

# Doctors of BC Response to the Ministry of Health's Scope of Practice of Regulated Health Professions Proposals

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Doctors of BC acknowledges that our organization is located on the traditional, ancestral, and unceded territories of the Coast Salish peoples, including the *xʷməθkʷə ʔəm* (Musqueam), *Skw̓x̓ wú7mesh* (Squamish), and *səlilwətał* (Tseil-Waututh) Nations, whose strong relationship with their territories continues today. Our employees, who are located throughout BC, work and live on many different Indigenous territories throughout the province.

Acknowledging that we are on the traditional territories of First Nations communities is an expression of cultural humility and involves recognizing our duty and desire to support the provision of culturally safe care to First Nations, Inuit, and Métis people in BC.

## Introduction

Doctors of BC values the opportunity to provide input on the proposed scope of practice changes currently under consideration by the Ministry of Health. We support the Ministry's goals of an effective, stronger, and more sustainable health care system.

A letter from the Ministry dated February 11, 2026, related to scope of practice, outlined an intention to evaluate scope of practice proposals in a collaborative and structured framework; however, these current proposals are being advanced independently and considered in isolation. This limits the nuanced discussion needed to evaluate what changes make sense, for whom, and how they should be implemented. BC doctors are acutely aware of the mounting health system challenges our province is experiencing and are concerned that the approach taken with these proposals may diminish access to care, increase costs and administrative burden, and further strain health human resources.

**We call on government to establish a collaborative policy development process that brings interest holders together to jointly develop more detailed and informative scope of practice proposals with the time and structure needed for representatives to engage their communities and return to the table with informed input.** Patients, health professionals, and the system need a process that matches the complexity and importance of these scope reforms. Our recommended approach would allow for dialogue across disciplines, producing more informed, considered, and ultimately more effective and sustainable outcomes.

As discussed in our detailed feedback on the physical therapist proposal, an invitation by their association to discuss it in greater detail allowed us to understand the nuance of the proposal, raise our concerns, hear responses, and begin to discuss a path forward. Our feedback in this submission reflects concerns based on the limited information presented in Ministry communications, however with more information, broader engagement, and further discussion, doctors' views on this and other proposals may evolve.

We note that the feedback throughout this submission reflects our best assessment given the information and time available. It is informed by comments from a significant number of physicians and conversations with physician groups, reflecting the considerable interest in and commitment to getting these reforms right. We welcome opportunities to work collaboratively with government and other health care partners toward reform that benefits patients, health care professionals, and the system.

*Note: We have included a letter from BC Family Doctors and Consultant Specialists of BC that supports our submission and outlines similar system-level concerns as an appendix.*

## Doctors of BC Position on Scope of Practice Proposals

In addition to the responses received from our member engagement on these proposals, our feedback is based on key policy principles to support patient safety and a sustainable health care system. All health care professionals play an important role in achieving these aims through reducing demand for health services, ensuring appropriate care, avoiding unnecessary testing and treatment, and reducing the environmental impact of health services. As outline in our Scope of Practice Policy Statement<sup>1</sup>, Doctors of BC recommends that any changes in health professionals' scope of practice:

- be supported with evidence of appropriate knowledge, training, and judgment of the professionals involved and consistent with current best practices,
- be integrated in team-based, collaborative care contexts to mitigate the potential for parallel or duplicative care,
- be accompanied by supports and training for professions impacted by scope changes to facilitate collaboration through inter-professional information sharing, communication, and coordination,
- be supported with evidence of cost-effectiveness prior to adoption and subject to rigorous monitoring, evaluation, and reporting post-implementation to evaluate outcomes for patients, health professionals, and the health system,
- be subject to regulatory oversight to ensure appropriate practice standards are in place and to eliminate potential conflicts of interest,
- coincide with adequate liability coverage for the affected health care professional that is proportional to their scope of practice,
- avoid any net increases in burdens on physicians, including increases in paperwork, EMR management, and/or other administrative burdens.

In their feedback some doctors are supportive of proposed changes, either as is or with recommended changes. Others proposals are not supported due to potential negative impacts on patient safety, quality of care, and/or stewardship of system resources. Should any of the proposals advance, we recommend an incremental approach be used, including piloting and phased roll out, followed by evaluation, before broad implementation to determine whether they achieve the desired aims and to identify and address unforeseen challenges.

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<sup>1</sup> Doctors of BC. [Scope of Practice for Health Professionals - Policy Statement](#). 2023.

For ease of reference, below is a high-level summary of Doctors of BC's position on each of the scope proposals. A more detailed response to each proposal is provided in the following section.

SCOPE PROPOSAL	POSITION	RATIONALE
<b>Pharmacists:</b> expanded conditions to diagnose and prescribe for	NOT SUPPORTIVE	Concerns related to patient safety, quality of care, efficiency, conflict of interest, and liability.
<b>Pharmacists:</b> diagnosis and prescribing of priority public health conditions	NOT SUPPORTIVE	Concerns this proposal could lead patients away from high quality STI management, leading to a risk of missing co-infections and bypassing the public health infrastructure that makes STI care effective at a population level.
<b>Pharmacists:</b> provision of emergency medication supplies	PARTIAL SUPPORT	Some support for refilling emergency prescriptions, substituting medications for cost or availability, and renewing prescriptions for existing conditions, provided there is consultation with the treating physician. However, there is opposition to modifying drug doses, regimens, or formulations, along with concerns about increased burdens and communication gaps.
<b>Physical Therapists:</b> make imaging referrals	NOT SUPPORTIVE	Concerns with this proposal focused on the potential impact on imaging resources, quality of care, and unnecessary imaging. There were suggestions that aspects of this proposal might work in certain settings and there could be potential to run a pilot, restricted to physical therapists ordering X-rays, to identify cost and benefits before further implementation. Employing the engagement approach taken by PABC may have enabled more support for this proposal.
<b>Midwives:</b> include POCUS to existing restricted activity of applying ultrasound	SUPPORTIVE	Doctors are mostly supportive of this scope expansion where it is supported by appropriate training, guidelines, and CME requirements and remains restricted to fetal heart rate monitoring and determination of fetal position and presentation. Communication between the midwife and treating physician is crucial.
<b>Midwives:</b> add levothyroxine to prescribing authority	NOT SUPPORTIVE	Doctors are concerned that without a physician's involvement in diagnosing hyperthyroidism, other factors may be overlooked, leading to unnecessary or inappropriate prescriptions of levothyroxine.
<b>Midwives:</b> add cabergoline to prescribing authority	NOT SUPPORTIVE	Doctors expressed concerns about expanding the use of cabergoline due to its high side-effect profile and limited current usage.
<b>Midwives:</b> add mifegymiso to prescribing authority	PARTIAL SUPPORT	Doctors are generally supportive, provided there is adequate training, guidelines, safeguards, and clear communication with the patient's treating physician. Concerns about potential complications from Mifegymiso and emphasis this should exclude authority to prescribe for high-risk patients.
<b>Optometrists:</b> oral drug prescribing and administration authority	PARTIAL SUPPORT	Some doctors recognize potential benefits of this proposal depending on the specific medications that optometrists could prescribe while highlighting serious systemic safety risks associated with certain oral drugs. We recommend looking at each drug individually based on risk profile rather than greenlighting a whole class of drugs. Other concerns include equity for patients, liability, and risk of conflict of interest related to optometrists prescribing and dispensing medication.
<b>Optometrists:</b> performance of laser eye procedures	NOT SUPPORTIVE	Strong opposition to this expansion in scope. Feedback focuses on the lack of a gap in patient access to justify the change, patient safety and quality of care, and increased burden and cost.
<b>Registered Nurses and Psychiatric Nurses:</b> application of x-rays for diagnostic/imaging purposes.	PARTIAL SUPPORT	Doctors see value in this proposal if the scope expansion is restricted to nurses working in underserved, rural/remote, or First Nations communities, where access to physicians and x-ray resources is limited.
<b>Audiologists:</b> dispensing a wearable hearing instrument	SUPPORTIVE	Generally, doctors did not identify significant concerns with this scope of practice expansion, though some were concerned about any potential increase in reports from audiologists requiring physician management.

# Detailed Responses to Scope of Practice Proposals

## Pharmacists

**Proposal 1:** *Expand the list of diseases, disorders, and conditions that pharmacists can diagnose and prescribe Schedule I drugs for.*

### Feedback:

Doctors reaffirmed the critical role pharmacists play in health care, but this proposal raises serious concerns related to patient safety, efficiency, conflict of interest, and liability. Doctors are concerned that the conditions described as “minor” could also be indicators of more serious illness that a pharmacist would not be equipped to rule out or diagnose. Common examples given were migraines, erectile dysfunction, and sinusitis which might appear minor or straightforward to treat but can also be a sign of more serious issues or may require further testing to identify the appropriate treatment. Treating these conditions without determining the underlying cause creates potential risk for patients and can lead to overprescribing, especially of antibiotics in the case of sinusitis. Further, pharmacists are not trained, nor do they usually have adequate resources (diagnostic equipment, private exam rooms, or the ability to order testing), to make thorough assessments of a patient’s condition. When patients access care outside of a comprehensive medical visit, there is also a missed opportunity for holistic assessment, screening, prevention, chronic disease management, and continuity of care that typically occurs during physician encounters. Pharmacists are not equipped to provide this level of care.

This proposal could undermine access to care due to adding burdens and creating inefficiencies for patients and the rest of their primary care team. A common issue raised was that pharmacists do not have access to the patient’s full medical record and may make diagnoses or treatment decisions that could negatively impact the patient’s health or undermine a treatment plan the patient is already on. The effects of these decisions will fall to the rest of the care team (primarily the family doctor) to address such as following up on treatment decisions and prescriptions made by the pharmacist, reassessing the patient and resetting the care plan, and addressing health-related consequences that result from diagnoses and treatment decisions made with incomplete information. This means extra work for family doctors, additional doctors’ visits for patients, potential negative health impacts, and greater cost to the system. Fragmenting care in this way can inadvertently delay definitive diagnosis, lengthen the pathway to appropriate follow-up, and create parallel systems that are harder for patients to navigate.

This proposal raises questions related to management of conflict of interest. Doctors in BC who wish to sell and dispense medication to their patients must seek formal approval to do so by their regulatory college, and strict practice standards apply even if permission is granted. This is because health care professionals who are permitted to both prescribe and dispense medication are at risk of a direct conflict of interest, which may

compromise the fiduciary relationship between health professionals and their patients. This proposal contemplates allowing pharmacists to both prescribe and dispense medication, contrary to the regulatory standard to which doctors are held.

Finally, input reflected medico-legal liability concerns. While generally not liable for the actions of others, doctors and other health professionals may be exposed to joint liability if they are made aware of an erroneous prescribing decision for their patient made by another health care practitioner and fail to act. This proposal expands pharmacists' ability to diagnose and treat without the corresponding responsibility for the outcome of those decisions. Doctors worry they may be deemed the most responsible physician and held accountable for adverse decisions made by pharmacists despite having no input or control over those decisions.

**Proposal 2:** *Enable pharmacists to diagnose and prescribe schedule I drugs for priority public health diseases, disorders, or conditions, using a Ministry of Health approved protocol, starting with sexually transmitted infections.*

**Feedback:**

Feedback on this proposal overlapped significantly with feedback on Proposal 1. Specific to this proposal, doctors are concerned that it may lead to a "diagnose-and-dispense" model of managing STIs. STI management is not a prescribing transaction. It requires sexual history, co-infection testing, partner notification, counselling, and follow-up. If this scope proposal means patients may not access high quality STI management, it leads to a risk of missing co-infections and bypassing the public health infrastructure that makes STI care effective at a population level.

**Proposal 3:** *Include provision of emergency medication supplies for continuity of care within the Pharmacists Regulation and ensure all four of these activities are authorized for all pharmacists (including non-dispensing pharmacists) as a prescribing related activity – i.e., where a diagnosis and prescription from a practitioner exists, a pharmacist may prescribe a schedule I or IA drug for the following purposes:*

- *To adapt an existing prescription to optimize treatment by modifying any of the following:*
  - *The dose of the drug*
  - *The formulation of the drug, and*
  - *The regimen of the drug*
- *To substitute a drug in an existing prescription with another in the same therapeutic class.*
- *To renew an existing prescription for continuity of care.*
- *To provide an emergency supply of drug if it is not reasonably possible for the patient to see another practitioner to obtain the prescription and there is an immediate need for drug therapy.*

### **Feedback:**

Doctors acknowledged that some aspects of this proposal could be beneficial, such as refilling emergency prescriptions, substituting medication of the same class for cost or availability reasons, or renewing/extending prescriptions for pre-existing and diagnosed conditions. However, doctors emphasize that this must be done in consultation and communication with the treating physician because there is often a clinical reason a particular medication, brand, or dosage was chosen. For example, in pediatric prescribing, prescriptions may be used off-label and carefully chosen. For this reason, doctors cannot fully support pharmacists modifying the dose, regimen, or formulation of a drug prescribed by a doctor. Concerns about increased cost and burden on the system were highlighted where additional time is required to follow up on changes to prescriptions, explain the rationale for prescription decisions, and potentially address issues that arise for patients due to a pharmacy-initiated prescription change. The current communications infrastructure between doctors and pharmacists is inadequate to ensure that this scope of practice expansion can be done safely while maintaining quality of care and avoiding increased burden and inefficiency.

## Physical Therapists

**Proposal:** *Add restricted activities related to issuing an authorization to apply hazardous energy for diagnostic or imaging purposes (e.g., ultrasound, X-ray, CT scan, MRI) – with certified practice requirement. Operational implementation may require a phased approach across public and private settings.*

### Feedback:

Feedback focused on the potential impact on imaging resources, concerns about quality of care and unnecessary imaging, and some suggestions for where aspects of this proposal might work. While this proposal aims to improve efficiency and expand access for patients, the current issue of significant wait times for imaging is not due to a lack of access to referrals imaging. Rather, it is a lack of sufficient imaging resources. BC is currently short approximately 58 full-time radiologists with projections indicating this gap will widen to 157 full-time radiologists by 2030. Current wait times across radiology modalities is at approximately 530,000 patients with projections this could reach 4 million by 2030 if no increase in radiology staffing is made. Doctors point out that expanding who can order imaging (especially for MRIs, CT scans, and ultrasound), without a coordinated and system-level plan, risks exacerbating these pressures and will lengthen wait times for patients requiring urgent diagnostic imaging. Expansion in scope of practice for imaging referrals needs to be aligned with existing system capacity and radiologist constraints.

Doctors are concerned that while physical therapists are experts in musculoskeletal issues, they do not have the same depth of training as physicians in determining what, if any, imaging is needed and how to interpret and manage the findings. Doctors worry that privileging physical therapists to order diagnostic imaging raises issues around follow-up and accountability. Imaging such as CT, MRI, or ultrasound frequently reveals unexpected abnormalities that need to be interpreted in the context of the patient's overall health and may require further investigation or follow-up. An increase in unexpected or indeterminate findings will generate further demand for management of the findings where a doctor would ultimately determine that none was needed. Furthermore, if imaging is ordered outside of the patient's primary care team, it may not always be clear who is responsible for reviewing and managing these findings. Without clear processes in place, there is a risk that incidental findings could lead to unnecessary testing, patient anxiety, or gaps in follow-up care.

Physician responses to this proposal indicated that a lack of sufficient background information on the intent, scope, and implementation plan made it challenging to assess risks and possible benefits fully. While there was some feedback that expanding physical therapists' scope to include ordering x-rays may be beneficial and improve efficiency for patients, doctors that support this recommend this be done as a pilot before broad implementation. Additionally, some doctors acknowledged that expanding scope for physical therapists to order imaging can work in very specific settings like the VGH Spinal Clinic where physical therapists are fully integrated into the care team, receive extra training, and work closely with doctors. However, doctors do not

see this working in private physical therapist clinics which are largely disconnected from the rest of the patient's care team.

As highlighted in the introduction, the Physiotherapist Association of BC (PABC) invited conversation on this proposal separate from the Ministry's consultation. PABC created an opportunity to discuss the proposal, its intent, physician questions and concerns, measures that could be taken to address challenges, possible implementation approaches, assessment and measurement concurrent with phased expansion, and other iterative ideas. This held considerable value. With the same opportunity for collaborative discussion on these and future proposals, this submission may look different.

## Registered Midwives

**Proposal 1:** *Under the existing restricted activity of applying ultrasound, add Point of Care Ultrasound (POCUS) for midwifery purposes.*

### Feedback:

Based on the feedback received, doctors are mostly supportive of this scope expansion provided it is supported by appropriate training, guidelines, and CME requirements and remains restricted to fetal heart rate monitoring and determination of fetal position and presentation. The need for regular and high-quality communication with the physician overseeing the patient's care was emphasized.

**Proposal 2:** *Add to midwives' prescribing authority: levothyroxine for hypothyroidism.*

### Feedback:

Concerns were raised that there may be other factors at play with hyperthyroidism that could get missed without a doctor involved in diagnosis prior to a prescription being given. Additionally, without proper diagnosis and ruling out of other factors, there may be an increase in the prescribing of levothyroxine when it is not needed or appropriate. There is some recognition that there could be benefit with this scope change in limited circumstances with strong training and guidelines in place and with clear expectations for communication with the treating physician. It is suggested that that this be piloted first to identify risks versus benefits before a decision is made to advance implementation.

**Proposal 3:** *Add to midwives' prescribing authority: Cabergoline for lactation suppression.*

**Feedback:**

Physician feedback included many questions as to why this scope expansion is being sought when Cabergoline is rarely used due to its high side-effect profile. Input indicated this is a medication doctors do not often use due to the side effects and they would not support further expansion of its use by non-physicians.

**Proposal 4:** *Add to midwives' prescribing authority: Mifegymiso for the management of early pregnancy loss and medical abortion.*

**Feedback:**

Provided adequate training and guidelines are in place and there are clear expectations for communication with the patient's treating physician, this proposal generally received support. Concerns focused on the potential complications or adverse side effects of Mifegymiso in some cases and the need for appropriate safeguards in place to respond if complications arise. Doctors also emphasized that prescribing authority for Mifegymiso, Cabergoline, or Levothyroxine should explicitly exclude situations where the patient is going through a high-risk pregnancy.

## Optometrists

**Proposal 1:** *Under the existing restricted activity of prescribing drugs, add oral drug prescribing and administration authority (e.g., anti-viral, anti-allergens, anti-biotics) for conditions of the eye managed by optometrists.*

**Feedback:**

Physician feedback includes recognition that there may be some benefit to this scope expansion depending on the specific medications that optometrists would be able to prescribe. Ophthalmologists point out that some oral medications frequently prescribed for eye conditions have serious systemic safety risks, such as electrolyte imbalances, general systemic side effects and kidney function. Because of the varying degrees of risk with different oral medications, there is a need to consider expansion of prescribing authority not on the basis of a whole class of medication, but rather the evidentiary basis of each medication and its associated risks. For example, doctors are less concerned with optometrists being able to initiate oral antihistamines and antiviral medications but have greater concerns around oral antibiotics. A pilot of prescribing authority expansion would be preferred over full implementation to assess risk versus benefit. Further, expansion of prescribing authority

to include new medications should be done in a collaboratively between government, physicians, optometrists, and other key interest holders and include requirements for adequate training and protocols for communication with the patient's treating physician(s).

Doctors have concerns around equity, liability, and conflict of interest with this proposal. They are concerned that patients with money who can afford to pay an optometrist for this prescription would get faster access than patients who go through the public system to get the same prescription from a family doctor. In this case, the optometrist could also be billing patients privately for the service of prescribing, which is provided publicly through MSP. These equity issues need to be addressed prior to any scope change. Concerns were also raised that absent clear liability frameworks, doctors may bear joint responsibility for adverse outcomes of prescriptions written by an optometrist. Finally, both prescribing and selling prescription medications creates a risk for conflict of interest. The same stringent measures that doctors must adhere to regarding conflict of interest for prescribing and dispensing should apply to optometrists.

**Proposal 2:** *Add the restricted activities of apply laser for the purpose of cutting and destroying tissue - for eye procedures (capsulotomy, peripheral iridotomy, and selective laser trabeculoplasty (SLT) with certified practice requirement.*

### **Feedback:**

Feedback indicated strong opposition to this expansion proposal. Input predominantly focused on the lack of an access gap to justify the change, patient safety and quality of care concerns, and increased burden and cost. A common theme in the feedback is that there is no backlog or significant wait times for patients who need laser procedures done. These are often not urgent procedures and are routinely done within an acceptable timeframe. Additionally, rural ophthalmologists are not seeing a significant gap in access to these procedures for their patients. Doctors emphasized that the current relationship and referral pathways between ophthalmologists and optometrists' works well for both health care professionals and patients.

Doctors are concerned about the safety and quality implications of this change. Ophthalmologists are required to do 5 years of residency and training to perform laser-based surgical procedures and are concerned that this scope expansion lowers the standard of training and care for these procedures. Expanding procedural authority without equivalent education, residency training, and regulatory oversight, puts patient safety at risk by creating a two-tiered system of care with differing standards.

Concerns were also raised around the potential for increased costs and burdens to the health system. While scope expansion is often framed as a cost-saving measure, it may paradoxically increase overall health care expenditures. Complications, delayed diagnoses, duplicated visits, overuse of resources, and increased referrals after incomplete management will increase system strain. Additionally, expanding procedural

privileges into private clinic settings risks shifting publicly funded care into mixed or private billing environments, increasing costs to patients and the system. Administrative oversight, regulatory changes, and liability coverage expansion will also carry costs.

## Registered Nurses and Registered Psychiatric Nurses

**Proposal:** *Add the restricted activity of applying low complexity X-rays for diagnostic or imaging purposes.*

### Feedback:

Doctors recognize the benefit for this scope expansion in underserved, rural/remote, or First Nations communities where access to a physician or technicians to perform X-rays creates a barrier to basic investigations. Doctors did not see a need for this scope expansion in well-served urban populations.

## Audiologists

**Proposal:** *Add the restricted activity of dispensing a wearable hearing instrument for audiologists.*

### Feedback:

Doctors did not identify major concerns with the proposed scope expansion. However, they noted that this scope change should be designed to ensure it does not increase paperwork or administrative burden for physicians or other health care professionals.

## Conclusion

Doctors of BC appreciates the Ministry of Health's effort to seek feedback on the proposed scope of practice changes. Our submission highlights that while doctors support initiatives aimed at improving access, efficiency, and patient outcomes, they are concerned about the current approach of considering scope changes in isolation, without full integration into a comprehensive, collaborative, and evidence-based health human resources strategy.

With the Health Professions and Occupations Act (HPOA) taking effect alongside these scope proposals, the timing of the potential changes is problematic. The implications and intended and unintended consequences of the HPOA will take time after implementation to be fully understood, making it challenging to appropriately assess the potential future impacts of these proposed scope changes. We recommend the Ministry first establish a comprehensive system-level scope of practice framework in partnership with health professionals before proceeding with any scope changes.

Doctors of BC remains committed to partnering with the Ministry to develop solutions that optimize care, protect patients, reduce waste and low-value interventions, and strengthen the health care system. Thank you for taking the time to review our feedback and for considering our recommendations in shaping the future of health care delivery in BC.

# Appendix – BC Family Doctors & Consultant Specialists of BC Letter



March 31, 2026

To the Executive Director, Professional Regulation and Oversight, Ministry of Health,

**Re: Proposed changes to Scope of Practice of regulated health professions**

We are writing on behalf of family physicians and consulting specialists across British Columbia to share our perspective on the Ministry of Health's proposed scope of practice (SoP) changes for pharmacists, physical therapists, registered midwives, optometrists, registered nurses, registered psychiatric nurses, and audiologists.

We applaud the government's efforts to improve timely access to care and increase health system capacity. BC Family Doctors and Consultant Specialists of BC welcome the valuable contributions of allied health professionals and support team-based care where health professionals work to their full scope of practice. As such, we believe any changes to scopes of practice for allied healthcare providers should not only optimize each team member's skills and expertise but be done within physician-led, team-based care environments to ensure patients receive high-quality, safe and coordinated care.

While we support some proposed expansions to scopes of practice for specific allied health professionals, we are concerned with the overall approach where scope changes are being considered in isolation of each other. This raises important concerns regarding patient safety, continuity of care, equity of access, and system capacity. These changes may lead to unintended consequences for patients and the healthcare system and add complexity for those providing and receiving care.

Several system-level concerns apply across many of the proposed SoP changes:

- **Patient Safety:** Expanding diagnostic and prescribing roles without equivalent training may increase the risk of misdiagnosis and inappropriate treatment. As an example, while pharmacists are highly trained in medication management, their training generally does not include the depth of diagnostic education required for the proposed expanded scope of conditions. This may result in patient safety and quality of care issues due to inappropriate diagnoses and treatments, and ultimately, cost the system more.
- **Continuity of Care:** Our health system is already disconnected and fragmented. As more health professionals independently order labs and diagnostics or prescribe treatments, patients' continuity of care will decline due to a lack of coordination. The absence of an integrated electronic medical record system in BC increases the coordination challenges between health



professionals and will further divide rather than connect care, result in unnecessary or duplication of diagnostics and treatment, and ultimately cost, the system more.

- **Equity of Access:** Several proposed changes intersect with services that involve out-of-pocket fees (e.g. physiotherapy, optometry), that could unintentionally widen disparities in access to diagnostics or treatment. For example, allowing physiotherapists to order imaging may create faster diagnostic pathways for patients able to pay the additional private pay fees and yet disenfranchise others who cannot pay. This will perpetuate multi-tier access to health services at a time when inequity in healthcare access in BC is rising due to a shortage of health professionals, geographical disparities, growing wait times for specialist consultants and an expanding for-profit health sector.
- **System Capacity:** Already strained, the health system's capacity will only be stretched thinner with expansions to scopes of practice. For example, enabling more health professionals to order diagnostic imaging without corresponding increases in the system's imaging resources and capacity, at a time when we face a shortage of radiologists and technicians, will only increase diagnostic wait times. There may also be increases in unnecessary lab test ordering and referrals to consulting specialists as some allied health professionals, such as nurse practitioners, have been found to refer patients more often than family physicians due to less extensive training.<sup>i</sup>
- **Administrative Burden:** Physicians are responsible for reconciling externally ordered tests, prescriptions, and treatment decisions. Expanding allied health professionals' scopes of practice adds additional layers of complexity to our administrative system with an increasing volume of reports to review, increasing physicians' administrative burden at a time when Canadian physicians currently spend 19.8 million hours<sup>ii</sup> on unnecessary administrative tasks annually.
- **Liability:** Further clarity is needed when it comes to care coordination, treatment and liability. Concerns over whether a physician will be liable for tests and treatments ordered by another health professional and inappropriately held accountable for the practices of other health professionals looms large. The lack of digital health records means physicians may not be made aware of these interventions in a timely manner and yet be held liable.
- **Conflict of Interest:** Physicians are barred from being able to both diagnose and dispense medication to uphold patient safety, however the proposal would grant pharmacists this ability, representing a potential conflict of interest as small business owners who may profit from diagnosing and providing prescriptions.

We understand that the expansion of scope of practice for many allied health professionals offers a potential solution to reduce pressure on primary care and emergency departments. However, we



believe these proposed changes will not have the intended outcome, and will reduce equitable access to care for patients, increase physicians' administrative burden, and drive up system costs.

We support collaborative, team-based care and the important role that allied health professionals play in our healthcare system. However, scope expansions must be carefully evaluated to ensure they improve patient outcomes without introducing new risks related to safety, equity, or system capacity.

We endorse Doctors of BC's policy statement on [Scope of Practice for Health Professionals](#) and fully support Doctors of BC's *Response to the Ministry of Health's Scope of Practice of Regulated Health Professions Proposals* submission (March 31, 2026).

BC Family Doctors and Consultant Specialists of BC welcome the opportunity to engage with the Ministry and work together to build an equitable, integrated healthcare system.

Sincerely,

A handwritten signature in black ink, appearing to be "Darren Joneson", enclosed within a hand-drawn oval.

*Dr Darren Joneson*  
President  
BC Family Doctors  
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A handwritten signature in black ink, appearing to be "Robert Carruthers", consisting of a stylized 'R' followed by a horizontal line.

*Dr. Robert Carruthers*  
President  
Consultant Specialists of BC  
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<sup>i</sup> Liddy, C., Deri Armstrong, C., McKellips, F., & Keely, E. (2016). A comparison of referral patterns to a multispecialty eConsultation service between nurse practitioners and family physicians: The case for eConsult. *Journal of the American Association of Nurse Practitioners*, 28(3), 144–150. <https://doi.org/10.1002/2327-6924.12266>

<sup>ii</sup> Canadian Medical Association (CMA), Canadian Federation of Independent Business (CFIB). *Losing doctors to desk work: Canadian physicians lose 20 million hours each year to red tape*. Ottawa: The Association; 2026 Jan. Available: <https://digitallibrary.cma.ca/link/digitallibrary1478> (accessed 2026 Mar 23).



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