COLLEGE OF HOMEOPATHS OF ONTARIO

COUNCIL AGENDA

Thursday, June 18, 2026

10:00 a.m. – 3:00 p.m.

Item	Time	Topic	Documents	Purpose
1	10:00	Call to Order & Introduction of New Council Member		Information
2	10:05	Agenda		
2.1		Consent Agenda [i] 1) Minutes, February 26, 2026 2) Update on Action Items 3) Executive Committee Report 4) Resources from SML	 2.1.1 2.1.2 2.1.3 2.1.4	Decision
2.2	10:10	Adoption of Agenda	2.2	Decision
3	10:15	Declaration of Conflict of Interest	3.1	Information
IN CAMERA *As permitted by the* Regulated Health Professions Act, 1991*, Schedule 2, section 7.2, there are times when it is appropriate for Council to discuss matters* in camera. *These include issues of public security; financial or personal or other matters of such a nature that it is desirable to avoid public disclosure; information related to a person involved in a criminal proceeding or civil suit; personnel matters or property acquisition; or instructions to be given to or opinions received from legal counsel. A meeting or any portion of a conference held* in camera *is not open to the public.*				
4	10:20	Bylaw Matter	4.1	Decision
5	10:40	*in camera* minutes, February 26, 2026	5.1	Decision
6	10:45	Finances 6.1 Statement of Operations 6.2 Reserve Policy	6.1 6.2	Decision
7	11:15	Membership 7.1 Renewal Report 7.2 Growth Strategies	7.1.1 7.2.1	Information Discussion

Item	Time	Topic	Documents	Purpose
8	11:45	Registrar's Report 8.1 Health Canada 8.2 Canadian Health & Life Insurance Conference 8.3 Complaints Update 8.4 Unregistered Practitioners Strategy	8.1.1	Information
	12:30	LUNCH BREAK		
9	1:00	Program Approval - MICH		Information
10	1:20	2026-2027 Strategic Plan	10.1	Discussion
11	1:40	Election/Evaluation Process Testing		Information
12	2:00	Election of Executive Committee		Decision
13	2:45	Other Business and Action Items		Discussion
14	2:55	HBS – Preparation Time		Information
15	2:57	Adjournment		Decision

NOTE: All meeting materials, discussions, and decisions are confidential to the College and cannot be copied or shared until they are made public.

[i] A consent agenda is a bundle of items that is voted on, without discussion, as a package. It differentiates between routine matters not needing explanation and more complex issues needing examination. The Chair will ask if anyone wishes to remove an item from the consent agenda. Any Council member may request an item be removed so it can be discussed. To test whether an item should be included in the consent agenda, ask:

Is this item self-explanatory and uncontroversial? Or does it contain an issue that warrants Council discussion? Is this item for information only? Or is it needed for another meeting agenda issue?

Council Meeting
College of Homeopaths of Ontario (CHO)
Minutes
Thursday, February 26, 2026
by telephone and video conference

Present

Council

Kerri Flood	Professional (Chair)
Akhlaq Ahmad	Professional
Sajeev Ampadi	Professional
Ayinde Azeez	Public
Catherine Kerr	Public
Kamika Mclean	Public
Sanjeev Nayyar	Professional
Bhupinder Sharma	Professional
Yen Tran	Public
Paridhi Wasal	Professional

Regrets

Tyler Groen	Professional

Staff

Kathryn Harvey	Deputy Registrar (recorder)
Basil Ziv	Registrar and CEO

Guests

Vivian Pang	Health Workforce Regulatory Oversight Branch, Ministry of Health

1 Call to Order

The President called the meeting to order at 10:03 a.m. and conducted a roll call. Guest Vivian Pang from the Ministry of Health was welcomed.

2 Agenda

2.1 Consent Agenda and Committee Reports

3.1.1 Minutes, September 25, 2025
3.1.2 Update on Action Items
3.1.3 Third-Party Evaluation Report
3.1.4 Executive Committee Report
3.1.5 ICRC Report
3.1.6 QA Program Update
3.1.7 Resources from SML

Motion # 1: To adopt the consent agenda
Moved by C. Kerr, seconded by S. Nayyar

That Council adopt the consent agenda.
CARRIED

DRAFT / CONFIDENTIAL

2.2 Adoption of Agenda
(Appendix 2.2 Council Agenda)

Motion # 2: To adopt the agenda
Moved by Y. Tran, seconded by P. Wasal

That Council adopt the agenda.
CARRIED

3 Declaration of Conflict of Interest
(Appendix 3.1 Council Member Declarations re: Conflict of Interest)

None declared.

4 Registrar's Report
The Registrar reported on a long list of initiatives focused on meeting the mandate of the College and encouraging growth of the profession. These included supporting interprofessional collaboration, educating the public, continuing to pursue the inclusion of homeopathy in insurance benefits packages, and establishing a library of professional education resources focused on regulatory issues.

5 Stakeholder Relations
(5.1 Report Form: Stakeholder Relations)

In response to a request from the Ontario Homeopathic Medical Association for a written policy on how the College interacts with external stakeholders, staff presented a proposal that would allow for College participation in events if and only if the event would be open to all CHO registrants at no cost and provided participation in the event was within the human resource capacity of the College.

Council opted to defer voting on a suggested motion so that consideration could be given to CHO participation in larger, paid events such as annual conferences.

6 OPGO
The Deputy Registrar provided a status update on items in the 2025-2026 Operating Plan, Goals and Objectives (OPGO). It was noted that the existing format of the document has been in place for several years and might benefit from reworking to reflect a more strategic approach. Staff will begin the process of developing a new, more streamlined way to set priorities and track deliverables.

Secretary's note:
As permitted by the Regulated Health Professions Act, 1991*, Schedule 2, section 7.2 there are times when it is appropriate for Council to discuss matters* in camera*. These include matters of public security; financial or personal or other matters of such a nature that it is desirable to avoid public disclosure; information related to a person involved in a criminal proceeding or civil suit; personnel matters or property acquisition; or instructions to be given to or opinions received from legal counsel. A meeting or any portion of a meeting held* in camera *is not open to the public.*

Motion # 5: To move *in camera*
Moved by S. Nayyar, seconded by K. Mclean

That Council move in camera at 11:47 a.m.
CARRIED

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9 Election Process Testing

Council members tested voting using the Zoom platform. It was agreed that this approach could be used for the election of Executive members in June, and that another rehearsal of the process would be conducted with a scrutineer prior to the election.

10 Other Business

None.

11 HBS Preparation Time

Half day preparation, half day meeting
Start time: 10:03 a.m.
End time: 12:08 p.m.

12 Adjournment

Motion # 10: To adjourn
Moved by A. Ahmad, seconded by A. Azeez

That Council adjourn at 12:08 a.m.
CARRIED

The Chair agrees these minutes are an accurate reflection of the meeting.

_____ _____

Chair **Date**

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COLLEGE OF HOMEOPATHS OF ONTARIO

UPDATE

Update	Disposition of Action Items since February 2026

1. Renewal [complete, see agenda item 7.1]
2. Standards and Guidelines Review [ongoing]
3. Complaints [in progress, see agenda item 8.3]
4. Academic Program Approval [completed, see agenda item 9]
5. Canadian Health and Life Insurance Association Conference [see agenda item 8.2]
6. Election of professional Council members in North and East districts [only one nominee in each district so no election necessary, new member's term starts June 18]
7. Appointment of auditor [completed by Executive, Welch LLP reappointed]
8. Quality Assurance [education ongoing, submission of learning plans early fall]
9. Clarify CHO relationship with professional associations [completed, see agenda item 2.3]
10. Review OPGO [agenda item 10]
11. Set Council meeting dates for 2026-2027 [to be done following June meeting]

June 2026

Agenda Item: 2.1.3

COLLEGE OF HOMEOPATHS OF ONTARIO

COMMITTEE UPDATE

Committee	Executive
Members	Kerri Flood (Chair) - Professional Akhlaq Ahmad - Professional Ayinde Azeez - Public Bhupinder Sharma - Professional Yen Tran – Public
Staff	Basil Ziv – Registrar Kathryn Harvey – Deputy Registrar
Meeting Dates	April 9, 2026
Submitted By	Kathryn Harvey

Issues Addressed

Program Approval

The Registrar detailed the extensive process involved in assessing the application for approved program status submitted by the Montreal Institute of Classical Homeopathy. This included examination of competencies, evaluation of submitted cases by the CHO's IA assessors, and consideration by a panel of the Registration Committee, which recommended approval of the program.

On behalf of Council, the Executive Committee approved the Montreal Institute of Classical Homeopathy as an approved program. [**NOTE**: It was later pointed out that the name of the school had changed to the MICH Academy for Holism and Classical Homeopathy.] MICH has been added to the CHO website as an approved program.

Stakeholder Relations (referred from Council)

By unanimous consensus, the Executive Committee determined that there is no need for any policy clarification with regard to participation of CHO staff in external events.

Appointment of Auditor

The Executive Committee, acting on behalf of Council, approved the reappointment of Welch LLP to conduct the 2025-2026 audit.

Renewal

The Deputy Registrar shared a number of observations on the recently completed renewal period, noting that only a few registrants had not yet renewed or otherwise been in contact with the College. Potential options for streamlining the registration process were discussed.

Next Steps

At its next meeting, the Executive Committee will be asked to consider the Registrar's annual performance evaluation, initial steps in the implementation of a strategic plan, and potential improvements to the registration process.

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GREY AREAS NEWSLETTER

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

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When Should Regulators Notify the Public of a Specific Risk?

Anastasia-Maria Hountalas

March 2026 - No. 312

A hospital in Australia recently expressed concern that it was not notified that a physician was under investigation by their regulator for conducting unnecessary gynaecological surgeries. The Executive Director of the hospital said that the lack of warning placed the public at risk. Ironically, the law in Australia was recently amended, not without some controversy, to permit the Australian Health Practitioner Regulation Agency (AHPRA) to notify the public of risks even though no public regulatory action had yet been taken. The Australian experience is familiar to Canadian regulators who wrestle with the question of at what point in the regulatory process they can and should publicly disclose concerning information about registrants or those engaging in unauthorized practice.

AHPRA has provided detailed guidance as to how it will use its new public notification powers. At the time of writing, the AHPRA website contains two public notifications made during the past year. Both relate to former practitioners who "may" still be providing health services.

AHPRA (and its affiliated National Boards) has issued the following guidance:

- The legislative test for publishing a notice is when the regulator "forms a reasonable belief that the practitioner or person poses a serious risk and it is necessary to protect public health or safety."
- "Examples of this are a person who continues to practise despite their registration being suspended, situations where patients may have been misdiagnosed or exposed to blood borne viruses or in the case of an unregistered practitioner, alerting the public to a 'fake' dentist."
- Generally public notification will occur only where the regulator is unable to manage the risk to the public with other regulatory tools (e.g., an interim suspension).
- Publication will help protect the public by enabling precautionary steps and encouraging anyone who has been exposed to the serious risk to contact the regulator.

- AHPRA acknowledges that the "making of a public statement potentially has a very significant impact upon the person who is named in the statement." The potential impact is one of the relevant factors the regulator takes into account before deciding to issue the publication. The individual is notified of the reasons why the regulator believes it is necessary to issue a public statement and is given an opportunity to make submissions. If a decision is then made to issue the publication, the regulator attempts to notify the individual at least 24-hours in advance.
- In addition to the individual's response to the notice of possible notification, the regulator also considers the nature and seriousness of the individual's alleged conduct, whether the public is already aware of the concern, and whether other regulatory action is sufficient to protect public health or safety.
- The public statement is typically made on AHPRA's website and on the public register (if the individual is listed there).
- The public statement will typically cite the legal authority for its making, a description of the concerns, "the necessary actions that the public should take to protect themselves from the risk", and "who members of the public can contact if they have any concerns."
- Once published, the statement can be revised or revoked at any time. The individual who is the subject of the statement can request such a change.

In Canada, few regulators have an explicit provision in their enabling legislation specifying when they can or should issue public warnings. Many regulators have confidentiality provisions that enable (but do not mandate) public disclosure of otherwise confidential information in certain circumstances (e.g., once an interim order has been made, upon a referral to discipline, or after a disciplinary finding).

Ontario's *Regulated Health Professions Act, 1991* permits disclosure "to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information." While this "public interest" criterion is broader than that used in Australia, the amount of information that can be disclosed is much narrower.

Also, many regulators can disclose otherwise confidential information in connection with the administration of their legislation, which could allow some flexibility (e.g., a call for witnesses to come forward for misconduct that typically has few third-party witnesses). Further, it is not unheard of for a regulator to publish notices in local media that an unregistered person is not authorized to practise the profession or use a protected title.

Having said that, some advocate for minimal public disclosure of information about registrants where allegations have not been proved or even fully investigated and screened. Also, it would be unusual for key interested parties (e.g., employers, health facilities) not to become aware of concerns early in the investigation process. Some would say that where there is a concern that a registrant poses an ongoing risk, at least, the authority to make interim orders is adequate to protect the public and the further authority to issue public warnings is unnecessary.

The Australian precedent could still be useful for policy makers considering whether an amendment to enabling regulatory legislation on this point would be appropriate. The Australian guidelines could be of assistance for Canadian regulators developing a considered and consistent approach to permitted public disclosure.

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The Evolution of the Public Interest in Self-Regulation in Canada

Emily Graham

April 2026 - No. 313

Articulating the public interest served by regulators of professions has always been a challenge. An article by a sociology professor explains that part of the reason for this difficulty is that the concept has evolved over time and, to some extent, place. See: Adams, T. L. (2016). *Professional Self-Regulation and the Public Interest in Canada*. Professions and Professionalism, 6(3).

Dr. Adams begins with some sociological theories about professional self-regulation, and concludes:

> Although scholars differ in the motivations they ascribe to professionals, many hold that professional self-regulation was historically the product of a regulative bargain between professions and the state….

The article "explores legislators' and policymakers' views on professional self-regulation and the public interest, with a focus on Canada where professional self-regulation persists." Dr. Adams conducted extensive research "relying predominantly on legislative records and policy reports." She analyzes how the "state" defined the public interest for self-regulating professions over three periods of time.

For the first period, Dr. Adams observes:

> By and large, from the 1860s through the 1950s, most legislation establishing self-regulating professions was viewed as being in the public interest, because it raised the quality of services provided. Here, the public interest was defined primarily in terms of practitioner qualifications, so the public's interest and professionals' interests were seen to go hand-in-hand. The emphasis on qualifications was accompanied by occasional concerns over access to services and consumer choice. These attitudes persisted into the late twentieth century, but by the 1960s social attitudes and legislative approaches to professional regulation began to change.

From the 1960s through the 1990s Dr. Adams summarizes the change in thinking as follows:

> … while professional self-regulation has many advantages, professionals cannot be trusted to put the public interest above their own; as a result, there needs to be more government oversight to restrict professionals' excesses…. Also in this era, shifts in the definition of the public interest became apparent. While a concern for service quality and practitioner competence persisted, the discourse shifted to include a consideration of efficiency and cost effectiveness.

Other public interest values sometimes articulated included public freedom of choice "within a range of safe options" and fostering the evolution of the scope of practice of professions.

Legislative change during this period included:

- more public members on boards and committees,
- reporting, appeal and other oversight mechanisms to make regulators more accountable,
- reducing the scope of practice monopolies that had previously existed, and
- limitations on the ability of regulators to set their own admission standards.

Also, the separation between professional regulators, acting in the public interest, and professional associations, representing the interests of the profession became more pronounced.

In the twenty-first century, Dr. Adams noted a shift as "governments increasingly applied private sector business models to the public sector." This was especially true in Ontario, where the "open for business" catch-phase became prominent. Reducing unnecessary barriers (e.g., for registration and inter-provincial mobility) was emphasized as much as (or, perhaps, even more than) public safety and practitioner competence. This resulted in governments' "increasingly exploring regulatory alternatives" to professional self-regulation.

Dr. Adams noted a divergence in approach between Ontario, British Columbia and Quebec in this development, with Ontario using the business model more than BC and Quebec using it least of all.

Since this article was published, there has been discussion of whether diversity, equity, and inclusion, cultural competency, reconciliation with Indigenous peoples, and registrant wellness should form part of the evolving, current public interest mandate of regulators. Regulatory forays into these areas have resulted in extensive and vigorous debate and legal challenges. In Ontario, the College Performance Measurement Framework for health professions, which was released in December 2020, has encouraged regulators to add these components of the public interest to their mandates without enacting legislative amendments.

Indeed, the *Health Professions and Occupations Act* of BC and *the Regulated Professions Neutrality Act* of Alberta take diametrically opposing views on these mandate issues. The Alberta approach, largely limiting the mandate of regulators to competence and ethics, harkens back to the approach Dr. Adams describes for the nineteenth century.

Nevertheless, Dr. Adams's historical analysis of the evolution of professional self-regulation provides valuable context to these debates, and can assist regulators in developing a nuanced approach to the continuing evolution of their mandates.

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Insights, Misconceptions or Both?

Ahmad Mozaffari

May 2026 - No. 314

Imposing disciplinary sanctions may be one of the more challenging activities for regulators. Discipline panels and the courts have developed a nuanced approach that has three main components:

1. Identifying the types of orders that will achieve the goals of discipline, including protecting the public, maintaining confidence in the profession and the regulator, and, where appropriate, facilitating the rehabilitation of the registrant.
2. Considering the factors that apply in the individual matter, such as the nature of the misconduct, the registrant's level of insight, and the registrant's past conduct history. These have often been called aggravating and mitigating factors.
3. Ensuring that the overall sanction is proportional to the circumstances and to orders made in other matters.

Given the challenges, it is sometimes useful to receive the considered views of those not involved in the discipline process on a day-to-day basis. A recent report by Dr. Danielle Buell et. al., entitled: *Assessing severity of physician misconduct and subsequent disciplinary actions: a cross-sectional survey and analysis of discipline summaries* may be of interest. It reports on a two-phased research project. The first phase was a survey of 17 physicians and 11 patients and family members to obtain their input on how severe the sanctions should be for various categories of misconduct. The second phase involved an analysis of over 200 discipline decision summaries from the College of Physicians and Surgeons of Ontario. The goal of the research was "to identify variables that may influence disciplinary action severity to determine if there was physician misconduct adjudication bias in Ontario, Canada."

The survey first ranked the seriousness of nine types of misconduct as follows (from most serious to least serious):

- Sexual misconduct
- Unlicensed activity / breach of a condition of registration
- Conviction of a crime
- Fraudulent behaviour / prevarication

- Self-use of drugs and alcohol
- Unprofessional behaviour
- Inappropriate prescribing
- Standard of care
- Mental illness interfering with practice.

The authors noted that the patients / family members rated standard of care issues and inappropriate prescribing as materially more serious than did the physicians who were surveyed.

The survey also ranked types of disciplinary sanctions according to severity. The ranking from most severe to least severe is as follows:

- Revocation
- Surrender of licence
- Suspension of licence
- Formal reprimand
- Restriction of licence
- Retraining / course / assessment
- Cost / fine
- Psychotherapy / counselling / professional support.

The authors noted that physicians rated surrender of license and restriction of licence as materially more severe than did the patients / family members.

The case summaries were assessed according to type of misconduct, severity of sanction, and the following characteristics of physicians:

- Gender identity (only male or female as there was insufficient data for non-binary physicians))
- Years of practice
- Place of training (Canada or outside of Canada)
- Specialty
- Previous discipline history.

The authors observed that sexual misconduct was much more common among male physicians than female physicians, and inappropriate prescribing was more common among female physicians.

In terms of physician characteristics, male physicians received more severe sanctions than female physicians (this may be largely attributable to their higher rate of finding for sexual misconduct and other more serious forms of misconduct). There were fewer material differences in the severity of the sanction based on the other variables (i.e., general practice vs. specialists, training in Canada, years of practice, and repeated misconduct).

The severity rating of the sanctions in the actual decisions was materially lower than that identified as appropriate by those surveyed for types of misconduct.

The authors concluded that more public members should serve on disciplinary adjudication panels based, in part, on the survey results finding that patients / family members characterized some types of misconduct (e.g. standard of care) as more serious than physician respondents did. However, as noted above, the sample size of the survey was quite small. It is also interesting, as noted by the authors, that the period covered by the research (ending in 2019) occurred two years before the creation of the Discipline Tribunal at the College of Physicians and Surgeons of Ontario, which now almost always results in a majority of non-physicians on hearing panels.

While subject to several qualifications, the observation that physicians trained outside of Canada do not receive more severe sanctions provides some assurance of fair treatment in the discipline sphere.

The authors also suggest that it might be beneficial “to establish a hierarchy of severity based on feedback from diverse individuals who have a stake in the healthcare system, including patients and families. This approach is critical in evaluating disciplinary

procedures and promoting equity in the self-regulatory process."

In addition to the small survey sample size, there are additional significant limitations to the research. The authors noted that the categories of misconduct are quite broad. For example, sexual misconduct could include criminal sexual assault, sexual relationships that are inherently abusive, and crossing of boundaries through comments or gestures of a sexual nature. Thus, assigning a severity score to a broad category of misconduct may not always be meaningful. Also, two of the types of the misconduct considered (i.e., mental illness interfering with practice and self-use of drugs and alcohol) are almost always handled through a different process (i.e., fitness to practise) and are generally only referred to discipline where there is other concerning conduct.

It is also noteworthy that the researchers relied only on the discipline summaries rather than the full text of disciplinary decisions available on CanLII. The complete decisions would provide a more detailed rationale for why a particular sanction was imposed in an individual matter.

Perhaps most significantly, the research focused on the severity of disciplinary sanctions. As noted above, the severity of misconduct is only one consideration that goes into formulating a disciplinary sanction. Furthermore, deterrence (which is often the principle relied upon to justify severe sanctions) alone is an inadequate rationale for achieving the goals of disciplinary sanction including protecting the public and maintaining public confidence in the regulator and the profession. A severe sanction may also be counter-productive to the rehabilitation of a physician when they are not permanently removed from the profession. It is, therefore, not a surprise that when, as legally required, one considers factors other than the seriousness of the misconduct, the severity of the sanction is often reduced.

Having said that, this research could point the way to additional studies that might contribute to more effective disciplinary sanctions.

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Safeguarding

Julie Maciura

June 2026 - No. 315

Due to some past concerns, the UK regulator for nurses and midwives, the Nursing and Midwifery Council (NMC), has done significant work on "safeguarding". This work is closely scrutinized by an Independent Oversight Group.

"Safeguarding" is a term used in the UK to describe the duty of individuals and organizations to protect vulnerable people (e.g., children, adults at risk) from physical, emotional and financial harm. The NMC has recently updated its Policy on Safeguarding and Protecting People.

While the NMC does not have a specific statutory safeguarding duty, like front line health care workers who have mandatory reporting obligations in various circumstances, it accepts that protecting the public is its core mandate. It identifies broadly those who should benefit from the policy:

> Our approach extends to all registrants, witnesses, members of the public and professionals that engage with us, as well as the colleagues that we employ at the NMC.

While, in Canada, reporting to child welfare authorities when a child is in need of protection is a familiar concept, such mandatory reports are less common for vulnerable adults. Many Canadian provinces only have such obligations for the neglect or abuse of residents in care homes. In the UK, it appears that the scope of vulnerable adults is defined more broadly to include any adult who, because of a disability or illness, is at risk of harm because they are unable to safeguard themselves or their property.

The NMC identifies three areas in which safeguarding concerns might arise:

- When the NMC deals with conduct concerns about registrants which, if not addressed appropriately, could lead to harm, especially to patients;
- When the NMC can share information with other agencies that may assist them in performing their safeguarding duties; and

- Assisting at-risk individuals who encounter the NMC.

The NMC policy sets out several strategies to ensure that it meets its safeguarding obligations including:

- The NMC has a safeguarding mailbox that is monitored during business hours where any staff member identifying a safeguarding concern can obtain guidance and support and, in appropriate cases, organizational intervention.
- An emergency helpline for urgent concerns. Examples are where there is an immediate risk of harm to an individual, where a mandatory reporting deadline is approaching, where an interim order against a registrant is sought, or where a concern arises during a discipline hearing.
- The NMC has a safeguarding hub consisting of specially trained staff to screen matters on a weekly basis. The hub reviews all new complaints and discipline referrals.

All NMC staff are required to undergo training on identifying the types of safeguarding concerns that might arise in their area of work and how to respond to or report them. Additional training is required for high-risk work areas (e.g., the complaints intake team). Further training is required for those serving on the safeguarding hub.

The policy identifies the role of its governing board to ensure the rigour of its policy, to ensure that its administration is adequately resourced, and to obtain appropriate assurances that the policy is being implemented. A specific committee is assigned to monitor and report on the NMC's safeguarding activities. Collected data includes the "number of referrals to our mailbox, emergency helpline and safeguarding hub." Trends and themes will be used to inform the NMC's safeguarding work plan.

The policy includes reference to how the NMC will ensure that it complies with its privacy obligations when sharing information with other agencies.

The policy also includes a discussion of how it will be applied to respect equality, diversity and inclusion:

> We recognise that safeguarding duties closely align with EDI duties. Many people who present with safeguarding needs have protected characteristics. We will ensure that when working with adults and children at risk we understand how any protected characteristics may impact their experiences. We will offer appropriate interventions and reasonable adjustments accounting for peoples' experiences.

Of course, it is difficult to understand how such policy language translates into actual regulatory activity. Fortunately, the Independent Oversight Group published minutes of its March 4, 2026 meeting where additional details were provided:

- The Group questioned the reduction of the organization's risk management rating for safeguarding concerns. The NMC responded that while safeguarding is an inherent risk with a potentially high impact, the likelihood of an adverse event is reduced "owing to the controls and processes put in place over the last year."
- The NMC disclosed that part of the training for its staff involves a new safeguarding handbook which "includes a decision tree which shows pathways for safeguarding and wellbeing issues."

- As of the meeting date, 93% of all NMC staff have completed their basic safeguarding training.
- The NMC reported that the complaints and discipline process was seen as the area of greatest risk. Staff across all areas of the complaints and discipline process have been consulted on how the policy can be made relevant to their work.
- On a related note, the NMC reported that it "recognised that panels and hearings are a high risk space for safeguarding issues, and that it is looking at what work it can do to support panel members to better manage safeguarding issues. Safeguarding training has been delivered to panel members and legal assessors…."
- "The NMC reported that it has seen an increase in the number of internal referrals made to its safeguarding team, a number of which were identified as high risk cases. The NMC said this is evidence of its actions creating greater awareness of safeguarding issues."
- "The NMC has created a safeguarding champions programme, with 40 staff members now designated as a safeguarding champion. The NMC said this these champions are in place to support better identification and reporting of safeguarding concerns."

The minutes also contained some informative illustrations of how the policy is being applied.

- "The NMC has developed a self-harm and suicide protocol following engagement with its mental health practitioner within the safeguarding hub. The NMC has also incorporated its death notification process into the scope of safeguarding, in order to identify any learning through action reviews. The NMC said in cases of death by suicide, it will review all cases and coroner reports to identify learning. One group member asked if there is Council oversight of deaths by suicide, and if this is reported publicly. The NMC confirmed that two of its Council members are responsible for overseeing work related to deaths by suicide, and emphasised that its suicide protocol is concerned with managing immediate risk."
- "One group member commented that there has been a trend of FTP referrals involving domestic abuse, including where the perpetrator is making a referral as a means of exerting control and coercion over a registrant."
- One group member "particularly welcomed the NMC escalating cases involving registrants with mental health issues at Interim Order hearings."
- One area of possible refinement is to assist NMC staff to distinguish between safeguarding from harm (e.g., suicide) and supporting individuals' well-being (e.g., temporary emotional upset) so that the safeguarding team could focus on the former and have less involvement in the latter.
- In a related refinement, the "NMC is also in the process of procuring a partner to provide a support line for all case parties (registrants, witnesses and referrers)." Referrals can be then made by the NMC to appropriate support providers.

Canadian regulators may wish to monitor these developments in the UK (which are not limited to the NMC) to evaluate whether such a comprehensive policy to prevent harm would be useful for them.

GREY AREAS NEWSLETTER

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College of Homeopaths of Ontario
Council Member Declarations
re: Conflict of Interest as of June 2026

Statement

Annually, CHO Council members complete a written declaration of Conflict of Interest which acknowledges and agrees to the premise that an actual or perceived conflict of interest can undermine confidence in the College and its ability to fulfill its public interest mandate. Council members review the College's Bylaws and conflict of interest policies and agree to take all reasonable steps to avoid any actual or perceived conflict of interest from arising and. If one cannot be avoided, Council members are required, in advance and at each meeting, to declare any real, perceived or potential conflict of interest and to remove him- or herself from any consideration of the matter in issue.

Council Member	Form Signed and Returned	Affiliations Identified	Conflict Identified
Akhlaq Ahmad	YES	Ontario Homeopathic Medical Association, Director 2017-2021 (resigned upon assuming seat on Council)	None
Sajeev Ampadi	YES	None	None
Ayinde Azeez	YES	Licensed Financial Professional/Trainer	None
Kerri Flood	YES	CCHM, contract teacher	None
Tyler Groen	YES	None	None
Catherine Kerr	YES	None	None
Maha Mansour	YES	None (reported as part of nomination package)	None
Kamika McLean	YES	Member, Federal Judicial Advisory Commission Member at Large, Ontario Bar Association	None

Council Member	Form Signed and Returned	Affiliations Identified	Conflict Identified
Bhupinder Sharma	YES	LIGA Homeopathica Medicorum Internalis, NVP Canada, 2009-present Ontario Homeopathic Medical Association, member, 2017-present Canadian Homeopathic Medical College, Dean, teaching homeopathy, 2016-present Past affiliations: Community Advisory Council, William Osler Health,Brampton General Hospital, member, 2009-2019 Community Care Access Centre, board member, 2009-2017 Homeopathic Medical Educational Center of Canada, teacher, 2006-2008	None
Yen Tran	YES	None	None
Paridhi Wasal	YES	Board of Directors, Ontario Homeopathic Medical Association, 2022-2024 (resigned upon election to Council)	None

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April 28, 2026

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Natural and Non-Prescription Health Products Directorate
Health Products and Food Branch
Health Canada
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Nepean, ON K1A 0K9

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Dear Mr. Norman,

Thank you for the opportunity to review the updated Natural Health Product Raw Material Policy and for your continued engagement with stakeholders. We acknowledge Health Canada's efforts to clarify the distinction between raw materials and finished natural health products (NHPs). However, after a detailed review, several core concerns remain unresolved and, in some cases, have become more pressing under the revised framework—particularly with respect to homeopathy and the ability of practitioners and patients to access essential remedies made from these materials.

The updated policy's expectation that imported substances must "clearly require further manufacturing or modification" before use places homeopaths in an untenable position. As noted in the original submission, "many remedies—though clinically considered raw materials—may be interpreted as finished products if dispensed without additional alteration." This interpretation does not reflect the realities of homeopathic practice, where remedies may be dispensed as purchased or further compounded depending on the clinical needs of the patient.

Homeopathic remedies are nontoxic, highly diluted, and have never caused harm. They must be differentiated from pharmaceutical products, which require strong regulation precisely because they do pose toxicity risks. As stated in the document, "It must be left to the homeopath to decide whether a remedy will be given to the patient in its original form… or compounded further for the patient." This clinical discretion is essential to safe, competent practice.

Background and Regulatory Context

The Natural Health Products Regulations establish requirements for the manufacturing, packaging, labelling, importation, distribution, storage, and sale of NHPs in Canada. Importantly, the practice of complementary, alternative, or traditional medicine—including homeopathy—is outside the scope of these Regulations and is not regulated by Health Canada.

In Ontario, the regulation of homeopaths is grounded in two core principles articulated in the Regulated Health Professions Act, 1991 and the Homeopathy Act, 2007:

- Protection of the public, and
- Ensuring access to treatment by well trained, competent, and ethical homeopaths.

Homeopaths are regulated by the College of Homeopaths of Ontario (CHO) primarily for public protection and to ensure access to qualified, ethical practitioners. Without reliable access to remedies, homeopaths cannot fulfill their legislated mandate.

Nature of Homeopathic Remedies

Homeopathic remedies originate from naturally occurring substances that are processed into highly diluted preparations. The juice of the flowering plant Pulsatilla is diluted and succussed through a series of steps to achieve the required potency (e.g., C30, C200), and such remedies are not toxic. These preparations may be used empirically, applied to sugar pellets, or further compounded for patient specific use.

The clinical reality is that these remedies function as raw materials within a practitioner–patient relationship, even when they appear in dosage forms that could be misinterpreted as finished products under the updated policy.

Alignment of Federal and Provincial Regulations

Federal NHP Regulations are designed to ensure public safety, while Ontario's regulatory framework ensures competent practice within a defined scope. Homeopaths prescribe homeopathic remedies as part of their regulated healthcare role. Without reliable access to these remedies, homeopaths cannot fulfill their legislated mandate in Ontario.

Global Practice and Standards

Homeopathy is practiced worldwide, and remedies are manufactured under stringent quality standards in multiple jurisdictions. Canadian practitioners depend on these global supply chains. Given the relatively small Canadian market, many remedies—especially new or less common ones—are not manufactured domestically. As the document notes, "the opportunity to obtain new remedies for their patients can only be satisfied through importation."

Concerns with the Updated Policy

1. Recognition of Homeopathic Remedies

Health Canada defines a raw material as a substance intended to be used in the manufacturing process to produce a finished NHP of different composition or form. In contrast, the CHO considers a substance a raw material when it is "prepared, combined, or modified by a practitioner to produce a patient specific final product."

This divergence creates a regulatory mismatch. Remedies that are clinically raw materials may be classified as finished products under the federal definition, even though they are not sold commercially as finished NHPs and are intended solely for practitioner guided therapeutic use.

2. Dosage Form and Clinical Use

The policy's emphasis on dosage form and "readiness for consumption" does not align with homeopathic practice. Remedies dispensed as pellets or liquids are individualized for each patient and do not constitute standardized products with fixed indications.

3. Therapeutic Intent and Classification

The policy's reliance on therapeutic intent as a determinant of NHP classification introduces subjectivity. Homeopathic prescribing is based on the totality of symptoms, not on condition specific indications. This creates a risk of inconsistent enforcement and misclassification.

4. Importation and Compounding Pathways

The narrowing of importation pathways to substances requiring further manufacturing or modification poses significant challenges. Many remedies that function as raw materials in clinical practice may be deemed finished products under the policy, disconnecting regulation from real world use.

New remedies not currently available in Canada may face import restrictions, placing patients at risk. This is one of the biggest challenge that homeopaths face.

5. Patient Access

The absence of explicit exemptions for personal importation of prescribed remedies creates uncertainty for patients. Many patients import remedies for personal use under the guidance of a qualified homeopath. Delays or restrictions in this process directly impact continuity of care.

6. Repackaging and Relabelling

Treating practitioner level repackaging or relabelling as licensable commercial activities does not reflect clinical reality. These activities are part of individualized dispensing, not commercial distribution.

7. Increased Regulatory Uncertainty

The combined effect of multiple overlapping criteria—dosage form, therapeutic intent, manufacturing status, and importation pathways—creates uncertainty for practitioners, importers, and patients. This increases the likelihood of inconsistent interpretation and enforcement.

Conclusion and Request

While the revised policy aims to provide clarity, it does not resolve the fundamental mismatch between homeopathic remedies and the conventional raw material/finished product distinction. Practitioners and patients continue to face barriers to timely, reliable access. As the document states, "Ultimately, it is the public that suffer when homeopaths are unable to provide remedies to their patients."

We respectfully request further dialogue to develop a regulatory approach that:

- Reflects the realities of homeopathic practice
- Ensures patient access to essential remedies
- Recognizes the non toxic nature of homeopathic preparations
- Maintains Health Canada's commitment to safety and quality
- Supports the continued effectiveness of a regulated health profession

Respectfully,

Basil Ziv, HOM
Registrar and CEO

cc: Dr. Karima Velji, Assistant Deputy Minister and Chief of Nursing and Professional Practice

Allison Henry, Director, Health Workforce Regulatory Oversight Branch