and Surgeons of British Columbia.

Any person who practices medicine in BC that is not licensed with the College of Physicians and Surgeons engages in unauthorized practice, commits an offence, and is subject to court-ordered sanctions.

The rationale for regulating professionals is to ensure that the public is protected from incompetent or unethical practices. Regulation ensures that professionals are meeting a standard of practice in providing professional services.

A. Self-regulated Professions

There are two basic models of professional regulation, regulation by government and self-regulation by the profession.

Regulation by government is where government regulates a profession under a statute. In BC, an example of a government regulated profession is public and private K-12 school teachers, who are governed by the Ministry of Education.

Self-regulation by a profession involves the delegation of authority by the legislature to professionals to regulate themselves in the public interest. In BC, health professionals are the largest self-regulated group of professionals. They regulate themselves under the *Health Professions*

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2 See: http://www.trc.ca/websites/trcinstitution/index.php?p=890

Act, R.S.B.C. 1996, c. 183 (the "*HPA*"). In BC, social workers are regulated under their own statute, the *Social Workers Act*, S.B.C. 2008, ch. 31.

The *HPA* enables the creation of regulatory bodies called "colleges" and each college has a board, which consists of a combination of professionals and government-appointed public members. Each college also has a number of committees which carry out its regulatory work. These committees typically consist of a combination of professionals and government-appointed public members. I'll address the function of the board and the committees in more detail later.

The object of all the colleges is to serve the public interest. The colleges do this by setting standards for entry into the particular profession, and enforcing standards through quality assurance programs, conducting investigations, and holding discipline hearings.

B. Scope of Practice

The scope of a professional practice, which are the activities a professional can practice, is determined by government regulation. Scopes may overlap between professions, so that more than one professional group can practice particular activities. Some activities are reserved to specific professions, or to only one profession.

The scope of a profession's practice can be very broad. For example, for medical doctors, the Medical Practitioners Regulation, B.C. Reg. 416/2008, defines "medicine" as the profession in which a person provides the services of

> (a) assessment and management of the physical or mental condition of an individual or group of individuals at any stage of the biological life cycle, including the prenatal and postmortem periods,
>
> (b) prevention and treatment of physical and mental diseases, disorders and conditions, and
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> (c) promotion of good health.

However, the scope of different professions with different approaches may overlap. For example, "midwifery" addresses health care, including counselling and support, "during normal pregnancy, labour, delivery and the post-partum period" (Midwives Regulation).

Another example is "naturopathic medicine" which covers "prevention, assessment and treatment of an individual's diseases, disorders and conditions using education and naturopathic techniques, therapies or therapeutics to stimulate or support healing processes and promote, maintain or restore the overall health of the individual" (Naturopathic Physicians Regulation). Naturopathic techniques may include physical manipulation, clinical nutrition, botanical medicine, and homeopathy.

C. Standards of Practice

The standards of practice of a profession are developed by the profession, and by the college. For regulatory purposes, standards represent minimum competent and ethical standards of practice. Higher standards of practice, or best practices, or "gold" standards may also be developed by professions and colleges, but do not represent the enforceable minimum standard.

D. Primary Functions of Regulators

Regulators have three essential functions:

- registration or licensure of professionals;
- maintenance of professional competencies; and
- investigation and discipline of breaches of professional standards.

Regulatory bodies are administered by boards, whose duties are to ensure that the regulator is serving the public interest. Under the *HPA*, boards may create bylaws and committees to carry out regulatory duties, administer the financial affairs of their college, and liaise with other health-care stakeholders.

1. Registration

Persons who wish to practice a regulated profession must apply for registration with the profession's regulatory body. The regulator, usually through the board and the registration committee, sets minimum academic, training and ethical standards which an applicant must meet in order to gain entry.

The registration committee is usually legislated with the duty to assess registration applications, and grant or deny entry into the profession. In assessing applications, a registration committee may be required to assess whether an applicant who does not meet conventional educational standards, but has substantial real-world experience, may be granted entry. A registration committee may also be required to assess the good character and fitness of an applicant to be a professional, where some history or medical condition may put their suitability into issue.

2. Quality Assurance

Regulators are tasked with ensuring the maintenance of professional competencies, and may do so through a quality assurance program. Typically quality assurance programs are created by the board and a quality assurance committee. Programs may include continuing education requirements, self-assessments, and inspections and audits.

3. Investigation and Discipline

In order to enforce minimum standards, regulatory bodies have the power to investigate complaints and hold disciplinary hearings. The powers of investigation are generally set in the statute that creates the regulator. For example, under the *HPA*, a college's inquiry committee may order an investigation by an inspection of records or of the registrant's place of practice, or may seek a search and seizure order from the court. These inquiry committees may resolve complaints through alternative resolutions, or may order that a matter be sent to a discipline hearing. If a matter is sent to a discipline hearing, then the discipline committee takes over, and hears the charges against the professional. The discipline committee is clothed with powers which allow it to administer oaths, summon witnesses, require production of documents, determine liability for professional misconduct, and issue penalties affecting the right to practice.

III. Intersections between Professional Regulation and Aboriginal Interests

In the Western model of professional regulation, places where we might expect to find Aboriginal engagement would include:

(1) educating professionals about Aboriginal culture to facilitate provision of health care;

(2) Aboriginal people as registered professionals;

(3) Aboriginal persons sitting on boards and committees within professional regulatory bodies; and

(4) traditional Aboriginal healing practices being incorporated into the scopes of practice and standards of existing professional regulatory bodies.

For this paper, we reviewed the websites of health regulators across Canada. In professional regulation, health regulatory bodies now use their websites as their primary means to deliver information to the public, and to registrants. Where their websites indicated some significant engagement with Aboriginal peoples or traditional medicine, we contacted the regulator to discuss the extent of the engagement.

Item 1: Educating professionals about Aboriginal culture

Given the past role of social services in apprehending Aboriginal children for residential school programs, the profession of social work has generally undertaken various initiatives to engage in consultation and reconciliation with Aboriginal peoples.

For example, the BC College of Social Workers is currently revising its standards of practice to reflect emerging scopes of practice, and also to reflect the needs of clients and communities in BC "from a cultural and practice perspective."[3] The College expressly acknowledges, in its Guiding Framework for the development of standards of practice, the need for a significant connection with Aboriginal peoples, so that "Indigenous perspectives and knowledge are inherent within the work of the College and the social work profession in BC."

As for other professions, in November 2005, the Governments of BC, Canada and the First Nations Leadership Council signed the Transformative Change Accord, to close certain gaps for First Nations in areas of education, health, housing and economic opportunities.[4] One of the action items included a curriculum for cultural competency for health authorities.

As a result, the Provincial Health Services Authority developed the Indigenous Cultural Competency Program, which provides training and develop individual competencies for health care providers who work with Aboriginal people.[5] The Program includes various basic and advanced courses for health, mental health, and other professionals, including knowledge about different Aboriginal groups, impacts of colonization, strategies for building collaborative relationships, and anti-racism skills.

The training is offered within the Ministry of Health. This course-work is also referenced by four BC regulators—the College of Physicians and Surgeons, the College of Pharmacists, the College of Midwifes and the College of Registered Nurses—either on their websites, or during my discussions with them.

There appears to be much room for regulatory bodies to encourage their respective professionals to develop cultural competency for working with Aboriginal peoples, such as by recognizing such programs through continuing education programs.

Items 2 and 3: Aboriginal registrants and members of boards and committees

A review of regulatory website and discussions with various regulators indicates that regulators do not appear to track statistics of Aboriginal peoples as registrants of regulated health professions, or as members of boards or committees. The exception with respect to boards and committees is where a regulator has a specific task force that calls for Aboriginal health care knowledge.

For the most part, health regulatory colleges do not formally integrate Aboriginal interests into their bylaws. But some notable exceptions arise.

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3 See: http://www.bccollegeofsocialworkers.ca/

4 See: http://www2.gov.bc.ca/gov/topic.page?id=7F6620F4C9004B9B845C5A105388A779

5 See: http://www.culturalcompetency.ca/

In BC, the College of Midwives of BC has bylaws which establish a Committee on Aboriginal Midwifery.[6] The Committee is required to consist of at least three Aboriginal persons appointed by the Board of the College (Bylaw s. 20(1) of the bylaws)). That committee "may nominate a person to fill a position *on each committee of the board*" (s. 20(3)) (emphasis added).

In Alberta, the bylaws of the Alberta College of Social Workers provide that the Council may establish an Indigenous Social Work Committee (Bylaw s. 3.10), which is to include seven Aboriginal social workers, to act in an advisory capacity to Council on matters related to Indigenous social work practice (Bylaw s. 3.10.1).[7]

Additionally, where an Indigenous person requests a review (of any decision of a committee, such as the registration committee or a hearing tribunal), the review panel must include at least one Registered Indigenous social worker (and one shall be appointed if the Council does not have any Indigenous social workers) (Bylaw ss. 3.7-3.9).

In Manitoba, the College of Midwives of Manitoba[8] (under the *Midwifery Act*, C.C.S.M. c. M125) expressly includes an Aboriginal perspective in the following ways:

- The College's bylaws state in their preamble that, "the College shall strive to meet its commitment to equity by: … (b) ensuring that groups that have experienced historical disadvantage such as … Aboriginal persons… are represented on the Council and committees of the College."
- The Council of that College is required to establish "a standing committee to advise the college on issues related to midwifery care to aboriginal women" (Bylaw 9.1(b)) [referred to as "Kagike Danikobidan"].
    - All members of that Committee must be of Aboriginal ancestry.
    - The purpose of the Committee, according to its terms of reference, is to provide the College with a perspective on midwifery that is deemed desirable and acceptable to Aboriginal women.
    - The formal scope of the Committee is notable:
        - the Committee appoints one committee member to serve on the Council of the College (Bylaw 16.12(a));
        - the Committee appoints one person for of the Board of Assessors, which has at least three members (Bylaw 14.1);
        - the Committee one person for the Standards Committee, which has at least four members (Bylaw 15.1);
        - where the Committee disagrees with a decision made by the Council, "it has the authority to require the Council to reconsider and consult further on the matter" (Bylaw 16.13).

Finally, in Nova Scotia, the bylaws of the Nova Scotia Association of Social Workers provide that a representative Aboriginal social worker is a voting member of the Council of the Association (s. 9 of the bylaws).[9]

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6 See: http://www.cmbc.bc.ca/

7 See: http://www.acsw.ab.ca/social_workers/council/governance/bylaws

8 See: http://www.midwives.mb.ca/index.html

9 See: http://www.nsasw.org/site/index

Item 4: The regulatory status of traditional Aboriginal healing practices

Many professions, such as pharmacists, nurses, and naturopathic physicians, are silent as to traditional Aboriginal healing practices, or "alternative" practices generally. Generally speaking, only the colleges of three professions address Aboriginal healing practices, or more generally alternative therapies, in their legal structures in some way: physicians and surgeons, midwives, and social workers. However, even within the three professions, some regulators of different provinces remain silent about alternative therapies. Those that do address non-Western therapies take different approaches.

1. Exemption from regulation: For example, Ontario's *Regulated Health Professions Act* simply does not apply to either "*aboriginal healers* providing traditional healing services *to aboriginal persons or members of an aboriginal community*," or to "*aboriginal midwives* providing traditional midwifery services *to aboriginal persons or members of an aboriginal community*" (s. 35(1)) (emphasis added).

The exemption of Aboriginal healers and Aboriginal midwives from the whole of the *Regulated Health Professions Act*—where they are providing services to other Aboriginal persons—means that they are not governed by provisions such as s. 27, which stipulates that no person shall perform a "controlled act" in the course of providing health care services unless the person is a member authorized by a health profession Act to perform the controlled Act. (Aboriginal midwives are, however, expressly authorized by the Ontario *Midwifery Act*, 1991, S.O. 1991, c. 31 to use the title, "aboriginal midwife" (s. 8(3).)

Similarly, in Quebec, under the *Midwives Act*, c. S-0.1, no person may engage in midwifery activities unless a midwife, but the government and a First Nations may reach an agreement which allows a "Native person" to engage in midwifery in accordance with any conditions in the agreement (s. 12(2)).

2. Inclusion in regulation: By comparison, the law of BC generally prohibits any person from carrying on various health services, broadly defined, unless they are permitted to do so by regulation. Under the *Health Professions Act*, if a regulation prescribes that a service may only be provided by a registrant of a college, a person other than a registrant must not provide the service (s. 13(2)). A person who does so commits an offence (s. 51). The widest restriction may be found in the *Medical Practitioners Regulation* which says (in s. 4(2)):

> Only a registrant may provide *a service of medicine* as set out in this regulation if, on the day before this section comes into force, the provision of the same service by anyone other than a person authorized under the *Medical Practitioners Act* was prohibited. (emphasis added)

Under the old *Medical Practitioners Act*, a person who practiced medicine while not registered committed an offence (under s. 81(1)), and the practice of medicine included (for example):

- diagnoses of disease, ailment, or injury;
- prescribing or administering any drug, medicine or substance for curing, treating or preventing any disease, ailment or injury; and
- administering a treatment or performing midwifery.

A similar restriction can be found in relation to midwives, as the *Midwives Regulation* sets out a list of restricted activities that only a registrant may provide (s. 5(1) and (1.1)). But the restriction on non-registrants "does not apply *on a reserve* to *an aboriginal person* who practised aboriginal midwifery prior to March 15, 1995." (emphasis added)

A provincial restriction on the practice of medicine, or midwifery, by any non-registrant may encompass traditional Aboriginal healing practices, at least off-reserve. This is illustrated by the

Ontario case of *R. v. Hill*, from 1907, where an Aboriginal person, residing on reserve, was convicted for practising medicine off-reserve, on non-Aboriginal patients, contrary to the Ontario *Medical Act*, R.S.O. 1897, ch. 176:

> 19 Section 111 assumes that an Indian may become a member of any of the learned professions, and I find nothing in the Act to indicate that, except where provisions are made which expressly or by implication declare his obligations and the consequences which attach to their breach or otherwise specially deal with him, the conduct and duty of an Indian in his relations with the public outside the reserve are not subject to the control of the provincial laws in the same manner as those of ordinary citizens. Parliament may, I suppose, remove him from their scope, but, to the extent to which it has not done so, he must in his dealings outside the reserve govern himself by the general law which applies there. He is no more free to infringe an Act of the Legislature than to disregard a municipal by-law, the general protection of both of which he enjoys when he does not limit the operations of his life to his reserve, but, though unenfranchised, seeks a wider sphere. If he may become a doctor of medicine, and take advantage of the Medical Act by registering under it, it certainly ought to follow that he cannot become a free lance and practise wherever he pleases without regard to its provisions. (emphasis added)

I am not aware of any case addressing the unauthorized practice of medicine by an Aboriginal person after the enactment of s. 35 of the *Constitution Act*.

If such a charge were to arise today, the case would likely engage asserted Aboriginal rights of persons to engage in and receive traditional Aboriginal healing practices. I touch on that later in the paper.

The extent to which traditional Aboriginal healing practices are permitted: In relation to both medicine and midwifery, although many provincial regulators are silent about traditional Aboriginal healing practices, some colleges do expressly permit *registrants* to provide "alternative" therapies. But these exemptions require that practitioners *first* qualify for and become a registrant or member of the profession.

A. Physicians

In BC: the BC *Health Professions Act* includes a provision which applies specifically to the College of Physicians and Surgeons which protects—to some degree—practices broadly described as "alternative medicine" (s. 25.4):

> **Alternative medicine**
>
> 25.4 The college must not act against **a registrant** or an applicant for registration solely on the basis that the person practises **a therapy that departs from prevailing medical practice unless** it can be demonstrated that the therapy poses **a greater risk to patient health or safety than does prevailing medical practice**. (emphasis added)

In Alberta: The Alberta *Health Professions Act*, R.S.A. 2000, c. H-7, contains a similar provision in Schedule 21, which applies to physicians, surgeons and osteopaths, and which protects—to some degree—practices broadly described as "non-traditional therapy" (meaning traditional from a Western perspective):

> **Non-traditional therapy**
>
> 5. Despite anything in this Act, **a regulated member** is not guilty of unprofessional conduct or of a lack of competence solely because the regulated member employs **a therapy that is non-traditional or departs from the prevailing practices of physicians, surgeons or osteopaths unless** it can be demonstrated that the therapy **has a safety risk for that patient that is unreasonably greater than that of the traditional or prevailing practices**. (emphasis added)

However, the statutory provision does not end the story.

The College of Physicians and Surgeons of Alberta requires, though a standard of practice relating to "Complementary and Alternative Medicine," that a physician wishing to engage in alternative practices must apply to the College's registrar for permission (unless the patient suffers from a fatal, incurable disease).[10] The physician must provide information about the therapy, and the physician's training and experience with the therapy, to obtain permission.

A discussion with that College reveals, however, that it has received no applications for practising traditional Aboriginal healing practices.

Elsewhere: Similar provisions may be found in

- the Manitoba *Medical Act*, C.C.S.M. c.M90, which permits "non-traditional" therapies which do not pose a "greater risk to a patient's health or safety" than the traditional or prevailing practice (s. 36.1);
- the Ontario *Medicine Act*, 1991 (which has similar wording, under s. 5.1); and
- the Northwest Territories' *Medical Profession Act*, s. 43(2).

Health and Social Services for the North West Territories has also declared that it will explore the potential to expand traditional healing practices, as well as work to design facilities are culturally appropriate (2014).

B. Midwives

The regulation of midwives in Canada shows different regulatory approaches to Aboriginal interests, such as express allowances for Aboriginal practices, and the potential for a unique registration classes, with different entry requirements and different standards.

In BC: The College of Midwives of BC regulates midwifery in BC. As I have already noted, the prohibition on non-registrants practising midwifery exempts Aboriginal midwives practice *on a reserve* since before March 15, 1995, but all midwives starting practice after that date must be registrants of the College.

While the College of Midwives of BC does not currently have a registration category for Aboriginal midwives, the Bylaws of the College establish a Committee on Aboriginal midwifery (consisting of at least three Aboriginal persons) which may, in addition to nominating persons to fill a position on each committee, recommend bylaws in relation to the creation of classes of registration for Aboriginal midwives (s. 20(2)).

The content of the bylaws that the committee may recommend may include:

- requirements for registration;
- standards, limits or conditions for practice;
- standards of ethics;
- standards of education; and
- requirements for continuing education.

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10 See: http://www.cpsa.ab.ca/AboutUs.aspx

The Bylaws thus contemplate the *possibility* of Aboriginal midwives falling into a distinct registration class, with entry and conduct requirements that may, in theory, differ from other midwives.

Although the committee's recommendations are simply that—recommendations—the bylaws also provide that if the board does not accept a recommendation from the committee, the matter may be referred to the Minister jointly by the board and the committee (s. 20(4)).

In the absence of a distinct class, anyone seeking to practice any type of midwifery must register with the College as a midwife. But the Midwives Regulation, B.C. Reg. 281/2008, expressly permits an Aboriginal registrant (meaning someone relating to the Indian, Inuit or Métis peoples of Canada) to practice "aboriginal midwifery" (s. 4(2)), which includes traditional and modern Aboriginal midwifery practices, and any combination of them (s. 1 "aboriginal midwifery").

Nunavut: A different approach can be seen in Nunavut, where all continuing midwifery education in Nunavut *must* incorporate traditional Inuit midwifery knowledge, skills and judgment, under the *Midwifery Profession Act*, Nu. 2008 c. 2008 (s. 6.1). The Minister is required to develop instructional content based on traditional Inuit midwifery knowledge, skills and judgment, and every instructor "shall" ensure that a curriculum includes that content.

Further, an express duty of the Midwifery Registration Committee is to promote the incorporation of traditional Inuit midwifery knowledge, skills and judgment in training programs, and in the practice of midwifery (s. 8(8)(e) of the Act).

C. Social Workers

For social workers in Alberta, Schedule 7.1 of the *Government Organization Act*, R.S.A. 2000, c. G-10, defines "Health Services Restricted Activities," and these include not only various medical procedures, but also "(p) psychosocial intervention," aimed at treating a "substantial disorder of thought, mood, perception, orientation or memory that grossly impairs" certain traits such as judgment, behaviour and ability to meet the ordinary demands of life.

Under the *Social Workers Profession Regulation*, Alberta Reg. 82/2003, a regulated member may perform psychosocial intervention by meeting certain training requirements (s.11), but the Regulation also permits "regulated members" to provide "psychosocial intervention *using traditional aboriginal practices* if the member has *received training* and guidance in the use of traditional aboriginal approaches *and is recognized by an aboriginal community as being competent* in the use of traditional aboriginal practices" (emphasis added). This provision essentially delegates to aboriginal communities the task of deciding on when a social worker is trained and competent to use traditional aboriginal practices.

IV. Conclusions about Current Approaches

Overall, the intersections between traditional Aboriginal healing practices and professional regulation are relatively undeveloped.

There is an awareness that health professionals need cultural competencies to serve Aboriginal peoples. In existing professional regulatory bodies, this means mostly integrating cultural competency courses into existing continuing education systems.

In relation to the engagement of Aboriginal peoples within the boards and committees of professional regulatory bodies, there is no available information. With the exception of professional regulatory bodies that have a specific focus on an aspect of Aboriginal healing, professional regulators do not track or pursue whether Aboriginal peoples are engaged in their governance processes.

The professional regulatory bodies for social work and midwifery are more actively engaged in integrating Aboriginal healing practices into their scopes of practices and standards. Surprisingly, the medical profession, which has a scope of practice that I would anticipate significantly overlaps with traditional Aboriginal healing practices, has either excluded such practices, or left the regulation of such practices largely undeveloped.

V. Areas for Thought and Development

Now I want to return to the question I asked you to consider at the outset of this paper, which is how you might model a system for the regulation of traditional Aboriginal healing practitioners.

The Western professional regulation model involves:

- governance of a profession by a mixture of professionals and "public" board members appointed by the provincial government;
- province-wide jurisdiction;
- uniform education and training requirements;
- quality assurance; and
- uniform standards of competence and conduct, enforced through investigations and discipline hearings.

The regulation of traditional Aboriginal healing practices may integrate all of these requirements, or only some of them, or none of them.

Full integration of traditional healing practices using the Western professional regulatory model could occur through regulation by existing colleges, with fewer or greater changes to account for traditional Aboriginal healing practices. For example, different approaches using existing colleges might involve:

- Aboriginal practices that might be added to an existing scope of practice, so that practitioners who hold registration with the regulator may practice those activities;
- a regulator might provide for a speciality certificate for some practitioners; or
- a regulator might provide for a unique registration category for traditional Aboriginal healing practitioners.

As illustrated by a few college already, Aboriginal perspectives may be incorporated through appointments of representatives to the board, or to key committees such as registration, quality assurance, inquiry or discipline; or through participation in working groups or committees aimed at developing entry and practice standards relating to traditional Aboriginal healing practices.

However, it is not a given that Aboriginal interests are best served by applying all of the components of the Western professional regulatory model. Such a conclusion can only be reached after some assessment of the impacts of Western regulatory components on traditional Aboriginal healing practices, and their compatibility with Aboriginal cultural values.

This paper is too limited in scope to provide a detailed discussion, but here are some issues that need to be considered.

Governance: The fact of the provincial government having final authority for overseeing every self-regulated profession is not a given where Aboriginal practices are concerned. Oversight of traditional Aboriginal healing practices could instead flow from a single, province-wide Aboriginal organization, or from individual First Nation governments. Such an alternative is illustrated by the Tsawwassen First Nations Final Agreement, which provides for the right of Tsawwassen First

Nations to make laws with respect to Aboriginal healers, including setting standards of practice and codes of ethics [Ch. 16, s. 87].[11] (The Agreement notably excludes the making of laws that affect the regulation of provincially—or federally-licensed professionals.)

The benefits of traditional Aboriginal healing practices being absorbed into one or more existing colleges is also not a given. For example, it is not clear whether or to what extent all or some traditional Aboriginal healing practices are meaningfully compatible with the practices that may appear at first to be similar, such as physicians, naturopathic physicians, or pharmacists, or if traditional Aboriginal healing practitioners are best treated as their own profession. Some useful knowledge might be drawn from the experience of Eastern health care disciplines becoming regulated in BC by the College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC.

Importantly, integration into existing colleges puts the regulation of Aboriginal healing practices in the control of a board and within committees where the significant majority of persons will undoubtedly not be Aboriginal persons. Undesirable consequences may include the subordination of the regulatory development of Aboriginal healing practices to conventional treatment practices. This problem is not so unlike colleges which currently have scopes of practice that legally include aspects of Aboriginal healing practices but which have engaged in very little or no regulatory development of Aboriginal healing practices.

Codifying knowledge and setting standards: Regulating traditional Aboriginal healing through a Western model also means at the least defining in writing what activities constitute traditional Aboriginal healing practices; core practice competencies; and the level of minimum competencies and ethical practices that apply. Regulating in this form and manner may be inconsistent with existing traditional practices.

For example, the written form, speaking from a single authoritative view, defining practices at a single point in time, are ways of conveying and maintaining knowledge that may not be consistent with Aboriginal communities that have communal and oral healing traditions. Likewise, the ways of organizing and privileging medical activities by placing them into limited scopes of practice, comparative standards of practice, and established core competencies, may also be inconsistent with Aboriginal communities that have a more dynamic perspective of how traditional medical activities are categorized and practiced.

However, such a shift may also create additional means by which the practice of traditional aboriginal healing can be preserved or transmitted to future generations. While the written, single perspective, point in time method of conveying and maintaining knowledge may result in some erosion of the oral or communal ways in which traditional aboriginal healing has been practised, it may also ensure the preservation and continuance of the practice. For some Aboriginal communities, the written method which necessarily means collecting and articulating traditional medical activities may also lend to restoring aspects of the practice of traditional aboriginal healing.

Discipline: Existing Western concepts of investigation into professional misconduct, discipline hearings, and issuing penalties that affect licensure may not easily mesh with Aboriginal concepts of restorative justice.

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11 See: https://www.aadnc-aandc.gc.ca/eng/1100100022706/1100100022717. See also: Westbank First Nation Self Government Agreement (Part XVII, s. 193), https://www.aadnc-aandc.gc.ca/eng/1100100031766/1100100031768#pre; Nisga'a Final Agreement (Ch. 11, s. 87) https://www.aadnc-aandc.gc.ca/eng/1100100031292/1100100031293; Yale First Nation Final Agreement (s. 3.17.4) https://www.aadnc-aandc.gc.ca/eng/1336657835560/1336658472497; and Tla'amin Final Agreement (Ch. 15, s. 85) http://www.aadnc-aandc.gc.ca/eng/1397152724601/1397152939293.

Integration with other elements of the Canadian health care system: Regulation through a known model may provide benefits in the form of the government or other parts of the health system better accepting a system they have experience with. The Western regulatory model is known and familiar to stakeholders including the public, health authorities, other healthcare organizations, and universities and colleges which educate professionals. A known regulatory model may lend "credibility" to a new profession (albeit a profession involving ancient practices) that could lead to other benefits, such as hospital privileges and access to resources within health authorities, an increased availability of funding for research into healing practices, funding for the education of traditional healers, or the availability of practice insurance for practitioners.

VI. Conclusion

One of the important aspects of the Report is the recognition of the value of traditional Aboriginal healing practices, and a call for their use as part of treatments.

Work to improve Aboriginal health care must, however, include the governments of First Nations, provinces and Canada addressing the roles of existing professional regulatory regimes, and the roles of First Nations governments, that will best facilitate the integration of traditional Aboriginal healing practices into the health care system.

The integrating of traditional practices may require clarification about, or changes to, how traditional practitioners are, or should be, regulated, including such matters as how they train, how they maintain their knowledge, how they work to certain standards, and how they ensure that others do the same.

In terms of a ready-made systems of regulation that may be influential, the Western professional regulation model is a well-known quantity, especially given the use of umbrella statutes which create uniform regulatory features for a number of different health professions. However, I think the discussion makes clear that such a model implicitly involves certain concepts—concepts such as governance by one's professional peers, oversight by the Crown, entry requirements, and enforceable standards—all of which needs to be assessed and discussed before anyone should assume they are suitable tools for regulating traditional Aboriginal healing practitioners.