Legal Barriers to Humanitarian Intervention in Natural Disasters

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>5</td>
</tr>
<tr>
<td>Background and Context</td>
<td>6</td>
</tr>
<tr>
<td>Domestic Case Study: Potential Catastrophic Earthquake in British Columbia</td>
<td>8</td>
</tr>
<tr>
<td>Foreign Case Study: Retrospective 2015 Nepal Earthquake</td>
<td>14</td>
</tr>
<tr>
<td>Conclusion</td>
<td>19</td>
</tr>
<tr>
<td>References</td>
<td>20</td>
</tr>
<tr>
<td>Appendix</td>
<td>24</td>
</tr>
<tr>
<td>Endnotes</td>
<td>27</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

When a natural disaster strikes, local governments often require immediate assistance in the form of external domestic and foreign humanitarian aid. Most jurisdictions can trigger emergency legislation, such as a declaration of calamity, to lower legal constraints and facilitate the deployment of aid. However, humanitarian organizations (HOs) face a tension between the need to respond quickly and the need to abide by the laws and regulations of the jurisdiction(s) affected. The lack of clarity regarding international and domestic rules, and the scarcity of time and resources to enforce such rules by authorities, may hinder the ability of these organizations to deliver health interventions efficiently, effectively and with the appropriate degree of risk.

In the process, HOs face a variety of legal challenges related to the deployment of medical personnel and controlled substances. In particular, permits to travel, licensing requirements, and liability for medical personnel, and controlled substances deemed necessary for any given health response vary by jurisdiction, both domestically and internationally.

This report aims to help prepare HOs prior to humanitarian intervention in a natural disaster as well as serve as a guide to governments and the judiciary in developing laws, policies and regulations to address the legal challenges facing health intervention during disaster relief. It examines the legal barriers to the deployment of medical personnel and the movement of controlled substances in the context of two case studies: (i) a potential catastrophic earthquake in British Columbia (BC), Canada; and, (ii) a retrospective analysis of the 2015 Nepal earthquake.

5 Key Messages

1. Engaging domestic emergency legislation triggers humanitarian response and lowers legal barriers for HOs.

2. Deployment processes for HO physicians can be streamlined through federal, provincial and territorial mutual aid agreements with HOs.

3. Domestic emergency legislation and mutual aid agreements are proactive strategies to indemnify physicians from tort liability, assuming conduct does not amount to gross negligence.

4. Adopt and adapt provisions from IDRL Guidelines into emergency legislation to facilitate the entry of international HO assistance within disaster-prone countries.

5. The movement of controlled substances during disaster relief efforts remains a complex venture. Legislative prohibitions and requirements, export restrictions, and customs issues can impede the supply of life-saving medication.
1. BACKGROUND AND CONTEXT

1.1 Introduction

Responding to a large-scale natural disaster requires coordination and preparedness. When the needs on the ground surpass local capacity, humanitarian organizations (HOs) provide life-saving support for affected populations.

HOs face significant legal challenges during the deployment of medical personnel and controlled substances following the immediate aftermath of a natural disaster, in both domestic and foreign contexts. Not only do assisting personnel need to meet travel permits and licensing requirements, but issues of liability may also arise for both medical personnel and the organizations that send them. Without the timely entry of medical personnel and resources, affected populations cannot receive urgently-needed medical treatment to survive. Ineffective or poorly understood domestic legislation may also lead to a bottleneck of controlled substances at customs instead of reaching those in need.

HOs typically rely on goodwill and the principle that it is better to respond than not respond. Even with the best of intentions, negligence may arise in the provision of relief and response. Nevertheless, HOs should strive to intervene in an emergency in both a legally-disciplined and efficient manner. In doing so, they can reduce the risk of liability for their organization as well as their personnel, and ensure that affected populations receive the highest level of care possible.

HO’s interventions in response to natural disasters are governed by International Disaster Relief Laws (IDRL), which provide a different legal framework for response, as opposed to International Humanitarian Law, which only applies in the context of armed conflict. This report is anchored in the tension between the humanitarian imperative to act quickly when faced with unforeseeable health emergencies and the need to understand and comply with legal and regulatory requirements in the affected jurisdiction.

Given the operational challenges to humanitarian aid, how can HOs better prepare themselves to minimize legal risk and deploy medical personnel and controlled substances in a more timely and efficient manner in the immediate aftermath of a disaster?

To answer this question, this report analyzes two case studies: (i) a potential catastrophic earthquake in British Columbia (BC), Canada; and, (ii) a retrospective analysis of the 2015 Nepal earthquake. These case studies will be informed by comparable real-life HO responses, such as the Fort McMurray wildfires response in 2016. The following three issue areas deriving from a standard response to a natural disaster emergency will be examined throughout the analyses:

- Deployment of Physicians
- Liability for Physicians
- Movement of Controlled Substances

Ultimately, the report aims to better equip HOs with the knowledge to effectively deploy and legally protect medical personnel, in particular physicians, and controlled substances during natural disaster emergencies both domestically and abroad.

1.2 Legal Challenges Faced During a Humanitarian Relief Intervention

An inherent part of humanitarian intervention is the tension between the need to provide immediate life-saving assistance to affected populations and the provision of assistance meeting domestic legal and regulatory standards. In real-time, humanitarian emergency assistance can, and does, by necessity get provided in an ad hoc and rushed manner.

While it must be acknowledged that HOs face constraints, such as financial and administrative considerations, it is more
efficient for HOs to prepare themselves before a disaster strikes. This will ensure that they have already met required standards, and have systems or agreements in place to respond despite the domestic legal and regulatory obstacles. Assistance can thus be provided to affected populations quickly and safely for all involved.

The following non-exhaustive list contains three issues that are the most significant barriers that HOs face when responding to a domestic or overseas natural disaster emergency:

- **Deployment of Physicians:** What are the barriers to the effective deployment of physicians (permission to enter disaster site and licensing requirements) in different jurisdictions and how can HOs ensure that they meet these requirements?

- **Liability for Physicians:** What are the ethical implications during health responses when physicians commit medical malpractice yet are unlikely to be successfully sued? How can HOs balance the need to protect themselves from liability while still supporting their personnel?

- **Movement of Controlled Substances:** What is the effect of different legislations on controlled substances and how can HOs ensure that their medical supplies reach affected populations when needed?

The remainder of this report will answer these questions using: (i) a case study of a potential catastrophic earthquake in BC, Canada; and, (ii) a retrospective analysis of the 2015 Nepal earthquake. In doing so, best practices and recommendations will be identified to help HOs and policymakers better negotiate the legal obstacles to efficient and effective health responses.

### 1.3 Stages of Natural Disaster Response

Responses to natural disasters are similar whether they take place domestically or abroad, but varying circumstances present slightly different barriers depending on the location of the disaster and who is sending support. Generally, when disaster strikes, the local authorities conduct a needs assessment to determine whether they have the capacity to respond to the needs on the ground. If they determine that they are not able to do so, there is often emergency legislation that can be triggered which then sets the entire emergency response into motion: standards for licensing and importation procedures are lowered, thereby reducing or eliminating legal barriers for incoming doctors or medicines from a different jurisdiction. As will be explained in case studies below, the way that Emergency Acts are initiated varies depending on the jurisdiction, but it is a precursor—and a necessity—to allow for HOs to send life-saving medical personnel and controlled substances.

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**Water and Sanitation (WATSAN) Standards for Humanitarian Responses**

While not necessarily a barrier to entry, HOs must meet certain minimum standards in delivering health interventions, especially in the area of WATSAN. There is no international convention on the required minimum standards during humanitarian responses. However, a group of HOs, the International Federation of the Red Cross (IFRC), and the International Committee of the Red Cross (ICRC) came together to form the “Sphere Project”. Published in 2000, this project provides minimum standards for humanitarian intervention in the context of water. Although it is not legally binding, the project is widely recognized as the minimum standards for humanitarian interventions (1).
2. DOMESTIC CASE STUDY: POTENTIAL CATASTROPHIC EARTHQUAKE IN BRITISH COLUMBIA

Southwestern BC is located in the Pacific Ring of Fire, an area prone to the world’s largest earthquakes. With a 12% chance within the next 50 years of a catastrophic earthquake occurring, this, as well as the ensuing events (i.e., liquefaction, landslides and a tsunami) would debilitate local government in this region and require the emergency aid from external jurisdictions. The threat also rests in one of BC’s most densely populated regions, the Greater Vancouver Area, translating to over 75 billion dollars in damages – or twice the annual budget of the province (4).

The effects of such damage would be felt almost immediately. Medical personnel and facilities would become overwhelmed and inoperable as injuries would far outweigh fatalities, and transportation routes would be devastated. Under these conditions, the deployment of emergency medical personnel and resources would need to be highly coordinated and robust.

Emergency Management BC (EMBC), an agency within the Ministry of Justice, is mandated to coordinate the management of provincial level emergencies and disasters. However, in a 2014 report by the Office of the Auditor General of BC, the agency was found to be inadequately prepared for a catastrophic earthquake and critiqued for not giving individuals and stakeholders sufficient information to fully appreciate the risks to themselves and their community (4). Following this report, the province issued a BC Earthquake Immediate Response Plan (IRP) to map out the network of actors and cascade the responses that should take effect immediately following the disaster (5).

The IRP calls for a multi-jurisdictional, cross-government and multi-stakeholder emergency response. In the sections below, we provide a legal analysis of this response as it relates to the deployment of medical personnel and controlled substances to BC.

Two emergency statutes govern the health response in a potential catastrophic earthquake in BC: (i) the federal Emergencies Act, which can be triggered during the state of war or conflict; and, (ii) provincial emergency legislation, such as the BC Emergency Program Act (EPA). Since it can be triggered in the context of a natural disaster beyond local capacity to respond, and lowers the legal and regulatory barriers to the deployment of medical personnel and controlled substances, the BC emergency legislation is of greater relevance. If there is a conflict with this Act, emergency legislation prevails during a time of emergency (6).

2.1 Deployment of Medical Professionals

The deployment of out-of-province and out-of-country physicians becomes necessary when local infrastructure is insufficient to provide adequate aid, the scale of a natural disaster overwhelms the jurisdiction, or it is more convenient to deploy physicians from an external source, such as an HO roster, than to deploy locally. It is possible that a pan-Canadian and overseas mobilization of aid will be needed in the immediate aftermath of a catastrophic earthquake in BC.
Competent and adequately qualified physicians will need to be deployed rapidly to the scene of the disaster.

In Canada, medical licensure is administered by provincial and territorial regulatory authorities. The BC Health Professions Act and associated bylaws, administered by the College of Physicians and Surgeons of BC set out the procedure for obtaining a license to practice in the province (7). Physicians licensed out-of-province and from foreign jurisdictions are required to undertake a complex, multi-step licensing equivalency procedure to demonstrate that they meet medical practice standards and are fit to practice in the province.

HOs seeking to deploy physicians to BC therefore need a legal solution to overcome barriers with regards to provincial licensing requirements. This may be achieved by referring
either to the broad ministerial power to waive or modify procedures under Section 10(1)(e) of the EPA (6), or to the Memorandums of Understanding (MOUs) and other agreements on mutual aid between governmental and non-governmental organizations domestically and abroad.

2.1.1 MINISTERIAL POWERS UNDER THE EMERGENCY PROGRAMS ACT

Under Section 10(1)(e) of the EPA, after the declaration and for the duration of a state of emergency, the Minister of Public Safety and Emergency Services may authorize the assistance of any individual qualified to provide aid to help alleviate the effects of the disaster. Section 10(1)(g) also grants the Minister the discretion to manage emergency medical, welfare, and other essential services.

Although broad and somewhat vague, BC’s IRP report noted that ministerial powers could be used to “increase capacity and human resources to support response operations”, citing emergency personnel and first responders as part of a non-exhaustive list of categories that can be called upon for aid in an emergency (5). This provision may also grant the Minister the discretion to waive licensing requirements for foreign physicians providing assistance in BC.

2.1.3 RECOMMENDATIONS

1. The ministerial power to authorize specialized medical aid under Section 10(1)(e) of the EPA is likely a valid exercise of authority in the event of an emergency.

2. Provinces and the Federal Government should conclude detailed agreements similar to the inter-jurisdictional OFMAR on the deployment of medical teams both from Canada and abroad with HOs such as the CRC and IFRC.

3. Modernize the EPA, especially with a view to clarifying roles and responsibilities in the event of an emergency and reflect infrastructure

2.2 Liability for Medical Professionals

This section addresses the liability that out-of-province and foreign medical personnel could face if intervening in a domestic emergency in BC. HOs seek to insulate their employees and their organization from liability to the highest degree possible using provincial emergency powers legislation as well as Good Samaritan legislation.

2.2.1 PROVINCIAL EMERGENCY POWERS AND GOOD SAMARITAN LEGISLATION

As of 2016, all common law provinces and territories have Good Samaritan legislation or an equivalent scheme (11). Generally, these take the form of providing protection for a volunteer and/or a health care professional that voluntarily acts or fails to act, assuming they are not responsible for gross negligence. Good Samaritan legislation aims to encourage bystanders to aid someone in need by providing a legal shield against tort liability. Gross negligence is defined as “very great negligence” and the issue must be left to the trial judge to put the matter to the jury with appropriate references to evidence if necessary (12). Despite its frequencies in statutes, the Supreme Court of Canada has been hesitant to give gross negligence a more precise definition in order to avoid creating degrees of negligence (13). More precise definitions have
evolved in the case law for matters of careless driving, and municipal negligence which are not directly transferrable to physicians.

It is not recommended that HOs rely solely on Good Samaritan schemes as legal protection for physicians deployed to a domestic emergency, as this is a reactive measure. An HO should rely first and foremost on the emergency powers of provincial ministers to insulate their medical personnel. These acts include a companion provision which protects the individual from potential civil liability during the performance of their emergency duties in good faith (14). For example, the BC IRP lists “exemption from civil liability” as a consideration in the use of EPA section 10(1)(e) (5).

Section 10(1)(e) (listed in the previous section) and 18(a)(b) may also be used to indemnify HO medical personnel:

The precarious legal status of field hospitals, and the varying definition of “volunteers” in respective provincial schemes adds a layer of uncertainty when relying on Good Samaritan legislation. Many schemes, such as legislation in Manitoba which contemplates medical professionals, may implicitly exclude them by a provision excluding persons employed expressly for that purpose (16). Insulation from liability hinges on whether HO medical personnel deployed to a province would qualify as volunteers despite still receiving compensation for services rendered in the form of a mission service allowance. Additionally, in the event of a massive emergency, field hospitals will likely be set up to help triage patients. Various Good Samaritan provincial legislation exclude services rendered by a medical professional in a hospital or an ‘adequate medical facility’ and provide protection only for those services rendered on the scene of an accident (17). Case law does not provide an answer to these questions: “The CMPA does not know of any proceedings commenced against Canadian physicians in Canadian courts or in foreign courts alleging negligence in providing emergency medical attention as a good Samaritan” (19). Despite the varying levels of protection offered by provincial schemes, the likelihood of being sued is accordingly quite low (19).

Ministerial Powers, BC EPA

“Section 18 of the Act exempts from liability, among others, volunteers and any other person appointed, authorized, or required to carry out measures relating to emergencies or disasters, for any loss, cost, expense, damage or injury to person or property that results from the person in good faith doing or omitting to do any act that the person is appointed, authorized or required to do under this Act, unless in some or omitting to do the act, the person was grossly negligent, or any acts done or omitted to be done by one or more of the persons who were, under this Act, appointed authorized or required by the person to do the acts, unless in appointing, authorizing or requiring those person to do the acts, the person was not acting in good faith.” (6)(15)

BC, the Good Samaritan Act

BC’s Good Samaritan Act uses “a person” instead of “volunteer” in their clause protecting good Samaritans from liability with the exception of cases of gross negligence (18). However, that section does not apply if the person rendering the medical services or aid, “is employed expressly for that purpose, or does so with a view to gain” (18). The legislation is largely untested, however s.1 may be a weak defence for medical professionals deployed in emergencies given they may be considered to be “employed expressly for that purpose.”
2.2.2 CROSS BORDER LIABILITY: PRIMARY CONSIDERATIONS FOR BRITISH COLUMBIA

Both foreign and domestic doctors that deploy could plausibly be sued by BC residents injured by medical malpractice in a BC Court. The BC Earthquake Immediate Response Plan contemplates that the CRC, US states and international aid agencies will provide healthcare in a catastrophic event (5). Jurisdiction of BC courts in cross-border matters (matters involving people or events that are connected to BC and another Canadian province or territory or a foreign state) are primarily governed by the BC Court Jurisdiction and Proceedings Transfer Act (20). Issues not addressed by CJPTA are governed by common law (22). Establishing jurisdiction is a two-step test. A BC court must have jurisdiction on enumerated grounds (presence, consent, or real and substantial connection) and it also must be forum conveniens (the most suitable forum) (22). Section 10(g) of CJPTA creates a real and substantial connection establishing jurisdiction of BC courts for a tort (physically) committed in BC, which subsumes medical malpractice (20). If a BC court finds that it has jurisdiction simpliciter, the defendant can attempt to challenge jurisdiction based on forum non conveniens (22). The doctrine empowers a court to decline jurisdiction if they believe another forum is more competent to hear the case (21). However, for a tort that physically occurred in BC, where the witnesses and evidence may also be physically located, it is unlikely that a BC court will decline jurisdiction based on forum non conveniens (20).

Another consideration in a cross-border dispute is the applicable law. Once a BC court has established its jurisdiction, it will determine which substantive law (the law of BC or another jurisdiction) will apply to the matter. A well-established rule in choice of law is that the law of the place of the tort applies (lex loci delicti), in this case BC where the victim was injured (21). Most Canadian jurisdictions consider the quantum of damages a procedural issue, governed by the law of the forum, which means that if a foreign law were to apply, the Canadian quantum of damages would still be applicable (22). This is particularly relevant since Canada has a cap on non-pecuniary damages, although settlements can be above this cap (23). For example, a BC resident injured by a US doctor may find it advantageous to establish the physician’s state as the appropriate jurisdiction to avoid Canada’s cap on non-pecuniary damages and to potentially receive a higher award.

The judgment of a BC court awarding damages may have to be enforced in another jurisdiction, depending on the domicile, residency and/or location of assets of the foreign doctor (22). The willingness and ability of the foreign court to enforce a Canadian monetary judgement are dependent on the conflict rules of that jurisdiction.

2.2.3 RECOMMENDATIONS

1. HOs should consult with the Minister to explicitly include CRC medical personnel in the declaration of Sections 10(1)(e) and 18(a)-(b) as a proactive strategy to indemnify personnel.

2. HOs should consult the province to include the CRC in their OFMAR Mutual Aid Agreement section 8 on liability indemnification to insulate staff intervening inter-provincially (9).

3. Certain HO medical personnel, including those affiliated with CRC and Médecins Sans Frontières (MSF), receive professional liability insurance (24). CRC and other organizations should speak of their medical personnel in official publications in the context of humanitarian spirit and volunteerism as MSF does (24). This could provide evidence suggesting medical personnel should be categorized as volunteers should litigation occur.

2.3 Movement of Controlled Substances

In the event of a catastrophic earthquake in BC, national and international HOs may be required to intervene and supply the province with appropriate controlled substances. Regardless of
where the controlled substances are being supplied from, all HOs will only be able to possess, transport, and use medication approved in Canada. During Fort McMurray, the emergency response was largely focused on providing psychosocial support.

Drug approval is completed through a federal review process. However, each province’s health plan formulary holds the decision making power over drug coverage. This is completed by listing the specific drugs that will be financially covered in part or whole by either public or private health care plans (25).

2.3.1 PROHIBITION

Without a license or authorization under the relevant legislation and regulations, including the Controlled Drugs and Substances Act (CDSA), the Food and Drugs Act (FDA), Food and Drug Regulations (FDR), the Narcotic Control Regulations and Benzodiazepines and Other Targeted Substance Regulation, HOs are prohibited from possessing, storing, transporting, and using, narcotics. Depending on the type of controlled substance, which schedule it is listed under the CDSA, and the quantity involved, a HO could face penalties, including criminal charges (See Fig 2) (28).

2.3.2 INTERNATIONAL INTERVENTION

For an international HO to import any controlled substance across Canadian borders, all relevant provisions in governing acts and regulations must be met (29). The Canada Border Services Agency (CBSA) will take actions at the border and prevent products that are prohibited, or pose an identified unacceptable risk to the health and safety of Canadians (30). The delays in the request for, review of, and approval of such an exemption, can reduce intervention efficiency.

2.3.3 COST RECOVERY

The cost recovery of storage, delivery, and distribution of controlled substances could be a barrier facing HOs. There is limited information as to whether there are cost-sharing
schemes available for HOs and provincial counterparts following the delivery and use of controlled substances in an emergency.

2.3.4 RECOMMENDATIONS

1. To facilitate a more rapid and effective response, the provincial, territorial, and federal governments should develop a deployment agreement to streamline the movement of controlled substances by HOs during an emergency. This should be done prior to an emergency and in collaboration with key HOs. The joint agreement should include:

   a. Clear instructions on how to apply for exemptions or interim orders under relevant legislation, particularly section 56 of the CDSA;
   
   b. Detail whether minimum institutional requirements of HOs are required;
   
   c. Outline which members of HOs medical teams are permitted to possess, transport, export or import controlled substances (e.g. cargo attendants, doctors, etc.);
   
   d. Provide a list of the anticipated and approved controlled substances, including maximum quantities, and preferred suppliers;
   
   e. Develop a cost-sharing scheme as to how financial expenses will be allocated; and,
   
   f. Provide anticipated approval times.

3. FOREIGN CASE STUDY: RETROSPECTIVE 2015 NEPAL EARTHQUAKE

The past few decades have seen a rise in natural disasters overwhelming domestic capacities, compounded by the effects of global warming and the populations living in precarious situations. The 2015 Nepal earthquake is one of the most recent examples of a natural disaster abroad that required a concerted response from the international community. Taking place on April 25, it was the deadliest disaster to hit the Himalayan country, killing nearly 9,000 people and injuring 22,000 (31).

After Nepal declared a state of emergency, HOs such as the ICRC were able to start medically evacuating the critically wounded and treat others in mobile and makeshift facilities (32). HOs were impeded from providing assistance quickly due to the Nepalese government insistence on routing aid through the Prime Minister’s Disaster Relief Fund and its National Emergency Operation Center (33). The Nepalese government eventually allowed NGOs already in the country to receive aid directly without going through the official government fund after approximately a month (33). There were also significant mismatches in aid provided and serious customs delays at Kathmandu’s airport (34).

In Nepal, in the days following the Earthquake, we had to quickly determine the licensing requirements for our medical personnel, the feasibility of importing drugs (including narcotics) from Canada, the liability and insurance requirements around malpractice – all that while negotiating landing rights and performing site assessments by helicopter and bad roads.

Stephane Michaud
Director, Emergencies and Recovery
Canadian Red Cross
already stationed in the country, were allowed to enter and provide medical supplies and support necessary for the health intervention during the 2015 earthquake. Although this did not bring down all of the legal and regulatory barriers, as explained above, it is still a necessary mechanism to allow humanitarian assistance to flow to affected populations following a disaster that exhausts local capacities.

The use of untrained or unqualified personnel was similarly noted by 42 per cent of respondents in the IFRC questionnaire. According to one HO staff, “the use of well meaning, motivated but untrained volunteers is commonplace in all major disaster responses” (2).

Currently, there is no clear domestic legal provision relating to international, regional or bilateral assistance if a disaster exceeds national coping capacity in Nepal. The Natural Calamity Relief Act 1982 is the core legal instrument governing disaster management, granting the Nepalese Ministry of Home Affairs authority to act for immediate rescue and relief (35). The National Strategy for Disaster Risk Management serves as the key policy document. Under this legal framework, HOs including the Nepal Red Cross Society (NRCS) play a supporting role to domestic government relief efforts.

When a large-scale natural disaster strikes, designated committees at the Nepali Ministry of Home Affairs must emit a formal request for international assistance. If such a request is lodged, Section 4(a) of the Act allows government to exercise discretion in granting foreigners permission to enter the scene of a disaster. Section 21 also allows the government to “frame necessary Rules to execute the objectives” of the Act. However, as a 2011 report by the IFRC detailed, “the existing legal provisions for obtaining temporary legal status, obtaining working visas, [and] recognizing professional qualifications... are too time-consuming for the disaster context” (36).

The NRCS and IFRC are currently working with the Nepali Government to implement a Guideline for International Assistance and Cooperation, with the aim of codifying processes for international assistance from HOs and the early registration of aid (37).

The central coordination, registration and verification of HO medical personnel by external, non-governmental actors can also help to alleviate the legal barriers to assistance. For instance, the WHO Emergency Medical Teams (EMTs) are composed of medical personnel, including physicians, affiliated with governments, charities, militaries and

While emergency legislation is necessary to trigger humanitarian response, it is important that countries, such as Nepal, end its state of emergency when it is no longer necessary. The failure to suspend an emergency declaration can have adverse legal consequences regarding possible continued infringement on citizens’ civil liberties (2).

### 3.1 Deployment of Medical Professionals

For a natural disaster abroad, HO physician deployment is subject to two significant legal challenges: (i) the acquisition of a permit to enter the affected jurisdiction; and, (ii) the recognition of foreign medical credentials. Depending on the legal context in a specific country, these can create significant barriers to the efficiency and timeliness of a response. For instance, the State of Louisiana Governor suspended licensure rules for foreign physicians responding to Hurricane Katrina, but only after two weeks (2). In the interim, a number of offers of foreign aid were turned away by the US federal government. In a 2006 IFRC survey of over 100 governments and HOs, nearly half of respondents reported problems to obtaining entry permissions (such as visas) for their relief personnel (2).
3.1.1 RECOMMENDATIONS

1. Modernize the Natural Calamity Relief Act 1982 with respect to licensing and visa provisions using upcoming Guideline for International Disaster Assistance and Cooperation and with reference to the IDRL Guidelines.

2. Build and expand partnerships between the international HO community and domestic governments in disaster-prone regions (e.g., WHO’s EMT-Coordination Cell) to pre-empt complex personnel travel and professional qualification requirements.

3.2 Liability for Medical Professionals

The risk of liability for medical malpractice faced by Canadian physicians who volunteer abroad in health care emergencies is coloured by the inherent tension between the humanitarian imperative to act and the corresponding legal realities on the ground. Civil society and humanitarian actors must consider ethics in foreign interventions where there is a low probability of a Canadian medical professional being successfully sued by their former patient. However, risk assessment is necessary for a number of reasons: There are a growing number of medical professionals, from medical students to practitioners, volunteering and practicing abroad (40). The rise in litigation in international events in recent years that required an international concerted effort suggest access to justice for victims is generally increasing (41).

The liability of Canadian healthcare professionals to patients for negligence abroad depends on the jurisdictional scheme of the country in question. For example, many civil law jurisdictions commonly have a positive duty to assist those in peril in their general laws and they may have Good Samaritan legislation protecting these volunteers as a result (42). Civil law jurisdictions may also have general laws that are penal in nature stipulating the criteria for negligence liability (43). Liability will specifically depend on whether a foreign physician qualifies as a “volunteer” in these circumstances which varies between countries, although there is little case law providing an affirmative answer (42). Other common law systems such as the US and Australia use a similar model to Canada’s pan provincial Good Samaritan legislation excluding liability except in cases of gross negligence, although they also consider criminal behaviour (42). The Common law tradition does not impose a positive duty to rescue others, and legal obligations and liability typically only commence once a rescue is attempted (44). Liability also depends on whether the country in question has a Disaster or Emergency Management Act which may allow the declaration of an emergency and certain rights, responsibilities, license equivalencies and/or liability waivers for volunteers (15).

Physicians providing emergency medical services during a disaster are at an increased risk for medical errors because of language barriers, limited time with each patient, unfamiliarity with the patient population and/or their practices (42).
The aforementioned factors may create ethical and legal issues with receiving adequate consent from the patient. Additionally, the risk of medical errors may be exacerbated by the unavailability or inadequacy of medical records, laboratory testing, examination facilities and follow-up treatment (42). For example, the CRC and other actors treated patients in makeshift field hospitals after the earthquake in Nepal.

Beyond operational medical issues, the rule of law in developing countries may be undermined by corrupt and inefficient judiciaries resulting in a general lack of accountability (45). The IFRC survey of humanitarian actors found that only 4% of claims related to negligence (2). Generally, there have only been a small number of lawsuits against North American physicians volunteering in the developing world, with many settled out of court for relatively small sums when compared to North American malpractice awards (42). Thus, the risk of being sued is quite low, which may be why a majority of medical professionals deploy without personal professional liability insurance (40).

3.2.1 CROSS BORDER LIABILITY: INTERNATIONAL CONSIDERATIONS

A foreign plaintiff could attempt to establish the jurisdiction of a Canadian court over the medical malpractice proceedings, or could in turn seek to have a judgment from foreign proceedings enforced in Canada against a Canadian physician. This will largely depend on which province the defendant physician is domiciled, resident, present, and/or has assets (22). In BC, Saskatchewan, and Nova Scotia, cross-border jurisdiction is governed by the CJPTA (20), in Quebec by the Code civil du Québec, while the rest of the provinces and territories rely on common law rules (22). Under common law rules, most recently articulated by the Supreme Court of Canada in Van Breda, there are four presumptive connecting factors that establish a real and substantial connection of Canadian courts for tort claims, which subsumes medical malpractice (46).

Assuming that there are no contractual provisions determining the governing law between the physician and the victim, choice of law issues for medical malpractice would likely be governed by the law of the place where the tort occurred (lex loci delicti) (22). Generally, it is the responsibility of the party seeking to introduce foreign law to both plead it and to prove it (22).

Foreign in personam monetary judgments, which includes foreign medical malpractice awards, are quite readily enforceable in any province in Canada assuming the judgment fulfills a number of conditions (47). However, for a Canadian court to enforce the judgement it would still have to establish jurisdiction over the defendant against whom the judgment is being enforced, based on one of the aforementioned three jurisdictional criteria (22).

3.2.2 RECOMMENDATIONS

1. Before deployment, CRC counsel should review whether the country in question has Good Samaritan legislation. Counsel should review it and other schemes designed to protect volunteers, for definitions of volunteers, whether both foreign and domestic volunteers are included, whether medical professionals are included or excluded, and whether compensation for services rendered disqualifies the individual. Much of the HO literature analyzed took the posture that any Good Samaritan legislation would insulate their staff. However, the degree of coverage can vary significantly.

2. There is no overarching consistency across countries regarding indemnification of foreign emergency responders from liability (2). Before deploying abroad CRC counsel should review the existence and availability of:
   a. General laws imposing positive duty to rescue for civil law jurisdictions;
   b. General laws imposing liability for negligent rescue for civil law jurisdictions;
With respect to importation, most disaster-affected governments have special arrangements in their customs law for incoming disaster relief items, such as medicine (2). However, customs issues continue to be among the most widely cited regulatory and legal obstacles facing HOs and can be due to a broad range of factors including:

- Taxes and duties imposed on relief items;
- Rigidity of clearance process including, excessive documentation requirements;
- Inflexible hours of border authorities;
- Volume of medication;
- Bureaucratic procedures and opaque regulatory processes. (49).

There are a number of non-binding international guidelines as well as a large body of international law that seeks to expedite the movement of medication and regulate customs in the context of relief items during a disaster (2). One example is the World Customs Organization/OHCA Model Customs Agreement, which if a government signs, provides United Nations (UN) agencies and NGOs acting “on its behalf” (2)(36) special customs privileges to expedite the import, export and transport of relief items (2)(36). This agreement would not apply to organizations under the Red Cross, as they are not under the direction or “act on behalf” of the UN (2).

### 3.3.1 Recommendations

The following highlights three recommendations for facilitating a more effective movement of controlled substances during an international disaster:

1. To enable an effective response, HOs should develop a pre-deployment plan prior to exportation. This should involve gaining a contextual understanding of the
recipient country’s basic medicine policies, procedures, and regulations, as well as existing health infrastructure (50). One strategy is to refer to a recipient country’s national formulary or standardized Essential Medicine List (“EMLs”) to determine which drugs are approved for use before deployment. EMLs provide a limited list of the most crucial medicine that is relevant to the priority healthcare needs and disease prevalence of a given country (48). In cases where national EML’s are not available, organizations can refer to the WHO’s EML model guide which lists the most efficacious, safe, and cost-effective medicine for a basic health care system (48). Such a pre-deployment plan will also assist in ensuring that medication does not contravene the laws and regulations of the recipient country.

2. Canadian HOs and the Federal Government should also incorporate and review the WHO’s Guidelines for Donating Medicine. While not legally binding, the guidelines serve as a best practice guideline for governments and HOs to review and use in their policy development prior to an emergency situation (51).

3. The Federal Government should provide a public guideline on how HOs can obtain exemptions under relevant legislation. There is currently a void as to what the best practice is. This guideline can include, instructions, relevant forms for customs documentation, and agency contact information (such as the CBSA).

4. CONCLUSION

HOs face legal barriers to health interventions, which makes it difficult for them to send doctors and life-saving medicine to those in need. These legal barriers continue to pose a risk in terms of delaying or reducing the effectiveness of health interventions both domestically and abroad.

This report provides best practices and recommendations for HOs to prepare themselves before an emergency takes place in order to reduce or eliminate these barriers. Through a literature review and discussions with the CRC, this report provides information on the three most significant issue areas: (i) deployment of physicians; (ii) liability for physicians; and, (iii) movement of controlled substances, through the lens of two case studies. Best practices necessitate domestic authorities to trigger their emergency legislation to allow for most of these barriers to be reduced or eliminated for HOs. This report presented a range of options and considerations that are available for HOs to better undertake relief interventions in the future.

Although this report is intended for individual HOs, governments play a key role in ensuring that external relief efforts happen as quickly and efficiently as possible in the aftermath of a natural disaster. In general, governments should ensure that their emergency legislation allows for relaxed regulatory schemes for HOs responding to an emergency and trigger their Emergency Act as soon as possible, where relevant.

To ensure that legal barriers do not impede health interventions to domestic emergencies such as an earthquake in BC or to foreign natural disasters such as Nepal’s 2015 earthquake, HOs should prepare ahead and maintain a high level of discipline so that humanitarian responses meet domestic legal requirements. In addition, national governments should make a concerted effort to implement a legal and regulatory framework that allows HOs to respond in a timely and effective manner. The health of entire populations depends on these mutually reinforcing efforts.
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### Glossary

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<thead>
<tr>
<th>Full Name</th>
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<tr>
<td>BC Earthquake Immediate Response Plan</td>
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<td>Canada Border Services Agency</td>
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<td>Canadian Red Cross</td>
<td>CRC</td>
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<td>Controlled Drugs and Substances Act</td>
<td>CDSA</td>
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<td>Court Jurisdiction and Proceedings Transfer Act</td>
<td>CJPTA</td>
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<td>International Committee of the Red Cross</td>
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<td>International Disaster Relief Law</td>
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</tr>
<tr>
<td>Médecins sans frontières</td>
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</tr>
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<td>Memorandum of Understanding</td>
<td>MOU</td>
</tr>
<tr>
<td>Nepal Red Cross Society</td>
<td>NRCS</td>
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<td>OFMAR</td>
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Methodology

For this report, we conducted a literature review, gathered information from key informants, and received feedback during the drafting process.

The literature review examined a combination of academic articles, media sources, and reports from international humanitarian organizations focused on humanitarian intervention in natural disasters such as the 2004 Asia Pacific tsunami, the 2015 Nepal earthquake, and the 2016 Fort McMurray wildfire. The literature review highlighted four main legal barriers to health interventions, which informed this report's structure. We should probably add the we went through BC legislation specifically because we all cite it significantly as well as BC Disaster response reports.

The CRC then provided information based on their employees' experience responding to health interventions in areas such as Fort McMurray and Nepal to confirm and elaborate on the issues discovered during the literature review. The CRC also provided anecdotes from key interlocutors in other international organizations to demonstrate how legal barriers affect health interventions and their experiences negotiating these obstacles.

During the drafting process, the CRC and other key stakeholders provided feedback to inform the content of this report.

Specifically, Anna Jeffery drafted the introductory sections of the report and case studies as well as the conclusion, Roojin Habibi drafted the sections on the barriers to deploying of medical personnel, Nicole Cvercko drafted the sections on the barriers with respect to liability for medical personnel, and Meghan Blom drafted the sections on the barriers to moving controlled substances. All members engaged in all stages of the report creation process as well as editing and formatting the final report.
ENDNOTES

The International Federation of the Red Cross and Red Crescent Societies has produced a series of guidelines called the Guidelines for the Domestic Facilitation and Regulation of International Disaster Relief and Initial Recovery Assistance (“IDRL Guidelines”). These guidelines provide a coherent set of recommendations that governments can use to ensure that their regulatory framework facilitates and allows for proper international response during an emergency. Accordingly, the IDRL Guidelines are a useful framework that all governments should adopt to ensure a more efficient and effective response to future emergencies such as a natural disaster. Consequently, a subsequent report on how the Canadian government in particular can adopt the Principles and Rules in order to better respond to an epidemic in Canada and overseas should be drafted.

In this report we focus solely on the deployment of physicians to effectively illustrate potential legal barriers faced. Similar barriers face other medical personnel, including nurses, though each professional category merits closer analysis.

The EPA was recently the focus of a discussion paper by EMBC, where the agency noted that the 1993 Act fails to mention the roles and responsibilities of the EMBC, the agency mandated to take on the role as the lead coordinating agency in case of a natural disaster emergency. Modernization of the EPA may therefore need to be pursued to update definitions of key concepts (such as what constitutes an “emergency”), and clarify roles and responsibilities.

The defendant foreign doctor can also be subject to the jurisdiction of the BC court as a result of consent (a pre-dispute contractual agreement or by voluntarily submitting to the jurisdiction of a BC court) or presence (if the foreign doctor is ordinary resident in BC), although these two are less likely factors.