## Prescriptive Authority

There is considerable overlap between the BC Prescribing Exam offered by Canadian College of Naturopathic Medicine (CCNM)-Boucher and the Prescribing Exam offered by the College of Naturopaths of Ontario (CONO). The deviation in the exams is with respect to the jurisdictional requirements. As such, CNPBC has updated the Prescriptive Authority Certification requirements.

To be eligible for certification in Prescriptive Authority a registrant must:

1. have the status of full registrant;
2. hold current Naturopathic Advanced Life Support (NALS) certification;
3. complete and pass the examination from The Canadian Therapeutics and Prescribing Course for Naturopathic Doctors offered by Therapeutics Collaboration Education and administered by:
    a) CCNM-Boucher
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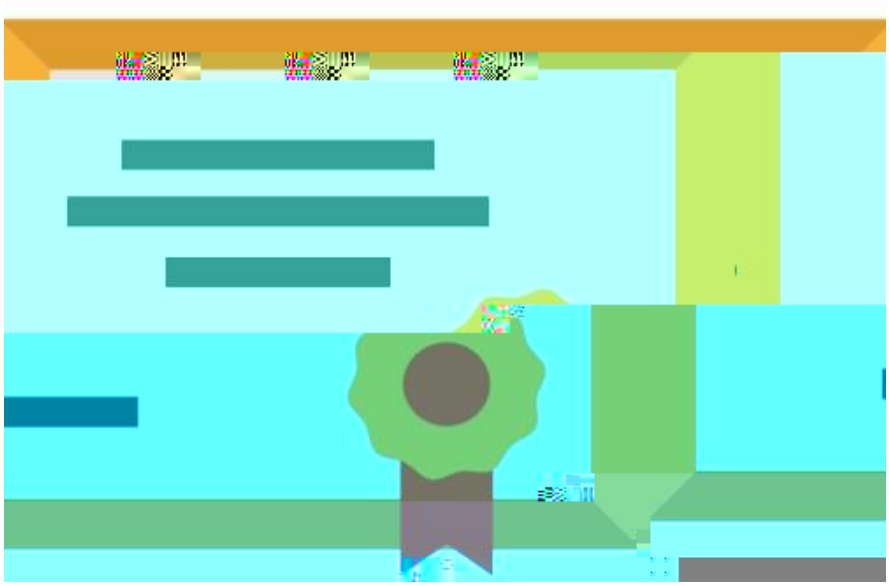
    b) CONO and complete and pass the Jurisprudence Pharmacy Exam in BC administered by CCNM-Boucher;
4. apply for certification within 24 months of completing the aforementioned exam;
5.

1. have the status of full registrant;

2. hold current Naturopathic Advanced Life Support (NALS) certification;

3. provide evidence of the completion of a Naturopathic Medical/Traditional Chinese Medicine Acupuncture program that includes a minimum of 50 hours of supervised clinical



## Continuing Education – Point-of-Care Information Tools

The College has recently reviewed the use of point-of-care information tools such as UpToDate and Dynamed with respect to the CNPBC Continuing Education (CE) program. These point-of-care information tools can be used as self-directed, online learning on topics relevant to a physician's clinical practice. The College considers the credits accumulated in the information tool to count towards Category D Education, Service & Professional Development CE hours. The College accepts up to a maximum of 10 Category D hours per CE period. Hours are granted on the basis of one (1) hour for each two (2) hours of activity.

## Indigenous Cultural Safety, Humility and Anti-Racism Practice Standard Survey

### Background

We

**TRIGGER WARNING:** The results described below contain statements and descriptions of racism and negative experiences that may be triggering to some.

**What We Learned**

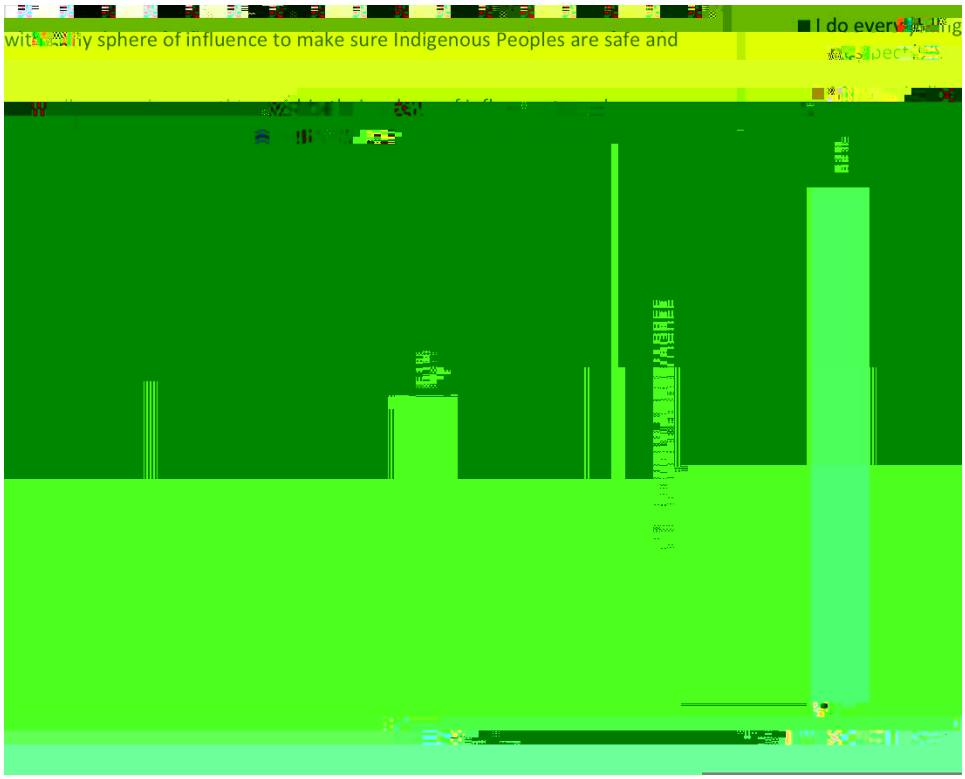
These results are a summary of the themes within the responses. While there were some differences in responses between colleges, these were not substantial enough to warrant reporting separately. In general, input was similar regardless of health profession.

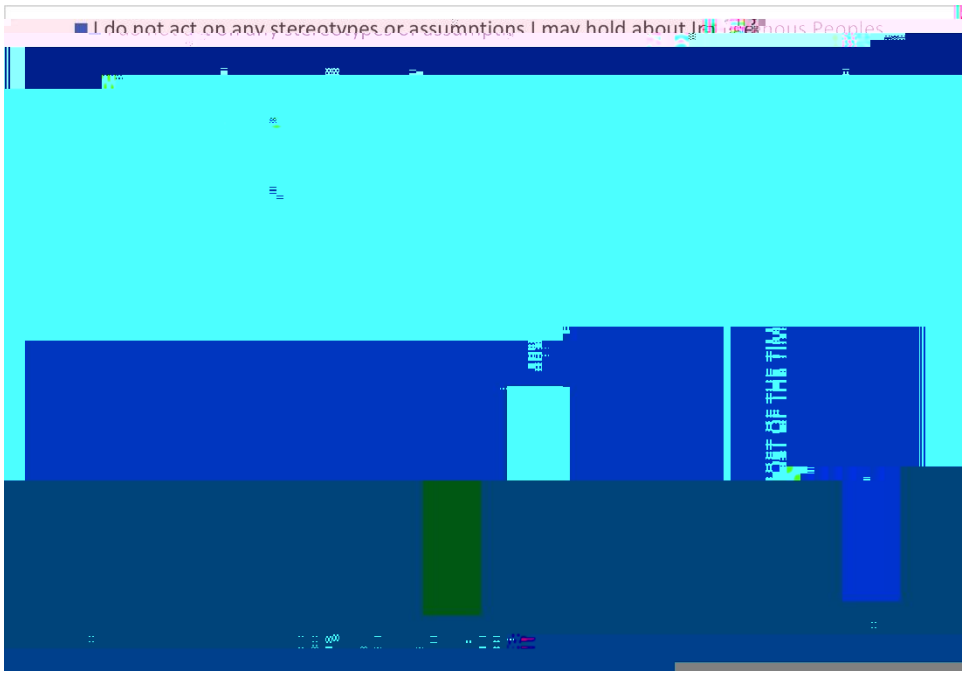
1. There is a continuum of attitudes and perceptions about Indigenous-specific racism reported by non-Indigenous respondents. Some agreed or strongly agreed with statements that represent stereotyping and contribute to perpetuating unsafe care and health inequities for Indigenous people. For example:

    7% of non-Indigenous respondents strongly agreed/agreed with the statement

believe the new Standard should have been adopted much sooner.

3. The attitudes, perceptions, perspectives, and behaviours of non-Indigenous respondents as self-reported differ from the words and behaviours observed by their Indigenous colleagues. This was consistent to various degrees throughout the results. While many non-Indigenous respondents believe their intentions and actions reflect safe and respectful care, the impact of their actions, as noted by Indigenous colleagues, is often not what it is believed to be. For example:






11%-12% of Indigenous respondents indicated that in the past year they have observed behaviours in their non-Indigenous colleagues such as failing to communicate adequately with Indigenous patients/clients and minimizing the concerns of Indigenous patients/clients.

4. Indigenous-specific racism exists beyond public healthcare settings. Eighty percent (80%) of all respondents recognize that Indigenous-specific racism is a problem in public and private healthcare settings alike.

5. Commonly reported barriers to implementation of the new Standard were competing priorities, overwhelming workload and being unsure of what learning opportunities are available/appropriate. However, 33% of respondents reported they have no barriers to implementation.

6. Between 13% and 31% (varied by Core Concept) of respondents require further guidance and education to implement the Standard. The preferred delivery methods for educational offerings were webinars and short reads. Of those who indicated a need for further guidance and education, 50% intended to start or continue their learning within three months.

***Note regarding interpretation of survey results:***

The overall margin of error was +/- 1.76%, 19 times out of 20. Comparisons between Indigenous and non-Indigenous should be interpreted cautiously given the sensitivity of the topic and the relatively small

BCCNM Building Knowledge Through Education

BCCNM Anti-Racist Practice (Taking action)

BCCNM Creating Safe Healthcare Experiences

BCCNM Person-Led Care (Relational care)

BCCNM Strengths-based and Trauma-informed Practice (Looking beneath the surface)

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## A Note From the Registrar

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as our lovely summer weather continues.

Stay well.

Carina Herman

***We acknowledge with respect that the land on which we gather is the unceded and traditional territories of the Coast Salish peoples - sḵwx̱wú7mesh (Squamish), sel̓íl̓witulh (Tsleil-Waututh), and xʷməθkʷəy̓əm (Musqueam) nations whose historical relationships with the land continue to this day.***



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