# BACKCOUNTRY MEDICAL RESCUE IN BRITISH COLUMBIA V1.0

A BCSARA Medical Advisory Committee (MAC) Discussion Paper

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# Executive Summary


- Providing Backcountry Medical Rescue for ill and injured people in British Columbia (BC) is a challenging task that is commonly managed collaboratively by local Search and Rescue (SAR) groups, Emergency Health Services (BCEHS), and the Ministry of Emergency Management and Climate Readiness (EMCR).
- When tasked by EMCR on behalf of BCEHS, current provincial legislation and policies support SAR groups providing emergency ambulance, first aid and, when necessary and available, medical care (healthcare services); as long as the providers are working within the scope of their first aid training or healthcare license AND the SAR group supports providing that level of care.
- Many SAR groups are asked to perform backcountry Medical Rescues for critically ill patients and some have developed sophisticated care models using volunteer licensed healthcare providers (i.e. paramedics, doctors, nurses) to provide care beyond the scope of first aid. A variety of SAR care models have been summarized to help support current programs and inform future policy discussion.
- Understanding of the legislation, scope of practice, potential liability and insurance issues associated with providing first aid and medical care during backcountry Medical Rescue is inconsistent across SAR groups and volunteers, EMCR and BCEHS. The relevant legislation, policies and how they interact have been explored and summarized to help understand current care models and assist with future development and support.
- The three way relationship between BCEHS (experts in the provision of healthcare), EMCR (experts in coordinating emergency response and supporting rescue teams but without any mandate or expertise providing healthcare) and SAR groups (local experts with diverse expertise facilitating backcountry Medical Rescue ) creates administrative challenges when it comes to planning and support for backcountry Medical Rescue in BC.
- Priorities for future work include provincial collaborative support for Medical Rescue infrastructure and administration, such as:

    i. equipment acquisition and maintenance
    ii. advanced first aid and medical rescue training
    iii. clinical practice guidelines
    iv. quality assurance
    v. medical direction
    vi. clinical documentation
    vii. rescuer wellbeing
    viii. helicopter transport resource optimization

# Definitions and Abbreviations

"Backcountry" Areas of British Columbia, beyond government roads, generally inaccessible to on duty BCEHS paramedics but within the operational capability of a SAR group

"BC" British Columbia

"BCEHS" British Columbia Emergency Health Services, website

"BCSARA" British Columbia Search and Rescue Association, website

"CMPA" Canadian Medical Protective Association, website

"ECC" Provincial Emergency Coordination Center, website

"EMA" Emergency Medical Assistant (paramedic), website

"EMALB" Emergency Medical Assistant Licensing Board, website

"EMCR" Emergency Management and Climate Readiness, website

"First Aid" Includes:
(a) treatment of minor injuries that do not require medical treatment, and
(b) treatment of a person, who does require medical treatment, for the purpose of preserving life, limb and minimizing the consequences of injury until medical treatment, and

does NOT include:
(c) treatment that may only be performed by licensed healthcare professionals or is otherwise considered a Restricted Activity.

Modified from: *Occupational Health And Safety Regulation*, B.C. Reg. 296/97, s. 3.14

"Healthcare Services"

Treatment that may only be performed by licensed healthcare professionals or is otherwise considered a Restricted Activity (i.e. medical care)

"HPA" *Health Professions Act*, R.S.B.C. 1996, c. 183 website

"Medical Care"

See "Healthcare Services."

"Medical Rescue"

A request by BCEHS, made through ECC, for a SAR group to rescue an injured subject. (see Provincial SAR Policy 2.12, page 2 BCEHS)

"MOH" Ministry of Health

"OFA" Occupational First Aid, *Occupational Health And Safety Regulation*, s. 3.14, OFA 3 manual

"Paramedic" Licensed Emergency Medical Assistant, website

"PHSA" Provincial Health Services Authority, website

"Provincial SAR Policy"

*2.12 Search and Rescue*, EMBC (created Sept 2008, revised July 2015), pdf.

"POGs" *Provincial Search and Rescue Operating Guidelines*, EMCR (Issued Sept 2012, revised October 2023), pdf

"Restricted Activity"

Invasive, higher risk activities that can only be performed by:

(a) educated and competent registrants of a health profession college who have been granted specific authority, OR
(b) if authorized in the bylaw of that college, may be delegated by a regulated professional who has the authority to perform and delegate the restricted activity. See MOH website

Section 55(g) of the HPA refers to the minister making regulations for the purpose of defining "restricted activity". A draft regulation from March 2010, listing restricted activities can be found on the MOH website with language similar to health profession college bylaws (i.e. BC College of Physician and Surgeon Bylaws s.10(3)) but official regulations published by the minister were not found.

"SAR" Search and Rescue – Search and/or Rescue for lost, missing, stranded, or injured persons located on ground or inland waters.

# Medical Rescue Statistics

Human adventure in British Columbia's wild backcountry is important to residents and the millions of tourists who visit every year. When people call 911 during a medical emergency, they expect to receive timely pre-hospital emergency services regardless of location. BC SAR groups respond to approximately 1,500 incidents per year and approximately 35% of these are Medical Rescues triggered by BCEHS when the patient cannot be reached using a traditional ambulance. In these situations, both the public and BCEHS depend on the rescue, first aid and medical skills of SAR groups. Thankfully, many advanced first aiders and healthcare professionals (i.e. paramedics, nurses, doctors) volunteer with local SAR Groups and have worked hard to develop innovative care models to meet the local needs and the needs of the patients.

More than 260 licensed healthcare providers (doctors, nurses and paramedics) volunteer with BC SAR groups. All SAR volunteers who go into the backcountry have basic first aid training (7hr minimum), and many go on to higher levels. Having licensed healthcare providers integrated into the teams and working on the front lines greatly improves the ability of the SAR groups to manage complex Medical Rescues.

# BCEHS Legislation and Scope

BCEHS, under the umbrella of the Provincial Health Services Authority (PHSA) and the BC Ministry of Health (MOH), is exclusively responsible for the provision of pre-hospital emergency services across the vast, wild and complex terrain of BC. With the exception of hospitals, clinics, worksites and the *Good Samaritan Act*, BCEHS has the exclusive legal authority to provide emergency ambulance, first aid or other health care services in British Columbia. Please see Appendix A: Emergency Health Services Act Highlights, for further information.

The crux for BCEHS, when it comes to backcountry Medical Rescue, is that despite having the infrastructure, expertise and equipment to provide every level of prehospital care, BCEHS lacks the ability to operate in backcountry terrain. The use of SAR Groups to extend their reach is an effective solution but formal systems for collaborative planning and resource sharing are lacking. Developing systems for collaborative planning and resource sharing with SAR groups will help both parties provide the best possible care for ill or injured people in the BC backcountry.

# EMCR Coordination, Guidelines, and Oversight

The BC Ministry of Emergency Management and Climate Readiness BC (EMCR) is responsible for coordinating the response to critical incidents when the required actions are beyond the capability of the responsible emergency service provider. When BCEHS cannot access an ill or injured patient, they request EMCR assistance via the Provincial Emergency Coordination Center (ECC) and often a local SAR group is tasked with performing the backcountry Medical Rescue. Please see Appendix B: Emergency and Disaster Management Act Highlights for further information. It is important to understand that EMCR's mandate does not allow them to engage in emergency ambulance, first aid or medical care (healthcare services) but rather to coordinate collaboration between agencies when BCEHS requests assistance.

EMCR is also responsible for authorizing public safety providers (such as SAR groups) and has the power to set standards, protocols and procedures. Best practice and EMCR Provincial Operating Guidelines (POGs) compel SAR groups to have first aid services available for SAR volunteers, similar to what would be available at a comparable workplace. It would seem logical that policy would also encourage SAR groups to have first aid and/or medical care (healthcare services) available for SAR subjects requiring Medical Rescue, however as noted above, EMCR does not have the appropriate government mandate to write such policy and BCEHS has not requested any policy to that effect.

The crux for EMCR when it comes to backcountry Medical Rescue is that they have the mandate to oversee the SAR groups who perform these complex rescues, the SAR groups are asking for help to improve their Medical Rescue capability but government protocol dictate that EMCR defer to BCEHS when it comes to emergency ambulance, first aid or other health care services until such a time as BCEHS requests assistance.

# SAR Groups Role in Medical Rescue

SAR groups understand the unique needs of their local terrain, environment, common accidents and illnesses. With the support of EMCR, the BC Search and Rescue Association (BCSARA), local government and their community; SAR groups build rescue infrastructure specific to local needs and resources. Rescue terrain includes: arid desert canyons, limestone caves, vertical rock walls, high alpine glaciers, rugged mountains, coastal rainforests, raging rivers and inland lakes. BC SAR groups have developed the skills necessary to operate safely in every corner of the province.

In BC, when a person is ill or injured in a location where BCEHS cannot access the patient, a request is made through the provincial Emergency Coordination Center (ECC) for a SAR Group to perform a Medical Rescue. The SAR group, acting on behalf of BCEHS, is thereby authorized to provide the emergency services necessary to preserve that individual's life, alleviate harm, treat pain and transport them to a location suitable for handover to BCEHS. All SAR volunteers train in basic first aid, some maintain advanced first aid certification

and some are also licensed healthcare professionals (i.e. paramedics, doctors, nurses). The arrangement of having SAR groups provide Medical Rescue was developed in response to local needs, with some SAR groups commonly caring for critically ill patients, while other SAR groups are rarely required to provide first aid. If a SAR group is tasked with a Medical Rescue and determine that they do not have the resources necessary to perform the rescue, they can request mutual aid from neighboring SAR groups or work with ECC to access the resources they require.

There are approximately 3,400 SAR volunteers in BC. Any volunteers deployed into the field are required to have basic first aid. Of the more than 2000 volunteers who provided the details of their extra training, ~23% have received advanced ~16hr training, ~35% have received professional level certification (32-70hr course) and ~13% are licensed paramedics, doctors or nurses. As of 2023, the number of licensed healthcare professionals volunteering in SAR has grown to an incredible 268 people. It is important to note that these resources are not distributed evenly across the province. The focus of this paper is on support for healthcare licensed SAR volunteers but does not address the enormous challenge faced by SAR Groups and communities where there are no professional advanced first aid or medical experts willing to volunteer.

The crux for SAR groups when it comes to backcountry Medical Rescue is that they are routinely requested to perform these rescues, they may or may not have advanced first aiders or licensed volunteers but they do not have formal support from EMCR or BCEHS to develop healthcare delivery infrastructure (as noted above; EMCR, in the absence of a request from BCEHS, cannot support the development of healthcare service programs). The licensed healthcare professionals who volunteer on SAR teams typically have excellent backcountry and clinical skills but may be unfamiliar with the best practices and policies required for their non-profit society (i.e. the SAR group) to become an organization that delivers backcountry first aid and medical care (healthcare services) to the public on behalf of BCEHS.

# First Aid, Healthcare and Delegation

First Aid encompasses a spectrum of care from reassurance and a band-aid, to stopping a life-threatening bleed with a tourniquet or providing CPR and restarting someone's heart with an AED. First Aid may be all that is required in some cases, or it might be the first treatment prior to medical care and transport to a higher level of care. In the community, First Aid can be provided by anyone, from untrained bystanders to certified professionals. This paper will limit the discussion to First Aid delivered by SAR volunteers with at least current First Aid certification. With the exception of licensed healthcare professionals, First Aid providers should limit their care and equipment, based on their first aid training and certification. Volunteer SAR First Aid providers, are acting as part of a professional response and therefore need to maintain current first aid certification, obtain appropriate consent, operate within the scope of their certification and maintain confidential First Aid records.

With the exception of paramedics, who are regulated by the *Emergency Health Services Act*, healthcare professionals in BC are regulated under the *Health Professions Act* (HPA, see Appendix C & E]. Scope of practice legislation across Canada is complex. In BC, health professionals are not bound by exclusive scopes of practice, but by their abilities and the range of services they can provide in a safe and competent manner. In contrast, paramedic scope of practice is specified in the *Emergency Medical Assistants Regulation* (see Appendix E). SAR volunteers are made up of certified basic or advanced first aiders and in some cases health care professionals; each with different qualifications and licences. The tasks that each professional is permitted to perform will vary and each member should review their certifications and licences to understand the limits of their ability to perform certain tasks. Some health care professionals may require an additional licence to perform certain tasks, while others may not.

In preparation for common SAR encounters, providers should review their qualifications and licensure before:

- prescribing or administering drugs
- reducing fractures or joints
- performing procedures/using equipment that goes below the skin or within body cavities (i.e. oropharyngeal airway equipment is within the scope of first aid but airway equipment which goes deeper [Igel, Kingtube] are not).

Delegation of healthcare activities by licensed professionals to other members of the healthcare team is common in many healthcare service settings. The rules of delegation are controlled by each professional college but the general principles are that the licensed professional maintains responsibility for the care and must ensure the delegate has the knowledge, skills, and judgement to perform the delegated task. As per the BC MOH webpage, in order for a health professional to delegate a Restricted Activity to a non-licensed provider, the professional college bylaws must authorize the delegation. See Appendix C: Health Professions Legislation Highlights for more information.

Because paramedic scope of practice is specifically defined and limited by legislation, delegation of healthcare tasks by licensed healthcare professionals to licensed paramedics is different from delegation to other healthcare professionals or non-licensed providers. Advanced care (ACP) and higher licensed paramedics are permitted to consult with a physician advisor but primary care and lower licensed paramedics have no delegation opportunities (see Appendix C & E).

Offline, guideline, or protocol-based delegation of Restricted Activities to providers not licensed to perform the delegated activity is a grey area of healthcare. SAR Groups may be offered programs by first aid or healthcare companies that train and oversee unlicensed providers to perform Restricted Activities such as administering prescription medications or performing invasive medical procedures. It is unclear to the author group of this paper if such programs are compliant with the rules of healthcare delivery in BC. In contrast, programs that include licensed healthcare providers being involved directly or remotely with authorization or delegation of Restricted Activities prospectively, using patient specific orders (after individual patient factors have been considered by the license provider), seem more likely to comply with healthcare regulations.

# Drugs and Medications

In BC, drugs (medications) are classified and their sale is restricted as per the Drug Schedules Regulation:

- Schedule I, prescription by licensed healthcare provider, example antibiotics or a vial of epinephrine.
- Schedule IA, triplicate/Duplicate prescription, example narcotics.
- Schedule II, behind the counter, no prescription required, example epi-pen.
- Schedule III, self-selection in a pharmacy, example acetaminophen (Tylenol).
- Schedule IV, may be prescribed by a pharmacist, example emergency contraception.
- Unscheduled, may be sold by non-pharmacists, example vitamins, herbal remedies.

Assisting an awake and alert person to take their own medication, at their own request, is part of basic first aid.

Provision of non-prescription medications by non-pharmacists to members of the public is a more complicated matter. A roadmap for best practices in the workplace, can be found in the OFA 3 Manual, page 199, “an employer may choose to purchase non-prescription drugs or medications to address common ailments.” The manual then lays out the best practices for managing and providing the medications. It seems reasonable that SAR Groups who wish to prepare their medics to help manage backcountry emergencies might stock helpful non-prescription medications and model their best practices on the OFA model.

The provision of prescription medications to members of the public requires a healthcare license with the appropriate scope. As noted in the delegation section, in the absence of direct involvement (in person or remote) of a licensed healthcare provider on a case-by-case basis, the author group of this paper is not aware of how an unlicensed provider could legally provide a prescription medication to a patient who does not already have a prescription for that medication.

Under the federal *Controlled Drugs and Substances Act*, S.C. 1996, c. 19, it is an offence to possess certain types of drugs without an exemption. BCEHS has an exemption, allowing on-duty employees to be in possession of buprenorphine, fentanyl, hydromorphone, ketamine, morphine and oxycodone for medical purposes. Healthcare professionals in possession of controlled drugs without an exception could potentially face legal peril. Implementing formal inventory management systems similar to those followed by BCEHS or non-hospital medical facilities would presumably provide some protection against being accused of recreational use or diversion for personal gain. As an example of an administrative solution to working within the regulations, Squamish SAR applied to the Office of Controlled Substances, met the administrative requirements and has been granted an exemption for their healthcare providers.

# SAR First Aid Guidelines and Equipment

SAR volunteers who provide first aid should be formally trained, certified and provide first aid within the scope of a recognized professional first aid certificate program.

All SAR volunteers must maintain, at a minimum, basic (i.e. 7hr) first aid certification. Depending on the number of volunteers, the risk of injury and the travel time to hospital, EMCR POGs specify the equipment and level of first aid attendant that should be available, similar to Schedule 3-A of the *WorkSafe Occupational Health and Safety Regulations*, B.C. Reg. 296/97. Outdated First aid kit requirements are specified in the EMCR POGs, and were originally based on the Workplace First Aid Kit Requirements. WorkSafe has announced plans to align their recommendations with the standards established by the Canadian Standards Association (CSA).

It is the opinion of the BCSARA MAC that SAR Groups should determine which first aid certificates (i.e. Standard, Wilderness or Occupational First Aid (OFA) are appropriate for various roles within their organization while still meeting the EMCR POGs training duration requirements (i.e. 7hr, 16hr or 70hr course). First aid training providers should ideally meet standards published by experts such as the Wilderness Medicine Society or the Canadian Standards Association. WorkSafe also maintains a list of approved first aid training providers and the BCSARA MAC is available to help answer first aid related questions.

When it comes to First Aid attendants and equipment, SAR Groups should consider that SAR volunteers need to have timely access to first aid attendants and supplies equivalent to those recommended by WorkSafe (Schedule 3-A and Workplace First Aid Kit Requirements weblink) adapted to the unique needs of specific SAR Groups geography, logistics and tasks. It is the opinion of the BCSARA MAC that SAR volunteers and groups optimize their first aid kits based on local conditions, the operational scenario, their level of training +/- licensure and the level of care supported by their SAR group.

# Liability and Insurance Issues

March 19, 2014 Search and Rescue Joint Health and Safety Committee Minutes

**A. Summary of Liability Coverage for Volunteers in Respect of Medical Acts**

If the **volunteer is not a medical professional** but is administering first aid within the limitations of his/her training or knowledge.

- Covered under the Commercial General Liability Policy.
- Exempt from civil liability under the Emergency Program Act.
- Exempt from liability under the Good Samaritan Act.

If the **volunteer is a medical professional** and does render medical treatment.

- Not covered under the Commercial General Liability Policy.
- Exempt from civil liability under the Emergency Program Act.
- May be exempt from liability under the Good Samaritan Act subject to an interpretation of the term "employed expressly for the purpose" as it pertained to the circumstances at the time of the incident that gave rise to the claim.

**Medical Professionals or those that are providing licensed medical care need to check with the medical license provider to see what liability coverage is provided.**

Caution[1]

[1]Caution: these minutes are provided for reference, they are not endorsed by the authors of this paper, they were written by Ian Cunnings (EMBC) in an attempt to provide clarification, they are not policy or legal opinion. Specifically, it is unclear to the authors of this paper if the Good Samaritan Act (GSA) applies to SAR volunteers. As stated, the government-provided Commercial General Liability (CGL) policy DOES NOT provide liability coverage for medical professionals volunteering with SAR groups but the SARVAC CGL policy explicitly does. Also note that the Emergency Program Act ("EPA") has been repealed and replaced with the Emergency Management and Disaster Act ("EDMA"). To clarify, the exemptions listed above are not absolute exemptions and do not apply when there has been gross negligence (extreme carelessness or significant departure care standards) and/or bad faith (intentional wrongdoing).

Limited liability protection for SAR providers operating under an EMCR task number is normally provided by the province and backed up by the SARVAC Legal Liability Insurance Program which covers all registered SAR volunteers, SAR Societies, and their Boards of Directors. If a SAR provider operates beyond the scope of OFA 3, EMCR has stated (as per the March 2014 minutes above) that they cannot provide any support. The SAR team & volunteer licensed provider would therefore rely on the SARVAC policy and the individual licensed providers private insurance (i.e. Paramedic Insurance, CMPA). See SAR Medical Direction for discussion about potential liability issues resulting from administrative aspects of Backcountry Medical Rescue.

For details of the coverage provided by the SARVAC National Insurance Program, please see Appendix F: Summary of Legal Liability Protections in BC

# SAR Medical Direction

Best practice suggests that SAR Groups wishing to support volunteer healthcare providers during Medical Rescues, ensure that quality assurance systems are in place regarding licensure, scope of practice, training, provision of care, liability and insurance. Practically this will often require a medical director and/or medical advisory committee, ideally at the local level as well as regional and provincial levels.

For medical doctors who choose to become involved beyond just caring for a patient during a rescue, it is important to understand the different roles and take steps to mitigate potential professional risk and liability. There are five common scenarios for SAR volunteer medical doctors.

1. Backcountry Medic. Responding to a call as a GSAR provider or resource member where your role is to provide medical care to the subject.
2. Online Medical Direction. Providing real time advice to a non-MD backcountry medic. Using phone, radio or other means, you discuss a case with a first aid or healthcare provider, provide your opinion and possibly suggest or delegate care for the patient.
3. Offline Medical Direction. Prior to any care being provided, you assist to develop care protocols, assist with acquisition of equipment, +/- provide prescriptions for medications to be given by licensed providers who are not prescribers (i.e. Paramedics or nurses).
4. Medical Advisory Committee Member. You provide your medical opinion to the committee but you are not the organization's medical director.
5. Medical Director. You become the medical director for the organization.

Liability and risk management in SAR is complex and all licensed healthcare provider would be wise to obtain their own advice specific to their own circumstances. For medical doctors who are members of the CMPA, it is important to understand that the CMPA is a mutual defence organization, meaning that when a doctor joins CMPA they agree to collectively share the costs, risks, benefits of other CMPA members. CMPA is not an insurance company, as it does not underwrite an individual doctor's risk through a contract of insurance, and it does not regulate the practice of medicine.

The CMPA extends discretionary assistance to members who experience medical-legal difficulties from their medical professional work (based on the facts and circumstances of a member's particular situation). In an attempt to provide good information (current as of March 2024), the authors of this paper have contacted the CMPA. Important principles to help stay within the reach of CMPA assistance include:

1. Operate within your area of expertise and scope of practice.
2. Obtain consent (ensure you and the patient understand the special risks of providing care in the backcountry).
3. For non-residents of Canada, confirm and ideally document that the governing law and jurisdiction is within Canada.

4. For online and offline medical direction, understand the licensure, scope of practice and delegation rules for any non-MD providers that are part of your SAR care team.
5. Understand that CMPA assistance is generally available to members for matters arising from their medical input, but not for matters related to non-clinical acts that members perform in their administrative role (i.e. clinical practice guideline development and prescriptions would likely be eligible for assistance but non-medical aspects of administration would not).
6. For any formal organizational roles (i.e. Medical Director), Members should obtain, in writing, confirmation from the organization that it will provide full defence and full indemnification for any legal matter arising from their administrative role. Members should carefully review all indemnification clauses in any contract or agreement with their personal lawyer prior to signing it. Note: the SARVAC policy will apply if the Medical Director position is officially part of the SAR Unit and the position is occupied by a medical doctor who is a member of that SAR Unit.

The Canadian Nurses Protective Society (CNPS) offers legal advice, risk-management services, legal assistance and professional liability protection related to nursing practice in Canada. The authors of this paper did not contact the CNPS and this paper has not investigated nursing specific SAR backcountry rescue issues.

# SAR Models of Care for Medical Rescue

For severely injured or ill patients, first aid alone may not be adequate and health care services may be required to preserve life or alleviate harm. In the context of SAR emergencies, health care services beyond first aid that are often required may include:

- administration of prescription medications
- joint manipulation
- procedures which go below the skin or into a body cavity (i.e. chest decompression, tracheal intubation)
- advanced diagnostics (i.e. electrocardiogram)

Many SAR Groups across BC have SAR volunteers who are also licensed healthcare providers. Several effective healthcare service delivery models have been developed by SAR groups to provide patients with essential care during backcountry Medical Rescue.

SAR group Models of Care:

A. Limited Scope Model (i.e. First Aid Only).
B. Volunteer Licensed Healthcare Provider(s) operating without written SAR Group policy.
C. Third-party Medical Direction for Specific Advanced Protocols.
D. Volunteer Licensed healthcare Providers operating using SAR Group provided and administered equipment, medications, clinical practice guidelines and quality assurance.

As per EMCR POG 1.11, all SAR Groups must have 7hr first aid providers available and are recommended to have advanced first aiders available in the field ready to care for injured volunteers, see above SAR First Aid Guidelines and Equipment for more information.

Model A: Limited Scope Model (i.e. First Aid Only)

For SAR groups that have licensed health care providers but decide to limit the scope of care delivery, it is recommended to create written policy to that effect, including the reasons the SAR group need to limit care (i.e. Absence of government support for provision of licensed healthcare services [medical care] and lack of in-house expertise to facilitate quality assurance). Having such written policies in place will assist the licensed healthcare provider to meet their ethical and licensing obligations. For example, paramedics have a duty to consider the well-being of the patient and to help them receive the best possible emergency health care (Code of Ethics (a) and (b)) but they must also follow the rules of their employer (Code of Ethics (b) and (g)). The EMALB Spring 2019 Newsletter specifically addressed this issue and confirmed that an employer may decide to limit a provider's scope of practice to services that the organization can support (equipment, training, risk management, quality assurance). For example, a SAR group might have several experienced OFA medics and PCP paramedics who have been operating to their respective scopes for years when a new ALS

paramedic volunteer joins the group. The SAR group might decide they don't have the ability to safely support the provision of ALS care in the SAR environment, in which case it would be helpful to write organizational policy that specifies scope of care limitations (Reference: Appendix E: EMA (Paramedic) License Categories, Endorsements, Scope and Ethics)

Model B: Independent Volunteer Licensed Provider

Health care professionals who are licensed for independent practice (doctors, paramedics, RNs) can provide care up to their level of licensure (March 19, 2014 Search and Rescue Joint Health and Safety Committee Minutes) provided their SAR group, SAR manager and the chain of command are supportive of such care. Unfortunately, EMCR policy specifically attempts to exclude 'licensed healthcare services' from their support, see Appendix E: EMCR Medical Rescue Policy Highlights. Practically, it can be challenging for non MD licensed providers to acquire the equipment and medication they require to provide care because of cost and regulations (i.e. EMALB providers cannot access prescription medications without the support of a physician). In the absence of formal written policy, the SAR group, the volunteer licensed provider and anyone involved in the procurement of equipment and medications will be exposing themselves to some risk and each of those parties will need to plan for liability and legal defense coverage. SAR Groups and volunteers signed into the task get protection from the SARVAC policy, provided the care delivered is within the scope of the provider's license. EMALB licensed providers who purchase private insurance through their provincial organization have additional coverage. RNs who are members of the Canadian Nurses Protective Society (CNPS) and MDs who are members of CMPA, can access individual assistance, see SAR Medical Direction for more information.

Model C: Third-party Medical Direction for Specific Advanced Protocols

The authors of this paper do not have the expertise to evaluate the risks and benefits for individual SAR groups of using third-party companies for the provision of advanced care training, equipment, medications, guidelines and quality assurance. Some third-party companies have years of experience supporting providers to deliver advanced care protocols. The administrative expertise and support of third-party companies may be particularly attractive to volunteer organizations. Many SAR groups in BC use companies like Peak and Odyssey as a turnkey solution to enable volunteer advanced care providers to deliver specialized care such as anaphylaxis management (epinephrine), advanced pain management (Entonox) and AED for cardiac arrest. Issues that will likely be important for SAR groups and members to understand include:

1. EMALB licensed members may be prohibited from using a certain type or class of medication based on their EMALB scope but that same medication or class of medication may be part of third-party medical training and guidelines. (i.e. EMA FR is not allowed to provide sympathomimetics (epinephrine) based on Emergency Medical Assistants Regulation , B.C. Reg. 210/2010, s.8(2)(a) and Schedule 1 but might be part of third-party medical training). Based on a historical EMALB decision, EMALB licensees could face discipline from the EMALB if they provide an out-of-scope medication and a complaint were lodged (even under the direct oversight of a licensed physician, unless the provider is an ACP, CCP or ITT and they consult with a medical practitioner who is designated by an employer as a medical oversight advisor).

2. Delegation of medical acts to unlicensed providers is a complex area of law, outside the scope of this paper, however the BC government scope of practice website states that a college bylaw is required before a licensed provider can delegate a restricted activity to an unlicensed provider. In emergency situations, when a licensed provider is not physically available, virtual consultation by phone or radio may provide opportunities for enhance patient care, particularly when equipment and advanced training have been put in place.

3. Third-party Medical Companies have expertise with the equipment, medications and guidelines they provide. They may not have expertise with the local complex rescue environment and therefore their responsibility is presumably limited to the use of their equipment and medications within the context of their clinical practice guidelines. Responsibility for task level decisions and advanced care delivery in the complex rescue environment are shared between the volunteer advanced care provider and the SAR chain of command. In other words, SAR Groups can likely expect third-party Medical Companies to own problems caused by specific guidelines (i.e. wrong medication dose) but don't expect third-party Medical Companies to take responsibility if a volunteer uses the provided equipment or medication in a way that deviates from guidelines (i.e. improvised care during times of cognitive overloaded or limited resources caused by a complex rescue environment). SAR volunteers, managers and the task chain of command are ultimately responsible for the care provided.

Model D: SAR Group 'In-House' Medical Direction

Volunteer Licensed healthcare Providers (i.e. EMALB paramedics, MDs, RNs) operating using SAR Group provided and administered equipment, medications, clinical practice guidelines and quality assurance. Several teams around the province have developed robust in-house medical direction programs, usually involving MDs providing medication prescriptions, in-house equipment and medication logging systems as well as a multi-disciplinary medical advisory committee to facilitate case review and quality assurance. Examples include:

I. **Offline Medical Direction Model:** Paramedics are the primary rescue medics, operating within their scope of practice, utilizing the BCEHS CPGs, quality assurance provided by the SAR Groups MAC. An offline MD who is part of the MAC writes the prescriptions for all the medications. The SAR group and the involved physician(s) have taken steps to ensure that adequate liability insurance is in place both for those signed into specific tasks and for those providing offline medical direction who may not be signed into the task.

II. **Online MD Medical Direction Model:** Paramedic, RN and MD response model. All providers can provide direct patient care (depending on task scenario, provider availability and skills) within the scope of their own license. Individual MDs signed into the task provide task specific medical direction. For care that requires delegation or clinical advice, if an MD is not onsite, an offsite MD will sign into the task and provide remote real time medical direction. A single MD usually prescribes all of the team medications. Licensed paramedics can administer in scope medications independently, while other providers (i.e. nurses) require a prescribing MD (onsite or remote) to delegate the medication administration task.

Note: For any model that has providers carry Controlled Drugs and Substances (i.e. narcotics), there is some risk of legal peril, see Drugs and Medications for more information.

# Expenses and Funding

SAR Groups use a variety of fundraising and revenue streams for the up-front purchase the equipment and supplies they require to successfully perform SAR tasks. In contrast, for non-Medical Rescues, most costs (such as supplies consumed or broken equipment) incurred during a SAR response are reimbursed by EMCR.

When it comes to first aid and medical supplies consumed during SAR tasks, EMCR has chosen to limit their reimbursement to care within the scope of occupational first aid. For those wishing to understand the policy, s.2.12.4 suggests that operational expenses and equipment replacement will be reimbursed but s.2.12.4(5) states that when it comes to 'licensed medical services', EMCR will only provide workers' compensation and liability coverage (not the operational expenses and equipment replacement reimbursement typical of all other SAR activities), see EMCR Policy s.2.12.4(5). EMCR has operationalized this policy by agreeing to reimburse supplies and equipment that are listed in the SAR OG 1.11 First Aid Kit contents but refusing to reimburse supplies and equipment that are not listed unless specifically approved by a regional manager.

It is the opinion of the BCSARA MAC that EMCR should develop policy that supports the reimbursement of any first aid or medical supplies and equipment, consumed or damaged during a Medical Rescue task (considering they were necessary to preserve life, limb or function, alleviate harm, treat pain and facilitate transport of the subject to a location suitable for handover to BCEHS). If EMCR does not have the expertise to approve expenses related to medical services beyond first aid, the BCSARA MAC can offer assistance or EMCR could consider collaborating with BCEHS. Ideally, BCSARA would also work with BCEHS or PHSA to provide SAR teams access to the Product Distribution Center, an existing government program currently providing BCEHS and other government entities discounted pricing for the up-front purchase and replacement of first aid and medical supplies.

Thankfully many BCEHS employees are aware that SAR teams are not reimbursed for supplies consumed during Medical Rescues and often offer during patient handover to replace items used on a task from excess ambulance stock. This courtesy is helpful when offered but cannot extend to drugs or big-ticket items. As a result, SAR Groups absorb both the up-front and rescue related costs of all drugs and medical supplies/equipment beyond the scope of first aid.

With respect to helicopter transport, EMCR reimburses the cost but has a policy that subjects must be transferred to BCEHS at the closest earliest opportunity. This policy could benefit from revision to include considerations for optimizing care for the patient and other government resources. An obvious example would be a patient who clearly needs helicopter transport all the way to hospital to prevent harm to life or limb but BCEHS does not have a helicopter immediately available. Ideally, the BCEHS dispatcher and transport advisors could work with the SAR team to optimize the care of the patient and location of transfer

to BCEHS. Sometimes this might include having the SAR team fly all the way to hospital for transfer to BCEHS rather than landing at the closest roadside.

# Appendix A: Emergency Health Services Act Highlights

In summary, relevant to the topic of Medical Rescue, the *Emergency Health Services Act*, R.S.B.C. 1996, c. 182, gives BCEHS the exclusive legal responsibility for providing ambulance and emergency health services (first aid or other health care without delay) to every person in British Columbia who needs urgent treatment for a life threatening or severe illness and are not in a healthcare facility or at work. Backcountry Medical Rescue, relies on longstanding arrangements with ECC to have SAR groups act on BCEHS's behalf to facilitate the service.

The *Emergency Health Services Act*:

- **Creates** the BCEHS corporation (s.2) whose purposes (s.5) include:
  - providing ambulance services and emergency health services (s.5.1(1)(a))
  - entering into agreements for the purposes of providing ambulance services and emergency health services (s.5.1(j)(i))

- **Defines** "emergency health services" as first aid or other health care provided in circumstances in which it is necessary to preserve a life, prevent or alleviate serious harm (or pain) but does not include services provided through a facility (hospital, mental health center, assisted living or community care facility)

- **Prohibits** others from providing ambulance and emergency health services (s.5.1(3)) **unless**:
  - they are acting on behalf of the BCEHS in accordance with an agreement or arrangement (s.5.1(3)(b)(i))
  - the person, who is NOT employed for that purpose or doing so for personal gain, is acting as a Good Samaritan (s.5.1(4)(a))
  - they are providing care in accordance with the *Workers Compensation Act*, R.S.B.C. 2019, c. 1 (s. 5.1(4)(b))

# Appendix B: Emergency and Disaster Management Act Highlights

In summary, relevant to the topic of Medical Rescue, the *Emergency and Disaster Management Act*, S.B.C. 2023, c. 37 requires EMCR to coordinate the mitigation, preparation, response and recovery relating to threats to health, safety and well being caused by incidents that are beyond the capability of the mandated emergency service providers. Important to understand is that the Act does NOT give EMCR a government mandate to invest in the actual provision of emergency ambulance, first aid or medical care (healthcare services) but rather to coordinate when multiple jurisdictions or agencies need to cooperate.

Relevant to SAR groups, the Act also puts EMCR in charge of authorizing organizations status as Public Safety Providers (including SAR groups) and gives EMCR the power to set standards, protocols and procedures.

The *Emergency and Disaster Management Act*, Bill 31 – 2023 (replaced the *Emergency Programs Act*, R.S.B.C. 1996, c. 11) on November 8, 2023:

- **Requires** the government have an Emergency Management Office (Division 2), the purposes of which include providing oversight, leadership and coordination of emergency management activities (s. 12).

- Important **Definitions** include:
  - "critical incident:" a single incident requiring prompt coordination to protect health, safety or well-being where the actions required are beyond the capability of the responsible emergency service provider (s. 1).
  - "public safety provider" means a person authorized to act as a public safety provider under section 30 (s. 1).
  - Four phases of emergency management: mitigation, preparation, response and recovery (s. 3(1)).

- Important **Sections** include:
  - Section 30 "Authorization of public safety providers", lays out the process for application and authorization of specialized volunteers.
  - Section 31 "Standards, protocols and procedures", grants the province the power to require training, qualifications, criteria, standards, protocols or procedures but it does not compel it to do so.
  - Section 32 "Requests for deployment", volunteer deployment may be requested in response to a critical incident by various parties, including police or emergency health service.
  - Section 154 "Protection against legal proceedings", outlines the limited legal liability protection afforded to persons, PSP's, their volunteers, and their directors.

# Appendix C: Health Professions Legislation Highlights

In BC, healthcare professionals regulated under the *Health Professions Act, R.S.B.C., c. 183* include: chiropractors, dental professionals, dieticians, doctors massage therapists, midwives, naturopaths, nurses, occupational therapists, optometrists, pharmacists, physical therapists, pediatrists, psychologists, speech and hearing professionals and traditional Chinese medicine/acupuncture. Each healthcare profession has their own college or licensing board that regulates the profession, and individual practitioners are responsible for understanding their scope of practice and only providing care within the scope of their competence and license. Emergency medical assistants (paramedics) are slightly different in that they are legally created by the *Emergency Health Services Act* and the EMALB is their regulatory body, rather than their own regulatory college.

The *Health Professions Act*, provides the legislative foundation for regulation of BC healthcare. The BC MOH webpage on Professional Regulation provides a good overview of scope of practice and Restricted Activities. It is the also the only place that specifies the rules for delegation of Restricted Activities. A proposed comprehensive list of Restricted Activities is published on a MOH webpage, but has not been added to the *Health Professions General Regulations*. The regulations for the health profession do provide some guidance when it comes to Restricted Activities and the individual college bylaws may or may not provide further guidance.

**Nurses**:

- Nurses (Registered) And Nurse Practitioners Regulation, B.C. Reg. 284/2008 link. Specifies which Restricted Activities can be provided independently and which require an order from a healthcare professional.
- BC College of Nurses and Midwives, Scope of Practice, Delegation website provides comprehensive information regarding delegation to both licensed and unlicensed healthcare providers.

**Doctors**:

- *Medical Practitioners Regulation*, B.C. Reg. 416/2008 link. Specifies that a registrant in the course of practising medicine may perform any restricted activity.
- College of Physicians and Surgeons of BC Laws and Legislation webpage and bylaws provide extensive information about delegation to licensed physician assistants but seemingly no guidance on delegation to other healthcare professionals or unlicensed members of healthcare teams.

**Paramedics** (Emergency Medical Assistants)

- *Emergency Medical Assistants Regulation*, B.C. Reg. 284/2008 link. Specifies the specific services that may be provided by each license category.

- Paramedics are licensed for independent practice, and the specific services they can provide are detailed in their regulations, see Appendix E: EMA (Paramedic) License Categories, Endorsements and Scope for further information. An oversimplification is:
    - FRs can provide first aid+ but not transport the patient
    - EMRs can provide OFA level 3+ and transport the patient
    - PCPs with endorsements can add IV/IO, some prescription medications, advanced airway, ECG, and needle chest decompression.
    - ACPs perform advanced cardiac resuscitation, have better medications (i.e. opioids, ketamine), more airway tools including cricothyrotomy, can reduce joints when the limb is threatened, have numerous critical care tools and tremendous training and experience managing sick patient in the prehospital care setting.
    - CCPS having even more tools including paralytics for airway management.
- Delegation of tasks to other members of the emergency team is a daily part of paramedic work but their regulations do not provide any ability for delegation of Restricted Activities to unlicensed providers.
- Delegation of tasks by other healthcare practitioners to paramedics is referenced in the EMA regulations as follows: ACPs, CCPs and ITTs may administer medications not otherwise listed in their regulations after consultation with a medical practitioner designated for oversight.
- Assisting patients to take their own prescribed medications, is allowed for FRs and above with endorsement.

# Appendix D: EMCR Medical Rescue Policy Highlights

As per EMCR Policy 2.12: Search and Rescue :

"The BCEHS may only request GSAR Volunteers to conduct task eligible activities in the context of a Medical Rescue."

Table 1: Task Number Eligible Response Activities

| Task Eligible GSAR Response Activities by Requesting Agency. | | | | | | |
|---|---|---|---|---|---|---|
| GSAR Response Activity[1] | Police of Jurisdiction | BC Emergency Health Services | Canadian Forces or Canadian Coast Guard | Parks Canada | BC Coroner Service | Fire Services |
| Missing persons | ✓ | | | ✓ | | |
| Persons in distress | ✓ | | | ✓ | | ✓ |
| Evidence search | ✓ | | | | | |
| Medical rescue | | ✓ | | | | ✓ |
| Downed aircraft/persons or vessel in distress | | | ✓ | | | |
| Search and recovery of human remains | | | | | ✓ | |
| Domestic animal rescue[2] | ✓ | | | | | |

[1] GSAR Groups will conduct response activities in support a Requesting Agency only through the application of appropriate techniques associated with their EMBC recognized skills and capabilities as described in 2.12 Annex.

The EMCR Provincial Search and Rescue Operating Guidelines OG #1.11 specify:

"GSAR volunteers are to only provide first aid to the level they are certified in, this is for their and the subject's safety as well as to stay within policies and limitations for liability coverage. At the first opportunity the injured subject is to be transferred to ambulance personnel."

In the March 19, 2014 Search and Rescue Joint Health and Safety Committee Minutes, the committee stated the following:

"a licensed BCAS Paramedic can perform first aid in the field on a SAR call to their level of training, meaning if you're a BCAS paramedic but on a SAR call you can treat that person with your paramedic skills to your level of training."

"If the situation occurs that the SAR volunteer/BCAS Paramedic is higher trained than the attending ambulance crew and the patient requires that advanced level of care, then the SAR Volunteer/BCAS Paramedic can travel in the ambulance with the patient. This is the only opportunity a SAR volunteer can ride with an ambulance crew and deliver treatment. SAR volunteers (non paramedics) are NOT permitted

at any time to accompany or provide treatment in the back of an ambulance. If the SAR Volunteer/BCAS Paramedic is required to travel to hospital, BCAS Dispatch must be made aware. Also, BCAS will assume the liability protection for the SAR Volunteer/BCAS paramedic once they place themselves in the ambulance. If a SAR volunteer who is a health care provider is treating a patient, they are to follow established guidelines under their respective license and or organization's policy. SAR volunteers acting as such must make the SAR Manager aware that they are treating at patient in the field. The SAR Manager can contact BCAS dispatch and inform them of treatments occurring so BCAS can respond appropriately."

As per EMCR Policy 2.12: Search and Rescue :

When GSAR groups are tasked, as per s.2.12.4(1) of the EMCR Policy, EMBC provides workers' compensation and liability coverages, reimbursement of operational expenses, and repair and/or replacement of equipment as per current EMBC policy.

BUT, as per EMCR Policy s.2.12.4(5), if the GSAR group provides any "licensed medical services", then EMCR provides *only* workers' compensation and liability coverage. BUT DOES NOT agree to provide "reimbursement of operational expenses, and repair and/or replacement of equipment". The policy goes on to state that the liability coverages for licensed medical service providers is provided by the *Good Samaritan Act*, R.S.B.C., c. 172.

The effect of this policy is to communicate to GSAR groups that EMCR does not wish to support licensed health care services provided during Medical Rescue: they will not reimburse expenses, repair or replace equipment and they hypothesize that any legal liability can be defended under the *Good Samaritan Act*.

# Appendix E: EMA (Paramedic) License Categories, Endorsements, Scope and Ethics

As per the *Emergency Medical Assistants Regulation*, B.C. Reg. 210/2010, EMA license holders may provide only the services specified for their license category as well as any endorsements they have successfully completed and are allowed for their license category. A summary of the services and potential endorsements for each license category are included below.

**EMA FR** (First Responder): scene assessment; assessment of level of consciousness, skin colour and temperature, pulse, and respiration; rapid body survey to identify and attend to any life threatening injuries followed by a secondary assessment consisting of a physical examination, medical and incident history, and vital signs; cardiopulmonary resuscitation; maintenance of airways and ventilation, including by insertion and maintenance of oropharyngeal airway devices and nasopharyngeal airway devices, and use of suction devices and bag-valve-mask devices; oxygen administration and use of oxygen administration equipment; use of automatic and semi-automatic defibrillators; wound management not requiring tissue puncture or indentation; fracture management and immobilization; lifting/loading and extrication/evacuation.

> **Potential FR Endorsements:** spinal motion restriction; administration of oral glucose; emergency childbirth; use and interpretation of pulse oximeters and CO-oximeters; use and interpretation of glucometers; administration of epinephrine by intramuscular auto-injector or intranasal or sublingual preparations; topical administration of pro-coagulants and anti-fibrinolytics; intramuscular and intranasal administration of opioid antagonists; non-invasive blood pressure measurement; intramuscular and intranasal administration of anti-hypoglycemic agents; administration of oral analgesics; administration of acetylsalicylic acid; assistance to a patient with the administration of a medication to the patient, provided that:
>
> - if, under the *Pharmacy Operations and Drug Scheduling Act*, a particular medication is available only on the prescription of a health professional, the medication has already been prescribed to the patient by a health professional,
> - the patient has requested the EMA to assist the patient with the administration of the medication,
> - the administration of the medication is related to emergency services the EMA is providing to the patient,
> - the medication is administered as prescribed, and
> - the patient is not being transported between health facilities;

**EMR** (Emergency Medical Responder): FR plus occupational first aid, transportation, and soft tissue injury treatment.

**Potential EMR Endorsements:** maintenance of intravenous lines without medications or blood products; chest auscultation; intramuscular administration of epinephrine; administration of bronchodilators by inhalation and nebulization; administration of the following oral, sublingual or inhaled medications:

- anti-anginal;
- analgesics;
- platelet inhibitors;

**PCP** (Primary Care Paramedic): EMR plus insertion and maintenance of airway devices not requiring visualization of the larynx; maintenance of intravenous lines, including use of infusion devices and saline locks; initiation of peripheral intravenous lines; point-of-care testing to inform emergency treatment or transportation decisions or to provide information for subsequent treatment; end-tidal carbon dioxide monitoring; administration of the following inhaled, intramuscular, intranasal, intraosseous, intravenous, nebulized, oral, subcutaneous or sublingual medications:

- opioid antagonist;
- anti-histaminic;
- sympathomimetic agent;
- procoagulant;
- anti-hypoglycemic agent;
- anti-pyretic;

**Potential PCP Endorsements:** administration of isotonic crystalloid solutions; endotracheal intubation; electrocardiogram acquisition; initiation and maintenance of non-invasive positive pressure airway devices; collection of capillary and venous blood samples; initiation and maintenance of intraosseous needle cannulation with local anesthetic instillation; taking microbiology swabs of dermal and mucosal sites; manual defibrillation with cardiac rhythm interpretation; electrocardiogram interpretation; needle thoracentesis; administration of chemical and biological agent countermeasures; administration of the following inhaled, intramuscular, intranasal, intraosseous, intravenous, nebulized, oral, subcutaneous or sublingual medications:

- anti-emetic — anti-nauseant;
- vitamins;
- corticosteroids;
- opioid analgesics;
- anti-cholinergic;

**ACP** (Advanced Care Paramedic): PCP plus, cardioversion and external pacing; initiation of external jugular vein cannulation; cricothyrotomy; gastric intubation and suction; maintenance of intravenous lines with medications; insertion and maintenance of advanced airway devices which do not require laryngoscopy; administration of colloid and non-crystalloid volume expanders; reduction of joint dislocations involving neurological or vascular compromise; administration of drug therapy after consultation with a medical practitioner who is designated by an employer as a medical oversight advisor and who has advised the EMA

to administer the drug therapy; administration of the following intravenous, oral, nebulized, endotracheal, intraosseous, intramuscular and rectal medications:

- anti-arrhythmic;
- electrolyte — calcium therapy;
- diuretic;
- anti-coagulant;
- sedative;
- anti-emetic — anti-nauseant;
- histamine antagonist;
- anti-convulsant;
- alkalizer;

**Potential ACP Endorsements:** automated mechanical ventilation; urinary catheterization; arterial line management and central venous pressure monitoring; infusion of blood products; collection of arterial blood samples; interpreting laboratory and radiologic data; chest tube management; central line management; management of parenteral feeding lines and equipment; provision of trans-venous pacing; invasive wound management; subcutaneous application of a local anaesthetic; finger thoracostomy.

**CCP** (Critical Care Paramedic): ACP plus, initiation of arterial lines; use of incubators for thermoregulation; chest tube insertion; initiation of central venous line; escharotomy; esophageal manometry; pericardiocentesis; mechanical ventilation management and strategy development.

**Paramedic Code of Ethics:** Emergency Medical Assistants must:

a) consider, above all, the well-being of the patient in the exercise of their duties and responsibilities;
b) develop and maintain working relationships with other health professions and associations to ensure that patients receive the best possible emergency health care;
c) protect and maintain the patient's safety and dignity, regardless of the patient's race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex or sexual orientation;
d) preserve the confidence of patient information consistent with the duty to act at all times for the patient's well-being;
e) not engage in any illegal or unethical conduct nor act in a manner that conflicts with the best interests of the profession;
f) report to the appropriate authorities any incompetent, illegal or unethical conduct by colleagues or other health care personnel;
g) carry out professional responsibilities with integrity and in accordance with the highest standards of professional competence;
h) strive to improve the professional competence of colleagues serving under their direction;
i) assume responsibility for personal and professional development, and maintain professional standards through training and peer mentoring;
j) strive to encourage and merit the respect and trust of the public for members of the profession;

k) refrain from impugning the professional reputation of a colleague or any other health care provider; and

l) promote and encourage compliance with the spirit of these standards within the profession.

# Appendix F: Summary of Legal Liability Protections in BC

**s.154 Emergency and Disaster Management Act**

i. excludes gross negligence and bad faith
ii. must be operating under a task #
iii. does cover SAR Unit registered as PSP's and their Directors
iv. does not protect against defence costs
v. Unclear if it covers provision of medical services

**Government Commercial General Liability Policy**

i. Only a $2m coverage limit
ii. Must be operating under a task #
iii. Does not cover SAR Units or Directors
iv. Has been applied inconsistently in the past
v. Does not protect against defence costs (deductible)
vi. Does not cover the provision of medical services

***Good Samaritan Act***

i. Need not be operating under a task #
ii. excludes gross negligence
iii. Does not cover SAR Units or Directors
iv. Does not protect against defence costs
v. Protects only "medical services or aid"
vi. Protects only those at the immediate scene
vii. Arguably does not apply to SAR at all
viii. Does not protect medical professionals

**SARVAC Liability Insurance Policy**

i. Includes coverage for gross negligence and bad faith
ii. Applies regardless of whether operating under a task #
iii. Covers members of SAR Units, SAR Units (even if not a PSP) and Directors
iv. Defence costs are covered (subject to a deductible)
v. Does cover the provision of medical services, even if a medical professional (Your professional medical insurance might respond first).
vi. Covers licensed SAR Volunteers providing Medical Direction.
vii. Has a $5m policy limit

Northern Insurance Brokers | NAVACORD

# Important Information: Commercial General Liability Insurance

The Commercial General Liability SARVAC Insurance Policy shall respond to third-party claims for Bodily Injury and Property Damage Liability, Advertising Injury and Personal Injury Liability, and Medical Expenses coverage.

**Named Insured:** Search and Rescue Volunteers Association of Canada and its Members

**Term:** 12:01 a.m. September 1, 2023 to 12:01 a.m. September 1, 2024

**Insurer:** Chubb Insurance Company of Canada ("Chubb")

**Policy Number:** 36027667

| General Liability Coverage | Limits | Deductible |
|---|---|---|
| Combined Total Aggregate Limit | $25,000,000 | |
| General Aggregate Limit per team | $5,000,000 | |
| Each Occurrence Limit | $5,000,000 | |
| Products/Completed Operations Aggregate Limit | $5,000,000 | |
| Advertising Injury and Personal Injury Aggregate Limit | $5,000,000 | |
| USA General Aggregate Limit | $2,000,000 | |
| Tenants Legal Liability Limit | $5,000,000 | |
| Medical Expense Limit | $50,000 | |
| **Employee Benefits Errors & Omissions** | | |
| Aggregate Limit | $5,000,000 | |
| Each Claim Limit | $5,000,000 | |
| Retroactive Date: September 1, 2014 | | |
| **Employers Liability** | | |
| Each Person Limit | $5,000,000 | |
| Each Accident Limit | $5,000,000 | |
| **Non-Owned/Hired Automobile** | | |
| Third Party Liability Limit | $5,000,000 | |
| SEF 94 Legal Liabilities for Damage to Hired Vehicles | $100,000 | $1,000 |
| **Forest and Prairie Fire Fighting Expense** | | |
| General Aggregate Limit | $5,000,000 | |
| Each Occurrence Limit | $5,000,000 | |

*Coverages are applicable as per the Policy Declaration; including exclusions, sub-limits of Insurance and other policy clauses.

Any statement of claim should be disclosed to your Broker, who will then report the claim under the policy.

This brochure has been prepared in connection with a group plan underwritten by Chubb Insurance Company of Canada. For ease of reference, it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult the policyholder.

# Important Information: Director's & Officer's Insurance

The Director's & Officer's Insurance Policy shall pay on behalf of an Insured all Loss which such Insured becomes legally obligated to pay on account of any claim first made against such Insured during the policy period, or, if exercised, during the extended reporting period, for;

a) A Wrongful Act

b) Employment Practices

c) Personal Injury or Publishers Liability

* Coverages are applicable as per the Policy Declaration; including exclusions, sub-limits of Insurance and other policy clauses.

## The Definition of Insured:

Insured Person means any natural person who has been, now is or shall become a duly elected director or trustee, duly elected or appointed officer, employee or committee member (whether or not salaried) of an Organization, and any natural person acting in a voluntary capacity on behalf of an Organization and at the specific direction of such Organization.

**Named Insured:** Search and Rescue Volunteers Association of Canada and its Members

**Term:** 12:01 a.m. September 1, 2023 to 12:01 a.m. September 1, 2024

**Insurer:** Chubb Insurance Company of Canada ("Chubb")

**Policy Number:** 8241-1797

## Coverages

**Limits of Liability**: $10,000,000 (Aggregate Limit) including Defence Costs

**Deductible:** None

Any potential incident that could give rise to a claim, should be disclosed to your SAR team, who will then gather all relevant information to provide to the National SAR Executive. Any claim will be reported through the National SAR Executive as the policy owner.

This brochure has been prepared in connection with a group plan underwritten by Chubb Insurance Company of Canada. For ease of reference, it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult the policyholder.

# Appendix G titled "Coverages for Injury or Death"

## Important Information: Special Risk Accident Insurance 2023

The Chubb Special Risk Accidental Death and Dismemberment Plan provides accident insurance coverage while the volunteer is participating in or supervising any volunteer work authorized by the Search and Rescue Volunteer Association of Canada.

All volunteers are automatically covered for an amount of up to $200,000 for accidental loss of life, speech, hearing, sight, limb(s), accidental brain damage or coma and $400,000 for accidental paralysis.

Chubb will pay a weekly benefit of $500 if employed or $100 if not employed, after an elimination period of 14 days for up to 26 weeks if accidental bodily injury causes the volunteer to suffer temporary total disability.

| Additional Benefits | Benefit Amount |
|---|---|
| Child Care Expense | Up to $5,000/child/year, maximum of $25,000 |
| Education Expense | Up to $7,500/child/year, maximum of $30,000 |
| Excess Accident Medical Expense | Up to $10,000 |
| Family Travel Expense | Up to $15,000 |
| Funeral Expense | Up to $5,000 |
| Home Alteration or Vehicle Modification | Up to $15,000 |
| Identification Expense | Up to $15,000 |
| In-Hospital | $100/day for up to 31 days after a 3-day elimination period |
| Medical Evacuation and Repatriation | Up to $15,000 |
| Psychological Therapy Expense | Up to $5,000 |
| Rehabilitation Expense | Up to $15,000 |
| Spouse Employment Training Expense | Up to $15,000 |

**Exclusions:**

There are certain situations we do not cover in our policy. These include:

- Owned Aircraft, Leased Aircraft or Operated Aircraft
- Aircraft Pilot or Crew
- Disease or Illness
- Incarceration
- Service in the Armed Forces
- Suicide or Intentional Injury
- Trade Sanctions
- War

This brochure has been prepared in connection with a group plan underwritten by Chubb Insurance Company of Canada. For ease of reference, it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult the policyholder.

**Search and Rescue Volunteer Association of Canada and its Members**
Policyholder Name

**6405-99-93** — **BC073**
Policyholder Number — Certificate Number

**September 1, 2023 - September 1, 2024**
Policy Effective Date

**Vernon Search and Rescue Group Society**
SAR Team Name

**20181081**
SAR Volunteer's Name — Association Number

The volunteer, or someone acting on the volunteer's behalf, must notify Northern Insurance Brokers within 30 days of the date a claim arises under the policy. Notification may be in writing:

**Mailing Address:**
Northern Insurance Brokers Inc.
200-855 Queen Street East
Sault Ste. Marie, Ontario P6A 2B3

**Toll-Free:** (888) 525-4662
**Email:** sarvac@northernins.ca