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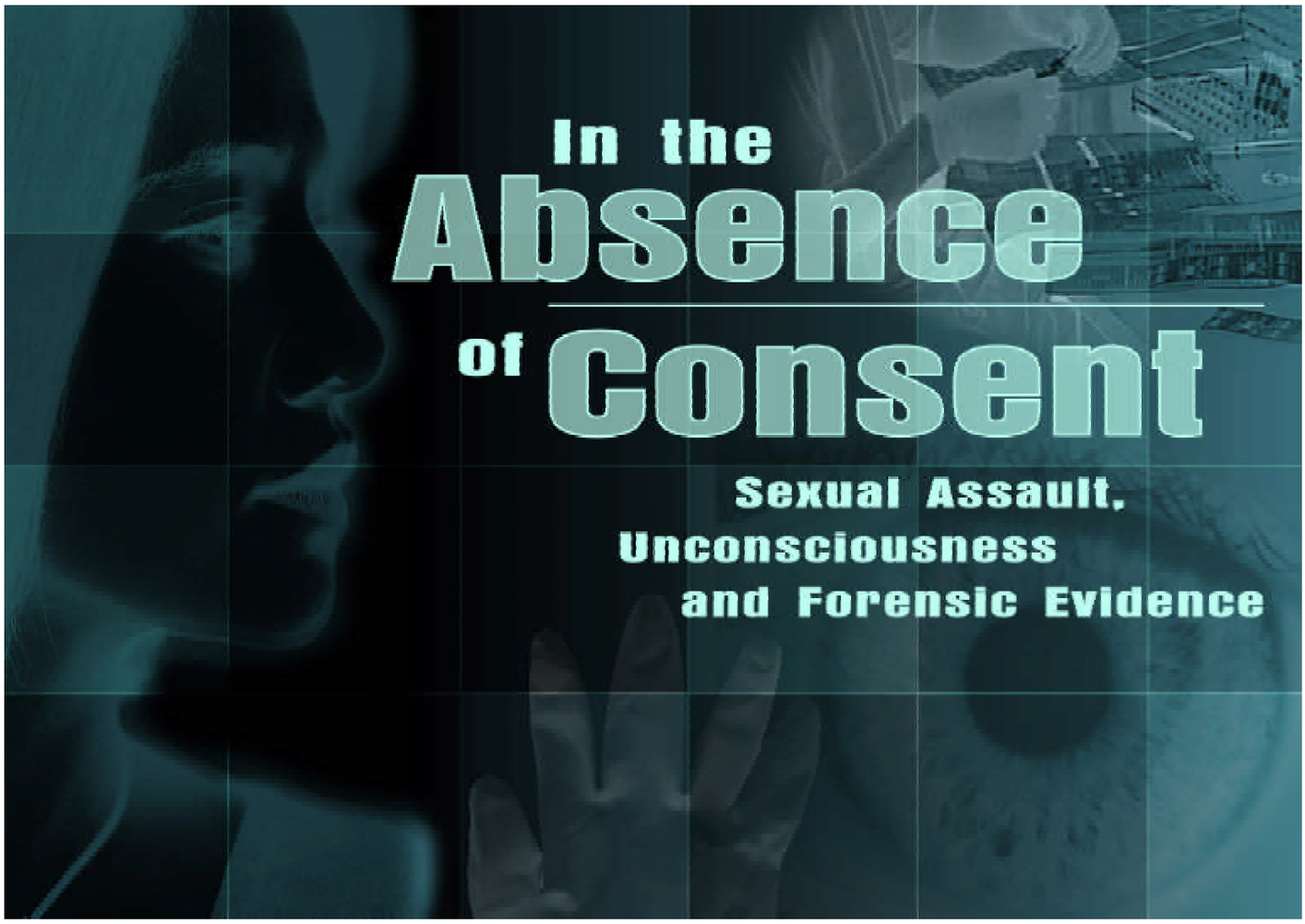

By Patricia M. Lee

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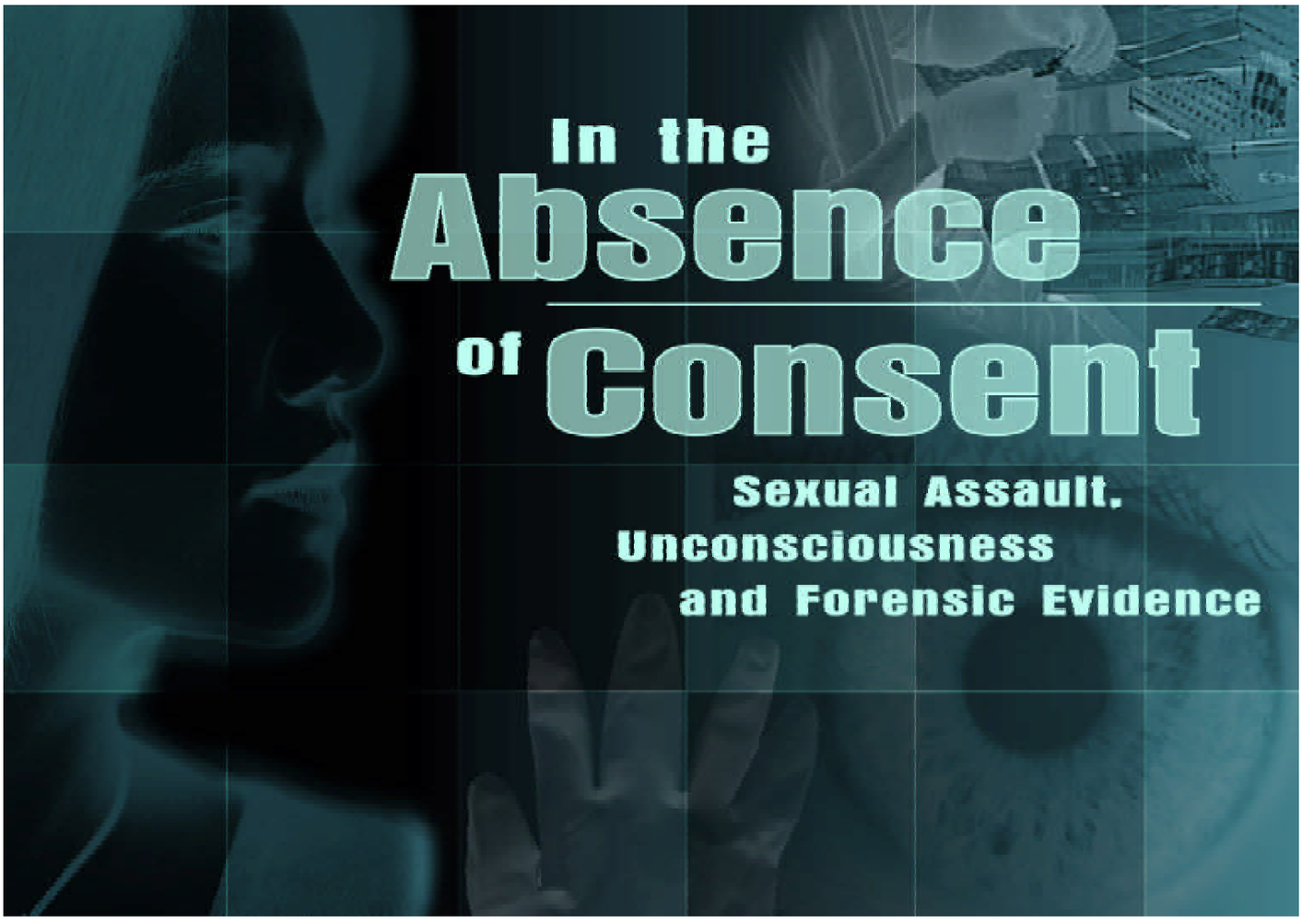

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Contents

In the few sexual assault cases where DNA evidence could be useful, it seems likely that attackers who realize the strength of the scientific evidence against them will switch from "identity" to "consent" as their defense. This means that instead of claiming that he was not the man who attacked her, the accused will claim that she agreed to sexual contact. It has already been demonstrated in Canadian courts that consent cases are harder to win. This could mean that with increased use of DNA technology, the conviction rate will not increase, and may even decrease.

Julie Kubanek
Vancouver Rape Relief and Women's Shelter
"DNA Evidence Under Feminist Scrutiny: Myths and Dangers Exposed"
Kinesis, 1997

DNA can focus investigations, and will likely shorten trials and lead to guilty pleas. It could also deter some offenders from committing serious offences. The increased use of forensic DNA evidence will lead to long-term saving for the criminal justice system.

Solicitor General Canada
"Establishing a National DNA Data Bank, Consultation Document", 1996

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Foreword

Should evidence collection be conducted on an unconscious patient/victim of sexual assault? The Sexual Assault Service at British Columbia's Women's Hospital and Health Centre currently answers this question: No. This paper examines how this question came to be raised, and what steps were taken to answer it. One of the steps was the commissioning of this research paper, which examines the question from a variety of angles. The question continues to be discussed, and this paper points the way to further needed investigation.

The Process of Developing the Unconscious Patient Policy

by Carolyn Dudley, Nursing Co-ordinator, Sexual Assault Service, British Columbia's Women's Hospital and Health Centre

The issue of taking evidence on an unconscious patient is a complex and emotionally charged one. This discussion paper is part of a four-year process undertaken by the Sexual Assault Service at British Columbia's Women's Hospital and Health Centre to better understand all aspects of this issue and consequently develop the best policy, one based on a critical analysis of the available knowledge. This process has been an opportunity for key stakeholders involved in caring for survivors of sexual assault (police, health care providers, counsellors, and criminal justice professionals) to work together to find a solution to this issue. In sharing this process with readers we hope that others will understand our efforts to create an informed and thoughtful policy.

For more than 18 years, British Columbia's Women's Hospital and Health Centre Sexual Assault Service (hereafter referred to as the SAS) has provided emergency care to survivors of sexual assault. This care is delivered by doctors, nurse examiners and nurses, and includes medical care, forensic evidence collection and supportive counselling. The philosophy of the SAS is to return control to the survivor. Following a sexual assault, a survivor often experiences a loss of control and a sense of powerlessness. Returning control to the survivor is the primary approach in helping her/him regain control in her/his life and begin the process of recovery. This philosophy guides all care in the SAS, includ-

ing the action of obtaining consent in every step of the sexual assault examination.

Several years ago, the SAS was confronted with the issue of whether or not to take forensic evidence on a sexually assaulted patient who was unconscious. Over the 18 years of the SAS's operations there had been a few cases in which unconscious sexually assaulted patients were seen in emergency. Then, in the summer of 1996, the SAS saw three sexually assaulted unconscious patients within a one-month period (the paper describes in more detail the events leading up to its being written). The sudden increase in numbers caused service providers to begin to question the ethical issues of taking evidence on a patient who could not give consent.

To address the query, an initial search of the literature was completed and revealed nothing directly related to this issue. Next, the service providers and co-ordinators met several times and struggled in numerous discussions with the issues of evidence collection on an unconscious patient. The opinions of providers ranged from taking evidence all the time to never taking evidence. Some of the questions service providers asked included the following: If no evidence were taken, would the perpetrator go free? What about the legalities of taking something from a person's body without consent? What would women want (some women would want evidence and others would not)? What about the highest societal good versus the individual rights? Are these types of perpetrators (those who would beat a woman unconscious) different than the typical perpetrators?

There was no consensus regarding a course of action, yet a policy needed to be made in the event that another unconscious patient were admitted to the SAS. At that time, it was felt that the best policy decision was not to collect evidence from a patient who could not give consent. The policy was based on the only relevant information available, the Canadian Medical Association (CMA) Code of Ethics that stated, any procedure done without patient consent must be limited to those necessary to save the life of that patient. Legal advice received on the issue also suggested that taking evidence from an unconscious patient could be considered battery. The policy was also guided by the SAS philosophy of returning control to the survivor and the recognition that it is a fundamental right for every survivor to determine what she/he wants done to her/his body.

Despite this decision, there remained some disagreement among service providers. The next step was to bring together a group of experts from a variety of disciplines to offer their perspectives on the issue. In the spring of 1997, three meetings were held with a group of experts to discuss the issues of collection, storage and transfer of evidence in cases where the sexually assaulted patient was unconscious. The experts included lawyers, ethicists, doctors, nurses, community counsellors and police officers.

At these meetings it became clear that there was no legislation and no research to clearly guide a policy in this area. Each expert had a different opinion depending on his or her background, and again no consensus was reached. It was very clear that the mandates of medical, legal, law enforcement and counselling professionals were in disagreement. The community-based counselling representatives attending these meetings represented the survivors who used the service, many of whom were from marginalized populations. These women relayed what survivors were telling them: that the legal system had often let them down. As a result, the survivors often did not want to involve the legal system following a sexual assault. These survivors generally did not want to have evidence taken from their bodies without their consent.

Given the lack of legislation, policy, research and information, and given the best understanding we had of what women wanted, the SAS decided to uphold the policy of taking evidence only with consent. This decision fell within the standards of care for medicine and nursing and addressed the little we knew about what women wanted. There were also concerns of eroding the SAS philosophy; that is, would taking evidence without consent imply that evidence could also be taken from women who were drugged, drunk, mentally impaired or unable to speak for themselves? The decision addressed both legal guidelines and the philosophy of the SAS.

Even so, there was a lingering feeling that perhaps there was some case law or research that may have been missed. As well, there continued to be general discomfort with the decision, in particular among the legal and police enforcement representatives who disagreed with the policy. In order to ensure that no relevant data, case law or research was missed, a paper was commissioned and a comprehensive critical analysis of the issue undertaken.

In 1998, a researcher was hired to complete this task, and an earlier draft of this report, entitled “Sexual Assault and Collection of Forensic

Evidence: The Role of Consent in the Case of the Unconscious Victim" was completed in the fall of 1999.

Highlights of the paper included:

• Clear legal documentation from the Canadian Medical Association Code of Ethics and the British Medical Association that only procedures considered medically necessary to sustain life can be undertaken without consent.

• Explication of discordant philosophies of feminism, law and medicine.

• Lack of research and case law on unconscious patients or patients unable to consent who require forensic evidence collection.

• Lack of legislation that relates to forensic evidence collection on unconscious patients.

• Clarification and guidelines for seeking consent when providing health care.

• The potential for examiners to be sued for battery or negligence.

• The overall low rate of reporting and low rate of convictions in sexual assault cases, and research that questions the usefulness of evidence in obtaining convictions.

• Increasing use of DNA technology.

Following this, the SAS revisited the policy, and some revisions were made. The revised policy stated that evidence would only be collected with consent of the patient, but that in the course of a medical examination, if forensic evidence were found, it would be stored for release later with consent of patient.

In December 1999, a meeting with all stakeholders was held to review the findings in the paper. These stakeholders all recognised that the policy was in line with the legal framework; however they expressed frustration that there seemed to be only one legal answer to the issue, with no room for change. Discussions occurred on the issue of obtaining warrants and of seeking change in policy on this matter. The stakeholder group identified a need for more knowledge in this area so that this new knowledge could inform new policy directions.

Numerous research ideas were generated, including the following:

• A nation-wide survey of what women would want.

• Long-term follow-up of unconscious sexually assaulted patients, what these women would have wanted and the results of cases if evidence had been collected.

• Review of criteria for obtaining warrants.

• More research on the use of evi-

dence and conviction rates and in particular the evolving role of DNA in convictions.

The stakeholders agreed to meet again to look at gaps in knowledge and next steps. It was also agreed that the final version of the research paper would be available on a national and international basis with hopes that other services could learn from our process of decision making about this issue.

In conclusion, the process has been an informed and comprehensive one. It has brought together representatives from law, health, counselling and law enforcement in an attempt to provide the best possible care to survivors of sexual assault. This process will continue as new research is uncovered and in light of new DNA technologies. The policy is one that is amenable to change as new information is learned. Although some stakeholders still disagree with the decision, they recognize that it is based on current knowledge and legal guidelines, and provides the best possible care to survivors at this point in time.

Carolyn Dudley, Spring 2000

Introduction

The collection of medical forensic evidence from an unconscious patient/victim who has been, or is believed to have been, sexually assaulted is a complex, contentious and emotionally charged issue. It raises practical, ethical, legal, political and social questions regarding the role and duty of health care providers, the necessity of medical forensic evidence in the justice system, the process of designing public policy, and most importantly, which institutions of power have the right to speak for the voiceless patient/victim.[1] There has been virtually no thorough, objective exploration of this topic outside the milieu of professionals who deal with sexual assault, and there is a disturbing dearth of research and literature, a gap that this discussion paper can only begin to address.

Conflicting and contested perspectives have been encountered throughout the research process of this project, suggesting that there is no ready solution to the constellation of complex issues. What is encouraging is that the process has facilitated an expansion of communication between different interest groups and a greater commitment towards the search for solutions.

III

Scope of the Project

The following report has been prepared for British Columbia's Women's Hospital and Health Centre Sexual Assault Service (SAS) and should be reviewed as a background document, a foundation to assist sexual assault services in B.C. in their deliberations about the complex issues pertaining to consent to collect forensic evidence from an unconscious patient/victim who has been sexually assaulted. The research focuses predominantly on the local situation of providing sexual assault services through the SAS based in Vancouver and other services in the lower mainland area of B.C., but within the broader context of the Canadian health and justice systems.

There are some significant gaps in the information generated by this research, particularly in the form of sociological examination and international perspectives. Subsequent research projects may focus more specifically on subject matter as yet unexplored: for example, gaining a clearer understanding about the "nature of the unconscious" and the capacity to make decisions following violent assault; the tracking of how forensic evidence is used in the B.C. court system; and the characteristics of Canadian women who are the targets of assault in the community and sometimes victimized in the courts.

The discussions in this paper are based on review of the "in-house" documents provided by the SAS, the information and guidance provided by members of SAS and the local professional and lay experts who were involved in the early debates as well as current debates on this topic.[2] Other authorities, mainly from within B.C., have provided additional advice and information. The library research has largely been limited to Canadian and British sources and has produced a disappointing lack of useful material. Many participants have been very helpful in supplementing this paucity. There may well be unpublished papers, position statements, etcetera that have been produced by other sexual assault centres internationally. Future efforts should certainly be made to solicit information from other centres in Canada and further afield[3] in order to take a broader view of the subject area. One way to extend networks and create a wider dialogue would be to circulate the present

document to interested sexual assault centres both nationally and internationally and to solicit feedback.

The researcher did not speak directly with women who have experienced the situation of being sexually assaulted and left unconscious, and she was not able to review patient files, counselling notes, etcetera which document their particular experiences.[4] While representatives of victim service organizations can advocate for, and, in some respects, "speak" for these women, victims' own stories are a critical piece of the picture that should be thoroughly addressed in the future. It is their views, the frequently subjugated, unauthenticated, marginalized and silenced voices, that need to be made central to the analysis. Emerging feminist and social science research is now endorsing collaborative, sensitive research methods that facilitate the documentation of previously underrepresented experiences and opinions. Research of this type requires all of the necessary institutional reviews for permission to conduct research in the behavioural sciences with human subjects. It is vital also that this type of research is conducted by experienced researchers, because of the potential adverse effects that could be produced by asking women to relive their traumatic experiences. Furthermore, it should be observed that qualitative research methodology is, itself, an invasive procedure and hence should be conducted by skilled researchers.

The development of a questionnaire, which was circulated to all members of the SAS and their counterparts in Surrey and Victoria, the Vancouver Police Department and some victim service workers, is an attempt by the researcher to reach out to some of the service providers involved with sexual assault. It is a test tool, which has not been pre-tested, and may need refining. It can be completed anonymously. All the completed questionnaires have been coded and the data has been partially analyzed thematically, providing a rich source of information. Preliminary analysis from some of the responses to the questionnaire has been incorporated into this background paper and further analysis of themes may be of value for future research.

This background paper is submitted in the hope that it may help guide the sexual assault team in its deliberations on whether or not to continue the present policy of not collecting forensic evidence from an unconscious patient admitted to the emergency department. It analyzes the discordant ideologies of feminist

encounters with law, medicine and law enforcement. It discusses the ethical dimensions of consent to treatment, informed choice in the problematic context of the hospital setting and the fundamental rights of patient/doctor confidentiality in the case of the unconscious patient/ victim of a sexual assault. It proceeds to examine three significant legal issues concerned with the collection of forensic evidence from the unconscious woman:

• concerns of examiners about charges of battery,

• the experiences of women in the court system with respect to sexual assault trials,

• the minimal and inconsistent use of forensic evidence in trials.

IV

Methodology

The research for and presentation of this background paper reflect a feminist qualitative methodology, which places women's health issues and safety at the centre of the analysis. This is consistent with the health care ethics of the SAS. Throughout this report, the dimensions of this topic are examined through a feminist lens, with the research approach being women-centred and inclusive of the many perspectives of the persons and institutions who work on behalf of victims of sexual assault.[5] This report recognizes that this particular subject is highly sensitive, polarizing, and political. Never was the aphorism "the personal is the political" more apt. In Western society the sacrosanct domain of human sexual experiences, especially in its "deviant" forms, does not stand up well to public scrutiny.

By its very nature, the research process will bring to the surface discordant perspectives, challenge particular loci of power and control, strain interpersonal relations, and aggravate some of the many who have the patient/victim's best interests at heart. It is therefore vital from the outset that these dynamics are recognized and allowed to percolate into the ongoing process of extending the communication on this issue to all the interested parties; a process that began before this document was formulated.

V

Discordant Ideologies: Feminist Encounters with Law, Medicine and Law Enforcement

There is an uneasy alliance between law/law enforcement and medicine, two of the most powerful institutions in Western society. Both institutions espouse value systems that are mandated to advocate for the best interests of the patient/victim. Professionals, health care providers, lawyers and police officers are all trained in specific epistemologies and are socialized over lengthy training periods to abide by the beliefs, practices and convictions of their chosen profession. They are not expected to internalize the value systems of other professions. When feminism is added into the equation, and a woman-centred perspective emerges, it further complicates the relationship between law and feminism, and medicine and feminism.

A. Law

Feminist lawyer Mary Jane Mossman has revealed the limitations of law's responses to the feminist challenge: "To put it bluntly, the relationship between feminism and the law is a paradox" (1998, p. 1). Feminist claims that challenge legislation and require broader analysis of context and its impact for women have been severely limited. "The judicial process often narrows the issue under consideration and limits the transformative potential so critical to a feminist approach" (Razack, 1991, p. 23). In essence, law separates the legal from the social problems. Furthermore, it has what Smart (1989) calls a "juridogenic"[6] effect, which is a term she coined to "apply to law as a way of conceptualizing the harm that law may generate as a consequence of its operation" (1989, p. 12).

The crime of sexual assault, like the debate surrounding the collection of forensic evidence from an unconscious patient, is about bodily invasion without consent.

"The essence of sexual violence is lack of consent. What separates sexual assault from other forms of sexual activity between adults under the law is whether or not both parties agreed to their participation. Upon reaching the age of 18, any type of consenting sexual activity so long as it is performed in private is legal. Anything else is sexual assault." (Johnson, 1996, p. 118)

The legal system may also perpetrate a form of bodily and emotional invasion. It can further limit the victim's right to consent, when demanding her participation in a criminal trial to face her assailant. This demand subjugates her free will to the authority of the courts. While law purports to be an institution that provides an avenue to justice, it can also be harmful because it is yet another form of control over the victim's person.

Because it is based on precedence, law does not provide room for context or personal circumstances; it tends to "skeletonize" (Kandel, 1992, p. 1) the complexity of people's lives and stories.

"Judges' and lawyers' particular backgrounds, socialization, and experiences...result in a patterning, a consistency, in the ways they categorize, approach, and resolve social and political conflicts. This is the great source of the law's power: it enforces, reflects, constitutes, and legitimizes dominant social and power relations...by means of social actors who largely believe in their own neutrality and the myth of legal reasoning." (Rigby & Sevareid, 1992, p. 6)

Conversely, feminism attempts to recognize the intricacies of human experience, and feminist ethicists "accept the argument offered within the realm of 'feminine' ethics, which demand that attention be paid to the interdependent, emotionally varied, unequal relationships that shape human lives" (Sherwin, 1992, p. 82).

As demonstrated later in this report, law is patriarchal and often upholds male authority.

B. Medicine

There is a less developed critique of feminism's encounter with health care providers.[7] The women's health movement has attempted to destroy the universalizing tendencies of the biomedical model and biomedical medicalization by redefining the knowledge base for women's health with a woman-centred approach, which is culturally and politically situated. This movement recognizes cultural diversity, oppressive differences and the universal interconnectedness of women's lives.[8] We now know that there is greater discrimination and a higher incidence of physical and sexual abuse among women "whose lives are compounded by oppression, including Aboriginal women, women of colour, lesbians and disabled women. Race, ability, age, class, and their intersections, are known to impact on the quality of health care service a woman receives"(Rodgers, 1995, p. 164).[9] As Roberts (1996) explains, we have a lot to learn from the critical

insights of women of colour because:

"To identify how the perspective of poor women of colour – their particular relationship to the institution of medicine – can uncover the way in which the practice of medicine, particularly the doctor-patient relationship, perpetuates hierarchies of power, can highlight women's forms of resistance to medical control, and pose a vision for transforming medical ethics and health care systems." (1996, pp. 116-117)

The research for this study has encountered a number of accounts of the discriminatory treatment that often occurs when women who have been sexually assaulted report to the hospital for treatment. One First Nations woman commented to the researcher that it is no coincidence that some women are met by a security guard and not a triage nurse when they enter the Emergency Department at St. Paul's Hospital in Vancouver: "It's not so bad for me, even though I look Aboriginal, because I look and act normally, but for some women that come in dirty, they get a bad rap. It wouldn't happen to you because you are white."

While feminist health care ethics are particularly sensitive to these issues, they are not exclusive to feminist thinking, and reflect the general shift in health care towards a more patient-centered approach. As noted by Fry, "any claim to feminist medical ethics must demonstrate that it has broader applications than either just to medical practice or just to females" (Fry, 1989, p. 94).

C. Law Enforcement

Ideologically, the police are committed to protecting the public. Their mandate is to focus on identifying and convicting the offender, and on promoting public safety. For the police, social justice must supersede individual rights. A member of the Vancouver Police Department's Sexual Offences Squad (SOS) stated: "I think that [societal safety] certainly overrides any individual privacy rights and that's certainly the position of the police department." Violence and chaos in society are part of the everyday experience of police officers who encounter the public. They are often the first on the crime scene when a woman has been found sexually assaulted and unconscious. They are not unaware of the reality of these women's lives and are genuinely concerned with protecting their future safety as well as the safety of other women.

Furthermore, police departments have experts who are all too aware of the psychological profile and patterns of serial rapists and sexual assaulters, and their policies are

designed to apprehend these people at all costs. One member of the SOS confirmed this point: "...without collecting the evidence we may have situations whereby serial rapists, serial sexual offenders, serial murderers, may be walking the streets when they shouldn't be."[10]

Unlike medicine, police agencies are not expected to be morally "neutral," they are protectors of the general moral standards of society; they are symbols of the "good guy." Indeed, the police force embodies Western concepts of masculinity: "strength, power, independence, forcefulness, domination, toughness. To conquer, to be successful, to win, to induce respect through force – all of these attributes are commonly associated with masculinity in our culture" (Hills, 1987, p. 298). While the law enforcement perspective is paternalistic, it preserves the societal expectations of safety and protection. Thus, police tolerance for the present policy of non-collection of evidence from an unconscious patient/victim by SAS is low. The police do attempt to respect the women-centered approach of SAS. They emphasize that at any point in the police investigation, a woman has the complete autonomy to withdraw from the process**.** However, the masculine nature of law enforcement does influence their view.

In contrast, the mandate of health care providers is patient care. The tension between these mandates may lead to conflict at the time of hospital admission and examination of a patient/victim. When the health care focus is specifically feminist in orientation, as is the case with SAS, tension may build.

D. Summary of Conflicting Perspectives

The "unconscious" is a metaphor for the "voiceless." What this research project revolves around, at its very core, are the rights of the unconscious "medical patient," and the voiceless victim of violence, "the legal victim." It is hardly surprising that the conflicting and contested discourses swirling around this silent embodiment of woman are fraught with tensions between paternalistic, patriarchal stances, and the variety of emergent women's resistances to power and control over their most intimate selves. If all interested parties assert that they hold women's welfare at heart, then how can this welfare best be realized?

VI

Mandate of the Sexual Assault Service

The Sexual Assault Service at British Columbia's Women's Hospital and Health Centre was established in 1982. Working in partnership with Vancouver Hospital, it is a medically based service providing comprehensive and sensitive emergency care for adolescent and adult victims of sexual assault in the Greater Vancouver area. It integrates medical, legal, counselling and support components. A roster of female physicians, nurse examiners and nurses is always on call to provide care for approximately 200 patients a year. Between April 1, 1997 and March 31, 1998, 212 patients were examined by a roster of 25 female physicians, 4 nurse examiners and 10 nurses (SAS Annual Report, 1997/8).

The SAS staff includes a co-ordinator/counsellor, a nurse clinician, two part-time physician co-directors and one half-time administrative support. Women Against Violence Against Women Rape Crisis Centre (WAVAW) is an integral component of the service, providing hospital accompaniment by victim service workers when required for sexually assaulted women. The SAS works in close cooperation with the Vancouver Police Department, but also sees patients from other police jurisdictions. It actively develops and delivers educational programs for nurses, physicians and the community. It has developed the Sexual Assault Nurse Examiner (SANE) program in B.C., and it provides training for Sexual Assault Nurse Examiners and physicians across the province. SAS is currently working on a mandate to train sexual assault teams throughout B.C.. It is instrumental in providing information and training sessions for a cross-section of community groups, including WAVAW, as well as continued in-service training sessions for SAS staff and Vancouver Hospital Emergency Department staff. It promotes new research projects and participates in related conferences.

The SAS is widely recognized as a leader in the field of sexual assault services in Canada. In consequence, whatever guidelines, protocols or policy are finally adopted by this service with respect to medical-legal examinations in the case of the unconscious patient/victim, may be considered for adoption by other services in B.C. and across Canada.

VII

Current Policy

The current policy adhered to by the Sexual Assault Service does not endorse or permit the medical/legal procedures for the collection, storage and disclosure of any evidence from the non-consenting patient/victim while in the unconscious state, other than those deemed medically necessary in relation to her physical health and comfort. It is important to emphasize that this policy is only in respect to forensic evidence, and that any essential medical treatment will be conducted without the consent of the patient. Similarly, this policy is rarely employed, as the number of unconscious victims of sexual assault admitted to the hospital is very low. There have been five cases at the Sexual Assault Service documented to the end of July 1999.

The new draft of the policy suggests that examiners attend the patient in hospital and provide a consultation where there is suspicion of sexual assault. This "women-centred" policy, which was reaffirmed in 1997, is the same policy that was established when the SAS program was started in 1982. A fully informed consent was the cornerstone of providing high quality care to women who had been victimized by sexual assault. At that time, issues to do with the unconscious patient were not foreseen and the policy reflected accepted ethical guidelines for established health care practices. The current policy, in its broadest interpretation, is based on a number of factors that have consequences for both the rights of the patient/victim and the standardized practices of the physician or nurse examiner, which reflect the patient's best interests.

Firstly, it is unethical for health care providers to conduct an elective procedure[11] without a patient's fully informed consent. This practice would undermine the basic principle of autonomy and self-determination by the patient/victim. Secondly, there are potential legal risks for the attending examiner of being charged with battery.[12] Thirdly, the health care provider axiom "do no harm" is invoked. It has been well argued that it is further violation to compound the forced act of non-consensual sexual attack with the invasive, potentially demeaning, and sometimes painful procedures involved in the collection of forensic evidence. Kee (1996) maintains that the plucking of pubic hairs, and internal vaginal

and anal examinations with surgical instruments are unquestionably painful and invasive under any circumstances, but in relation to plucking clumps of pubic hair “it is incalculably more so when it is done shortly after a sexual assault” (1996, p. 9). The SAS examiners never pluck hairs even on a conscious patient. The only surgical instrument used is a speculum. However, the invasive techniques of collecting forensic evidence are likely more physically painful and emotionally difficult after a sexual assault.

VIII

Background to the Current Policy

Within a one-month period in the summer of 1996, three women were admitted to hospital in Vancouver who had been sexually assaulted and were unconscious. The attending police investigator in each case had requested the collection of medical forensic evidence to aid the investigations. The service providers of the SAS were put in a very difficult situation. They were unable to follow their usual procedures of obtaining consent to examination and collection of forensic evidence for either storage or for immediate transfer to the police. It was left up to the physician and nurse on call, in consultation with the physician co-directors, in each of the three cases to make a professional decision in a highly stressful situation. They were under pressure from the police to collect forensic evidence and hand it over immediately.

In the first two cases, the physician attended the woman and conducted a medical examination to evaluate vaginal bleeding. Due to the violence of the assault and the severe nature of the injuries, the physician decided to assist the police investigation by collecting samples without the requisite consent and released them to the investigating officer. In the third case, there was a miscommunication between the physician and the police officer about whether the elderly woman, who had been admitted unconscious, had been sexually assaulted. In retrospect, the physician thought that she could have done fingernail scrapings and at least an external genital examination. Based on the latter, she would have decided whether or not to do an internal vaginal examination and collect the evidence, which she would have retained until the woman's neurological state was better established. Each of these cases presented complex issues and difficult decisions.

Consequently, a discussion of the issues occurred during the August 1996 meeting of the SAS co-ordinator/counsellor, the medical directors and the nursing co-ordinator. A letter was sent by the service co-ordinator on August 20, 1996 to the SAS team requesting that it prepare in advance to discuss at the September 23, 1996 SAS meeting issues about whether to perform medical examinations on unconscious patients, and furthermore, whether to collect and transfer forensic

evidence to the police in the event of continued unconsciousness. At this regular SAS meeting with roster examiners and nurses, a broad spectrum of opinions and conflicting views about consent was expressed. These views ranged from cooperating with the police at the earliest reasonable stage as being in the patient's best interests,[13] to a concern for erosion of patient's autonomy and rights.

In January 1997, the Deputy Registrar of the College of Physicians and Surgeons was contacted to find out if there was an existing policy regarding examination of the unconscious patient. She was unaware of any such policy. In the same month, participants with a wide variety of expertise were invited to attend discussion groups.[14] Three discussion groups were scheduled over a three-month period in March, April and May of 1997 to discuss the three pertinent aspects of the problem:

• whether or not to conduct a medical/legal examination on an unconscious patient;

• whether or not to store the evidence until the patient recovered consciousness and could consent;

• whether or not to transfer the collected evidence to the police without the patient's consent, if she remained unconscious.

Invitees to the discussion groups included representatives of Crown Counsel, Victims Services, the Vancouver Police Department Sexual Offences Squad, community lawyers experienced with sexual assault, an ethicist, the lawyer for The Canadian Medical Protective Association, SAS nurses and doctors both past and current, and the service co-ordinators. In June 1997, a meeting was held between SAS and representatives of community groups who worked closely with victims. The Downtown Eastside Women's Centre (DEWC) and WAVAW Rape Crisis Centre were represented at this meeting. Both representatives for these organizations shared the sentiment that the criminal justice system discriminates against downtown eastside addicts, alcoholics and sex trade workers, and that women have a fundamental right to the sanctity of their bodies. They expressed concern that the police would find a way to appropriate evidence if it were collected from an unconscious woman.

Following the first discussion meeting, another unconscious woman suspected of being sexually assaulted was admitted to hospital. As with two of the earlier cases, the examiners decided to collect forensic evidence and release it to the police

without obtaining patient consent. At the September 4, 1997 SAS Team Meeting, the Vice-President of Programs and Services at British Columbia's Women's Hospital and Health Centre summed up the process of the discussion groups. She raised concerns that taking forensic evidence without patient consent would erode the SAS fundamental long-term philosophy, would make the service less accessible to all women, and would shift the focus from patient care to supporting the legal system.

Most women who are sexually assaulted neither involve police nor seek medical care. It is estimated that about 70% of women utilizing the SAS do report to the police. In general though, only 1 in 10 women who are sexually assaulted report the incident to the police, and in the case of date rape, the number rises to 1 in 100.[15] According to the Statistics Canada Victimization Survey (1993) more than one in three adult women have been sexually assaulted since the age of sixteen, and 94% of these cases never come to the attention of the criminal justice system. This tendency for women not to involve the police or the courts may suggest that taking evidence from unconscious patient/victims is a regressive step for women in general. However, it has been argued conversely, that one of the factors in the self-selected sub-group that report 70% of the time is the degree of injury. The more severely a woman has been injured, the more likely she is to present at the hospital and/or report to the police, or vice-versa. Thus it may well be that unconscious patients may be even more than 70% likely to wish police to investigate. Although this issue was contentious and created ethical struggles for some SAS providers, it was decided by the SAS (following the results of the discussion meetings) to continue with the policy of not collecting forensic evidence in the absence of consent.

It was further agreed that until a final policy was formulated, that the current policy[16] would be maintained. This policy, in effect, reiterated and reinforced the fundamental SAS policy concerning the gravity of the fundamental health provider ethic of obtaining consent. This ethic upholds basic principles of empowering the woman by respecting her bodily integrity, thus encouraging her to maintain control.

IX

Ethical Dimensions

In the case of the unconscious patient/victim, consent to treatment, informed choice in the problematic context of the hospital setting, and the fundamental rights of patient/doctor confidentiality are each at risk of being compromised if forensic evidence is collected. The key question is who should represent the interests of the voiceless victim of sexual violence (the unconscious woman) if those charged with her care do not?

A. Consent to Medical Treatment

In the health care setting, consent is the "autonomous authorization of a medical intervention...by individual patients" (Beauchamp and Faden, 1995, p. 1240). Patients are entitled to make their own decisions about their medical care and have the right to be given all available information relevant to their decision. Consent is reached through a series of negotiations, and is therefore "not a discrete event, rather it is a process" (Lidz, Appelbaum and Meisel, 1998, p. 1385). The Canadian Medical Protective Association in its Consent: A Guide for Canadian Physicians (1989) states that consent may be explicit or implied. As Etchells et al. point out, "Signed consent forms document but cannot replace the consent process. There are no fixed rules as to when a signed consent form is required" (1996, p. 178).

The Canadian Medical Association Code of Ethics (1996) states: "Recommend only those diagnostic and therapeutic procedures that you consider to be beneficial to your patients or to others. If a procedure is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law" (p. 14). It continues, "When the intentions of an incompetent patient are unknown and when no appropriate proxy is available, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests" (p. 20).

In the opinion of the British Medical Association (BMA) (1996), if there is doubt as to the patient's real intention, the law and public interest urge

doctors to do all they can to sustain life. "In an emergency, however, the doctor should not exceed the treatments necessary to sustain life and health. For example, elective measures or procedures such as the use of blood samples for forensic rather than diagnostic purposes are not condoned" (p. 1:3.1). Later in the text, under discussion of examination of victims of crime, the point is made that in the drive to act quickly to protect others in the case of sexual crimes, it is important to recognize the pace that the patient finds comfortable. Pressure from the police should be resisted. "It is important that the doctor does not assume that the subject's presence implies consent and ensures that the patient does indeed consent to what is entailed in an [evidential] examination" (p. 9:6.3).

Analogously, it is the position of the BMA that samples for drug or alcohol estimations cannot be taken from people who are unconscious or feign unconsciousness, because "samples taken for diagnostic purposes may later be released to the courts if the person consents, when able, to analysis" (p. 9:6.4). In summary, "if the patient is unconscious or otherwise incapable of giving consent, examination and essential treatment should be carried out. Other procedures not necessary to protect the subject's life and health cannot be undertaken at the same time. Specimens may be taken for diagnostic purposes, but not for forensic tests. The results of diagnostic tests must not be used for forensic purposes without the individual's consent" (ibid).

A victim service worker substantiates this directive well:

"Forensic exams have not been perceived by the Collective or by WAVAW well.... If the woman is unconscious then the question is, is it a medical procedure? Or is it a collection of evidence procedure? And I believe it's a collection of evidence procedure. So is it necessary at that point to do it without patient consent? The woman is there, she could be dead. The main thing is health care, not evidence."

B. The Nature of the "Unconscious"

Issues of consent, informed choice and confidentiality become complex in the case of an unconscious patient/victim. Unconsciousness is not only indicative of an individual's physical/medical condition, it also reflects her mental and emotional capacities.

Based on the accepted definitions of "competence," the unconscious victim of sexual assault fails to meet the criteria necessary to make her own decisions regarding her medical

treatment. Brock notes that "three distinct capacities are needed for competence in treatment decision making: the capacity for understanding and communication, the capacity for reasoning and deliberation, the capacity to have and apply a set of values of conception of one's good" (1991, p. 389). Unconsciousness takes away the most important part of patient autonomy: the ability to communicate. Inevitably, unconsciousness strips away the victim's power to consent, protest, or ask questions regarding her options after an assault.

Given this unfortunate reality, it is easy to construct the unconscious body as passive, and to assume that all people experience unconsciousness in the same way. Somehow the needs of society seem to take precedence over the unknown personal wishes of the victim; after all, she is unable to protest or influence any decision-making. Therefore, decisions surrounding her care, including whether or not to collect evidence, run the risk of serving the interests of institutions and public good over her own. As articulated by one SAS physician:

"The woman is not 'public good.' You're not trying to save society, even if there is somebody in custody. Why are we putting that whole sole responsibility on the woman who is unconscious, who needs health care at that point versus being violated again. I don't believe that it's the social responsibility of the woman to be always sacrificed for the system to do its job."

If, as Sherwin (1992) suggests, bioethics is indeed moving away from universal rules and abstract, broad models of reasoning towards a more contextual approach, it runs into a barrier with the unconscious patient: she is unable to articulate the personal context of her experience. It is impossible to take on the "moral view point" (Fry, 1989, p. 94) of the victim if she is unconscious.

However, as noted by several respondents to the questionnaire, representatives of the Department of the Attorney General, Victims Services Division and by the Vancouver Police Department, collection of evidence may also serve the individual interests of the victim. Regardless of her race, age, class or the particular circumstances surrounding her assault, no one person or policy can express or know the choices she would make. One sexual assault examiner sums up the dilemma succinctly:

"How can we best preserve the rights of the patients who do not wish to pursue, while not irreversibly losing the evidence (perhaps the best or only evidence) for the pa-

tients who wish to pursue? These women have rights as well."

Although studies indicate that forensic evidence does not necessarily play a large role in conviction, that does not eliminate the possibility that an unconscious patient/victim may wish to have had the evidence collected and charges laid. Due to the small number of women admitted and remaining in an unconscious state for a considerable period of time, there have not been any studies addressing this particular issue. However, some recent studies have examined the relationship between the severity of bodily injuries sustained in a sexual assault and the laying of charges.[17]

A unique Canadian report (McGregor et al., 1999) found that there was indeed an association between the extent of documented physical injuries (moderate and severe)[18] and laying of charges in cases of sexual assault. In the one-year retrospective cohort study, the charts and medical-legal reports were reviewed for all of the 95 sexual assault cases handled by B.C. Women's SAS in 1992 for which a police report had been filed. The research discovered, however, that neither the presence of genital injury nor the visual identification of sperm at the time of examination were associated with charge laying (McGregor et al., 1999, p. 1565).[19] This led the authors to conclude that many questions remain unanswered about the effectiveness of the medical component of gathering evidence during a medical-legal examination, such as the time-consuming nature of documenting microtrauma of the genital region by means of colposcopy. "It is therefore important to have good evidence that the time spent on the forensic part of the examination does indeed influence the legal outcome of the case" (ibid, pp. 1568-9). The report calls for extending this line of research to learn more about other variables that predict the laying of charges, and even more important, the securing of a conviction.[20]

Head injuries that cause unconsciousness for an indeterminate period of time constitute severe trauma perpetrated at the time of sexual assault. Due to the unique nature of unconsciousness, decisions surrounding the patient's care must be made by others. This raises the possibility of surrogate decision-making in the case of the unconscious victim of sexual assault. Several respondents to question 10 in the questionnaire (Appendix 1) expressed that they felt there might be scope for people who are close to the victim to speak for her, especially if a perpetrator were in custody or highly suspected.

"I think that a surrogate decision-maker who could make a best interest judgement should be considered at times when the safety of the public is at issue."

However, other respondents acknowledged the complexity of this possibility, as family members or friends, particularly spouses and boyfriends, may be the perpetrators. Likewise, the victim may not want to include family members in the decision.

"I believe the family or significant other should be approached for consent if possible. It should be kept in mind that if they refuse to give consent to the collection of evidence it could be that they are the perpetrators. If there is any possibility of this a court order should be obtained before evidence is collected."

From the police perspective the issue of next of kin authorizing collection of evidence rightly is not considered a police matter.

"I don't think the next of kin issue is any problem for us. It's a problem that the hospital or the SAS have in wanting to take permission from next of kin."

Two recent pieces of British Columbia legislation, the Adult Guardianship Act (AGA) (2000)[21] and the Freedom of Information and Privacy Act (1998), provide some guidance about substitute decision-making, although neither specifically discuss the unconscious person in hospital care. AGA, which was proclaimed in February 2000, discusses the duty of confidentiality and information-sharing in terms of the right to have access to information and the obligation to keep that information confidential. At any time one person who may want access to certain information means that someone else is required to disclose it. Whereas AGA sets out the rights and obligations as they apply to designated agencies and the Public Trustee, the Freedom of Information and Privacy Act applies to public bodies in general, and to those which are funded by these bodies.

Wherever possible the adult should be asked for permission to release information about her/himself. Occasionally, however, it is necessary to go to other sources. AGA gives the Public (Guardian and) Trustee and designated agencies the right to any information that is necessary to enable them to carry out the roles assigned to them under the Act (s.62(1)) and any of the aforementioned are obliged to disclose it (s.62(2)). However, the Public (Guardian and) Trustee must not disclose information they have obtained under the Adult Guardianship Act unless required to do so in

order to perform their duties or functions under the Act.

C. The Health Care Context of Informed Choice

"We believe it is imperative, especially in the case of an unconscious survivor, that all systems work to ensure that she has options about police involvement and that we don't inadvertently take these options away from her. The failure to collect forensic evidence from an unconscious survivor, in essence undermines the survivor's ability to make that choice." (Position statement, B.C. Association of Specialized Victim Assistance and Counselling Programs, January 29, 1999)

The health care context constrains choice and decision-making by offering a narrow set of options. This section moves the discussion of the general definition of consent into a feminist/ethical interpretation of the nature of informed choice, a term which has more resonance for feminists, but is also rapidly becoming part of mainstream health care. Patient autonomy (or self-direction or self-determination) is a central value in all approaches to health care ethics. However, protection of autonomy is particularly difficult in health care settings because sick patients are dependent on the care and goodwill of their caregivers. Therefore "it [dependency] reduces patients' power to exercise autonomy and it also makes them vulnerable to manipulation, and even to outright coercion by those who provide them with needed health services" (Sherwin, 1998, p. 20).

Given that patients currently are less influenced by paternalistic physician practices, a greater emphasis is now put on the patient's decisions in making up her own mind about receiving the specific health services that reflect her best interests, so long as she is competent to do so. As Addison states, "Our goal is to assist her in regaining her own self-determination. One way of doing this is providing the options available to her and supporting whatever decision she makes. It is our belief that the survivor knows best what she needs" (1998, p. 17). As the previous section shows, unconscious patients are unable to exercise that autonomy, thus the question arises: who defines what is in the patient's "best interests." It is here that the opposing voices of medicine and law grow louder.

Essentially, the exercise of autonomy is influenced by power imbalances, which is clearly seen in the context of the ill patient, who may, as a member of a particular group, be subjected to systemic discrimination, based on gender, race, class, disability, age, sexual preference or lifestyle.

These features may coalesce in certain identified oppressed groups. In the case of the patient/victim who has been sexually assaulted, there may be tendencies to stereotype the sort of woman who is perceived to be "at risk" for assault.

However, a strong ethically based feminist approach will "strive to be sensitive to the ways in which gender, race, class, age, disability, sexual orientation and marital status can undermine a patient's autonomy and credibility in health care contexts and most are aware of the long history of powerful medical control over women's bodies" (ibid, p. 23).[22]

Sherwin argues that autonomy seems to be an essential feature of any feminist strategy for improving health services for women and achieving a non-oppressive society. She goes on to explain some of the problems with the autonomy ideal. While ensuring some measure of informed choice to receive or decline treatment is a laudable mechanism for promoting patient autonomy, in practice informed consent falls short of protecting full autonomy. It is a time-consuming business, and heavy patient loads and staff shortages compromise the best intentions of caregivers in identifying patients' values and preferences. Furthermore, health care providers have to contain health care costs and be ever mindful of not making themselves liable to lawsuits. Compounding these factors is the limited training they may have in the communication skills necessary to ensure the patient's full understanding, especially taking into account cultural and linguistic barriers.

Sherwin, in developing her ideas of relational autonomy, points out how bioethics has focussed quite narrowly on the decisions of individuals. As mentioned earlier, it does not pay sufficient attention to the context, the situational ethics in which decisions are actually made:

"Patient decisions are considered to be autonomous if the patient is (1) deemed to be sufficiently competent (rational) to make the decisions at issue, (2) makes a (reasonable) choice from a set of available options, (3) has adequate information and understanding about the available choices, and (4) is free from explicit coercion toward (or away from) one of those options. It is assumed that these criteria can be evaluated in any particular case, simply by looking at the state of the patient and her deliberations in isolation from the social conditions that structure her options. Yet each of these conditions is more problematic than is generally recognized." (ibid, p. 26)

What is not taken into account by this set of options is that they may seriously limit the patient's autonomy by prematurely excluding other options the patient might have preferred. A series of complex decisions may shape the set of options the health care provider may be able to offer. Institutional decisions may reflect discriminatory values and practices. This may be one of the dilemmas encountered when SAS protocols that attempt to take the time to facilitate patient preferences conflict with other health care providers' mandates and schedules. Emergency room and intensive care services may be unwilling to adjust their pace to accommodate time-consuming decision-making strategies on the rare occasions they are involved in sexual assault cases. Some of these providers may never have received training about the need for specific strategies when dealing with a sensitive issue such as sexual assault. However, they too will follow the ethical practice guidelines for obtaining consent for procedures in general. Training of this kind does change the practice paradigm and if applied across all health care institutions and disciplines it will result in better care for women.

D. Confidentiality and Disclosure

A patient's right to confidentiality, like consent, is a cornerstone for ethical treatment. If women know that their privacy will not be respected in the health care process, they are less likely to seek medical and psychological help for the effects of sexual assault. The SAS, WAVAW and other women-centred services strive to ensure that women feel safe in the health care setting. With appropriate consent, these women choose what is documented and what is withheld about themselves and their experiences.

However, the Information and Privacy Commissioner for British Columbia explains in his recent discussion paper that Codes of Ethics for doctors and nurses do not always prohibit disclosure of patient's personal information. Rather, they allow for disclosure in limited circumstances, particularly where disclosure is permitted or required by law. For example, the Canadian Medical Association Code of Ethics (1996) restates the patient's right to confidentiality in this way:

"Respect the patient's right to confidentiality except when this right conflicts with your responsibility to the law, or when the maintenance of confidentiality would result in a significant risk of substantial harm to others or to the patient if the patient is

incompetent; in such cases, take all reasonable steps to inform the patient that confidentiality will be breached." (Article 22)[23]

The Registered Nurses Association of British Columbia (RNABC) provides ethical standards for the nursing profession in the Standards for Nursing Practice of British Columbia (1998). In Indicator #5 of Standard 4, the nurse "acts as an advocate to protect and promote a client's right to autonomy, respect, privacy, dignity and access to information." Furthermore the Canadian Nurses Association Code of Ethics (1997) advises that:

"Nurses disclose confidential information only as authorized by the client unless there is substantial risk of serious harm to the client or other persons, or a legal obligation to disclose. Where disclosure is warranted, both the amount of information and the number of people informed is restricted to the minimum necessary." (ibid)

When a conscious patient is admitted to hospital following a sexual assault, the examiner explains each part of the consent form to ensure the patient understands and agrees to all procedures. The woman may or may not agree to sign any part of the consent document. The first part of the consent document relates to a medical examination and treatment for the effects of sexual assault and the second part relates to consent to conduct a medical-legal investigation. This may involve an extensive and invasive physical examination and the collection of samples from the vagina, anus and rectum, as well as collection of blood and urine samples for analysis to determine presence of alcohol or drugs. At this point the woman may decide to have that evidence stored at the hospital and to proceed no further with reporting the assault. The patient has a year in which to change her mind and report. After this time the evidence will be destroyed by SAS. If she decides to sign the third part, she is consenting to informing the SAS and the police that a sexual assault has been committed and that the collected evidence, along with a written report of any information and observations, including health records, may be released to the police to assist in their criminal investigations. The completed consent form must be witnessed at the time of signature, with the time and date noted.

The same process applies to minors (under 19 years of age), if the physician or designate believes the young person understands the nature and consequences and the reasonably foreseeable benefits and risks of health care. In the case of a mentally incompetent person, regardless of level of competency, an informed

consent must still be obtained.

In the case of the unconscious patient, it is safe to conclude that since examiners are not obliged to assist police in investigations, they should not compromise the unstated wishes of the patient by performing any further investigations that may assist the police, other than those that are medically necessary. When the patient regains consciousness, the examiner can then, and only then, follow the patient's wishes.

X

Legal Dimensions

Three significant legal issues arise in considering the collection of forensic evidence from an unconscious patient/victim. One relates to concerns of sexual assault examiners that they may be charged with battery if they collect forensic evidence from a non-consenting unconscious patient/victim. The other two issues are even more disturbing: the experiences of women in the court system at sexual assault trials, and the minimal or inconsistent use of forensic evidence in trials. There is growing evidence that women have good reason to fear an encounter with the courts. With the expectation of retribution, some women find that clever defense counsels construct a reversal whereby the victim is portrayed as the instigator of the circumstances leading to the assault, while the assailant becomes the unsuspecting victim.

A. Battery

Obtaining consent to medical care is both a legal and ethical requirement. Treating a patient without his or her consent constitutes battery under the common law.[24] Treating a patient on the basis of inadequately informed consent constitutes negligence.[25] British Columbia recently revised its health care consent legislation, with the Health Care (Consent) and Care Facility (Admissions) Act (2000). It is similar in many ways to Ontario's Health Care Consent Act (1996), which provides for what can be done without consent in urgent or emergency situations and in other situations with consent from a "temporary substitute decision maker" (usually a family member). However, neither of these laws would apply to the situation of collecting forensic evidence from the unconscious patient because they apply to "health care" only, while the taking of bodily tissues and fluids for forensic purposes is not health care, except in the cases of communicable diseases.

There is no common law surrounding this subject. If there were a way to take samples until the patient/victim recovers consciousness and the capacity to make her own decisions, then it could be argued that the taking and preserving of forensic samples may be an ethically neutral act. However, in the absence of legislation or, at the very least, authoritative guidelines with which all sexual assault services, the police and

Crown counsel have undertaken to comply, this is unworkable. Otherwise, warrants may be issued defeating the purpose and potentially going against what the woman herself wants or would have wanted. The present legal vacuum and the related confusion it places on examiners suggests that this is a subject that the Ministry of Attorney General should address.

Nevertheless there exists a very real concern among examiners that they could be charged with battery. Ambivalence and uncertainty were expressed by many participants who completed the questionnaire, as they reconciled the differences between conducting medical examinations for health care purposes, and conducting medical examinations for legal purposes. In general they were unclear as to whether they might be sued, while recognizing that for non life-threatening medical reasons, i.e., legal reasons, they might be liable because of the lack of informed consent. One examiner with 14 years of experience reasoned that the survivors she has seen who are usually unwilling to report a sexual assault are those who are the least able to seek legal redress.

A sexual assault nurse examiner (SANE) expressed that she would be more prepared to take a chance on being sued for collection of evidence, than bear the guilt of appearing to "obstruct justice" by not assisting the police in their investigations. An e-mail correspondent said that she could not imagine a SANE or physician being charged with assault because they were acting in good faith when collecting evidence, analogous to saving the life of someone attempting suicide. The dilemma for examiners between being sued or "obstructing justice" suggests that firmly enforced SAS guidelines are needed to resolve this conflict of interest. While the SAS does have clear policies regarding this issue, the responses on the questionnaire reveal that many SAS examiners feel ambivalent and unsure about following the guidelines. Almost all the respondents to question 8 (which asks if guidelines should be streamlined provincially) believed that guidelines or policies should be instituted at a provincial, if not the national level. Question 10, which asks whether examiners should be able to make arbitrary decisions regarding collection of evidence on the unconscious patient, received more mixed responses, unveiling the confusion around this policy. A nurse states, "If there was a consistent set of guidelines there would be no need to ask individuals to make arbitrary decisions. The decision should come from government policy."

The general concern for firmer guidelines may relate to ambivalence about the definition of and circumstances surrounding a perceived "obstruction of justice."[26] One examiner put it this way: "Is it obstruction when we refuse to do them [the police] a favour by taking it [forensic evidence], or only if we refuse to after being warranted to?" The different ideologies underlying the different sexual assault services may affect perceptions of "obstructing justice." While B.C. Women's SAS is mandated to focus exclusively on women-centred health care, other services may promote a more legal evidence-based health care approach. Another difference may be that more experienced examiners are less intimidated by police pressure. Since the SAS has a strongly developed ethos about the rights of women to autonomy in the context of collecting forensic evidence, this imperative is more strongly transmitted to new examiners who continue to join the service.

There may be some other circumstances where a service not strictly related to provision of health might be administered to a non-consenting patient. A bioethicist gave the following examples: in the case of organ transplantation, the surgical procedure performed on the donor would not promote his/her health, in fact it would terminate that life. Obviously in this case a person has signed an organ donation card, or a proxy decision has been made by a next of kin. Another example might be palliative care,[27] where the intention of the doctor is not to bring on death, but rather to ease pain, even though the strong medication would ultimately contribute to premature death. The Law Reform Commission's Working Paper recommended that although continued criminal prohibition of euthanasia and assisted suicide should remain in force, a doctor should never refuse palliative care to a terminally ill person only because it may hasten death.[28]

It could be argued in the case of the unconscious patient/victim, that it is the intention of the examiner to leave the woman's options open by retrieving viable evidence that might not be available when she regains consciousness. However, under the common law, a physician must accept the patient's instructions to refuse or discontinue medical treatment because to continue to treat the patient when the patient has withdrawn consent to that treatment constitutes battery. Canadian courts have recognized this right in Malette v. Shulman (1990) 72 O.R. (2nd) 417 (Ont.CA). Caught in the quandary of the best intentions of the examiner and strictures of the present laws, the only possibility is that examiners

place themselves in the onerous situation of liability to be sued. If and when such cases appear before the courts, a body of case law will ultimately emerge, which will better inform regulations relating to patient consent, particularly in the case of the unconscious patient.

A less articulated concern, which is the reversal of battery, is the potential for a woman to sue the examiner for not collecting evidence, if she regains consciousness after the time has elapsed for collection of viable evidence. If she wishes to report the sexual assault and initiate a civil lawsuit, she might well require the substantiating evidence. To date, no cases have been reported, but like battery, this possibility is likely a simple matter of time in our increasingly litigious society.

B. The Unbalanced Scales of Justice

"The court does not work in favour of women. It's like the woman is the criminal and the assailant is like a poor victim. It's a reversal. It's really horrible. The woman's life history is dragged out by the defense counsel – her sexual history. Even though Bill C-46 got by with a narrow margin, it is not written in stone in the courts. It's at the discretion of individual judges." (Quote from interview with a victim service worker who accompanies women to court)

Paradoxically, despite the continued patriarchal practices of the courts, more cases of sexual assault are coming before them. Recent trends in the official rates of sexual and non-sexual assault in Canada demonstrate a rapidly rising rate of violent crime. This increase has been noticeable since the reform legislation of 1983, when Parliament reviewed the Criminal Code revisions relating to assault. Sexual assault is undefined by the Criminal Code, except that the general definition of assault described in s. 265(1) applies to all forms of sexual assault. This had the initial effect of causing uncertainty for police in differentiating between assault and sexual assault, as well as affecting how they classified official statistics.[29] (See Appendix 2, Table 1.)

Finally, in 1987, R. v. Chase provided guidelines by the Supreme Court as to what constituted sexual assault, and the three parallel offenses of sexual assault came into effect.[30] Following these legal changes Canadian police departments became more active in laying charges, particularly in cases of domestic violence against women and children by known perpetrators.

While legal reform accounts for the steady increase in reports of sexual assault, other significant factors are the social changes which "have

brought about growing efforts to eradicate the biases that have confronted complaints of sexual assault and wife assault in the justice system and to provide better treatment and services for victims. All of these factors may have had an effect on victims' willingness to report sexual assault, even in the absence of law reform" (Johnson, 1996, p. 36).

Despite the laudable intentions of the above statement, the reality is that, for various reasons, 85% of women who are sexually assaulted never report to the police. Some of these reasons are catalogued in the study prepared for SAS by Herbert and Wiebe (1989),[31] who were interested in the reasons for not reporting a sexual assault. Because of the sensitivity of the subject the researchers did not ask victims specifically, but required physician examiners to check off as many reasons for not reporting as they thought applied in each case.

Of those women who do report a sexual assault in B.C., more than half do not proceed to trial according to recorded data for 1988 and 1990 (Herbert & Wiebe, 1989).[32] In 1988, of the 40 of the 93 cases examined by the researchers that did proceed to trial, only 13 men were found guilty. In 1990, only 11 out of the 52 cases examined proceeded to trial, and two were found guilty. The average sentence for those found guilty was 5.7 years. These outcomes partially reflect what happens to those women brave enough to confront the courts. For these victims, it is all too frequently a minefield of aggressive defense counsels, negative stereotyping of witnesses and inappropriate admission into court of confidential personal records (medical, psychiatric, counselling).

Flaherty's (1998) recent discussion paper attempts to sift through the competing goals of effective law enforcement and appropriate protection of personal privacy. The guidelines he proposes will help health care providers to clarify two important principles: the individual's right to control her own information, and the "need to know principle," which is a valuable tool for determining what information should be disclosed to whom. However, the problem still arises that if such evidence does get into the courts, it is used too often to disadvantage the victim. Ensuring that minimal essential information is divulged by health care providers is an important first step.

The recent series of papers published by Metropolitan Action Committee on Violence Against Women and Children (METRAC) in Toronto

entitled Can Confidentiality Survive: A Day of Study on Disclosure of Personal Records in Sexual Assault Cases (1998) discusses several problems encountered by women going into the courts. Sampson's (1998) discussion familiarizes readers with the issues of production and disclosure of personal records of complainants in sexual assault trials. It reviews the case law leading up to the introduction of Bill C-46 and the legal landscape in the post Bill C-46 era. She argues that: "The efforts of defense counsel to access the third party records of complainants in sexual assault trials can be characterized generally as part of the retrenchment movement against equality advances made by women in Canadian society. This backlash movement can be understood to represent a specific targeted assault on the progress made by women who have been working toward the goal of ending violence against women in Canada" (Sampson, 1998, p. 4).[33]

Throughout the 1990s there have been a series of cases that have promoted and truncated women's equality rights in the criminal context of sexual assault. The Seaboyer decision in 1991 is a watershed case.[34] The public outrage concerning this decision led to the introduction in 1992 of Bill C-49, often referred to as the "rape shield" legislation. It prohibited admission of evidence relating to a complainant's past sexual history. This had the effect of preventing defense counsels from focussing on sexual histories and instead discrediting complainants by using their personal records to produce discriminatory stereotypes of women, who fabricated allegations of rape and suffered from "false memory syndrome."

The infamous O'Connor case[35] in 1995, led to a majority decision by the Supreme Court of Canada that a complainant's records were almost always relevant in sexual assault trials and were ordered to be produced. There was no section 15 Charter rights equality analysis of this major decision. The increase in production of complainants' records had the effect of intimidating women to abandon their allegations, and of offensively stereotyping women as unreliable or suggestible. In essence, it had the detrimental effect of using the very people working for assaulted women – support workers, such as counsellors, crisis workers, and sexual assault health care providers – to work against them. As a result, these support workers limited to a minimum the documentation of information that could be subpoenaed into court.

In May 1997, new production and disclosure laws were introduced through Bill C-46.

This feminist legislation reflects the gendered nature of sexual assault as an equality rights issue. It recognizes a complainant's privacy rights and the perpetuating discriminatory nature of women's experience with the courts. The constitutionality of the legislation has continued to be challenged. The Brian Joseph Mills case,[36] in particular, highlights the offensive nature of the defense's attempt to violate the confidentiality of personal records. "It is the first and one of the most important cases in the court this winter as it balances the rights of the accused to a fair trial and a sexual assault complainant's privacy rights" (Tibbetts, 1999, pp. A1-2).

The sexual assault trial of Albertan Steve Ewanchuk, in February 1998, which led to his acquittal by Court of Appeal Judge, John McClung[37] has caused further backlashes against feminism in the courts. The interpretation of "implied" consent, a non-existent concept in Canadian law on sexual assault, was finally quashed by a unanimous decision by the Supreme Court of Canada in February 1999. In her ruling, Supreme Court Justice, Madam Justice L'Heureux-Dube rebuked McClung for promoting sexual stereotypes about sexual assault. He retaliated by suggesting her personal convictions were responsible for the high rate of male suicide in Quebec.[38] So it would seem that each small success achieved by feminists in the courts is fraught with further jeopardy.

The researcher heard some compelling personal accounts about how the courts continue to harass victims. It is as though the last 20 years of efforts to advance women's rights with feminist legislation have not always played out in the practices of the court.

C. The "Mystique" of Forensic Evidence[39]

"There is this mystique around DNA testing – it wasn't available until the last five years really and there's this sense that the police would love to fingerprint everybody in society so that when you go to get a sample they know just exactly who they're going after... There's this mystique that comes from television partly, which is that if we just had this DNA all we need to do is get the guy." (Personal interview with experienced examiner)

In July 1995, the federal government passed warrant legislation in the form of Bill C-104, which permitted the collection of DNA samples from suspected criminals without their consent. The government has proceeded to promote development of a DNA Data Bank, which would permit the storage of the genetic

information or the biological samples indefinitely.[40] At the time, the Solicitor General's Office asked for input about this initiative. Miller, a presenter at the consultation meeting on behalf of the Feminist Alliance on New Reproductive and Genetic Technologies, points out how proponents of the technology make it appear like a quick fix:

"Those who promote the technology – police, government and scientists – claim that the use of DNA evidence will enable police to 'do their job.' Indeed the government's consultation document argues that 'DNA can focus investigations, and will likely shorten trials and lead to guilty pleas. It could also deter some offenders from committing serious offences. The increased use of forensic DNA evidence will lead to long-term saving for the criminal justice system.'" (1996, p. 1)

The RCMP estimate that expenditures for DNA[41] casework will cost about $6 million annually, and another $5.8 million is needed to build the biology section of their new forensic laboratory. In Ontario, as Miller discusses, while there is no money for women's survivor or advocacy organizations, another $2.2 million has been found to double the capacity of the DNA testing unit at the crime lab[42] (1996, p. 2).

Therefore the perceived value of forensic evidence depends on whether a policy, law enforcement, judicial or a woman-centred approach is endorsed. "You can never have enough evidence," one crown counsel told the researcher. However, the Crown's perspective on the use of forensic evidence in court runs the gamut from "the more corroborating evidence, the better the chance of a successful prosecution" to "the evidence of injury that is the most helpful to doctors and police officers frequently focus too narrowly on the more technical aspects of the examination and fail to record basic observation of injuries that would corroborate the complainant's allegation that contact was not consensual" (Kee, 1996, pp. 16-17).

Kee reveals how views differ on the impact of forensic evidence in the plea bargaining process. Where there is denial of sexual assault, that denial is not shaken by the presence of medical evidence. However, with the increased availability of DNA evidence from the accused, this trend may change. If there is not any evidence in the file, the defense is more likely to proceed to trial, because this lack of forensic evidence may eventually lead to an acquittal (ibid, p. 17). But if there is evidence available, it will have to be incontestable. Juries in the future will want 99.999% likelihood of guilt when

evidence is admitted. They will be inclined to discount the verbal testimony of witnesses, which cannot carry the statistical reliability of scientific evidence. Thus, reasonable doubt will be skewed by this incredible technology, which will work against women in many cases (Miller, 1996, p. 4).

In Kee's searches of court files of prosecutions in B.C. concluded during 1994-1995, she found that**,** particularly in Provincial Court, where transcripts of court proceedings were not made, it was impossible to determine what impact the introduction of forensic evidence had on outcome (ibid, 1996). In an earlier study for SAS, Herbert and Wiebe (1989), who were curious about the usefulness of evidence in the legal process, audited the charts of 130 cases assessed in 1986 to determine the application in court of the medical-legal evidence.

"Of the 25 cases in which charges were laid (out of 99 cases dealt with by police) 17 proceeded to trial. 143 subpoenas were available from roster physician records, which were used to obtain from the court registry the reasons-for-judgement documents. Only 5 judgements were written, and two of them were unavailable. Of the remaining 3, only one mentioned the medical evidence, with the judge stating, 'So notwithstanding the corroboration provided by the doctor's evidence... and dismissing the charges.'"(1989, p. 97)

The researchers concluded that medical evidence did not appear to be useful, therefore sexual assault centres should be aware that the legal aspects of medical-legal examination might be minimally important in court. They suggested that lawyers and judges should make better use of forensic evidence, and that better tracking to determine outcomes of the legal process for victims and their alleged assailants was necessary.

A recently published Vancouver study by McGregor et al. (1999)[43] examined whether documented injury by the sexual assault physician examiner was associated with legal outcomes, and which patient, physical examination, and assault characteristics appeared to be associated with charge laying. Although the number of convictions was small for the examined data, it appeared that charge laying was a positive outcome of medical-legal examination. However, a lack of association between charge laying and genital findings was found. Because examiner time demands are critical for victim "debriefing," medical treatment and counselling services, the study concluded that examiner time spent on documenting microtrauma with colposcopy might

not be a useful strategy. However, other factors such as the characteristics of women who fall in the lowest income groups (often substance abusers and sex trade workers) might bias the justice system against laying charges. Therefore socioeconomic status plays a role in affecting legal outcomes.[44]

Without charge laying a conviction cannot occur. Statistics from the study by Kee show that even if forensic evidence is available, it is rarely used in court. Of the 452 files she searched, only 230 included court proceedings, in which a trial or a preliminary inquiry were held. It was only in those cases, therefore, that medical forensic evidence could have been admissible. The table of results speaks clearly to the limited use of forensic evidence in B.C. courts. Proportionately the Supreme Court statistics show a 1:3 conviction rate as opposed to a 1:5 conviction rate for all court locations (See Appendix 2, Table 3).

Kubanek, while working as a victim service worker with the Vancouver Rape Relief and Women's Shelter cautioned that police and courts often can do their job without the technological tool of DNA. She asserts that they could make better use of other available evidence, rather than being preoccupied with expensive and time-consuming forensic evidence collection and analysis, because "It has been the lived experience of rape crisis and transition house workers, and of the women who call us, that police and the courts choose not to do their jobs. Every assertion to the contrary must be resisted" (1997, p. 4).

Therefore, suggesting that SAS examiners and the SAS are negligent if they do not collect evidence is a red herring. There is a disjuncture between examiner values and efforts to collect evidence on behalf of the justice system, and the value placed on the evidence once it is collected. This paradox is clearly articulated by an examiner:

"Some of the reaction you can get from, for instance, one of the recent cases at VGH is the sense that there's something magical than happens when somebody does a vaginal examination and takes a forensic sample. If you look at the data, most of those samples are never used, most of the time assailants are never caught, and most of the time when they're convicted or caught and charged, there's a plethora of other evidence that goes to…whether they're convicted or not. So this sense that, if somebody doesn't do an examination of a woman who is unconscious, and doesn't take the DNA evidence,

society is going to be harmed by that; it's just nonsense, it's absolute nonsense at this stage." (Interview with an examiner)

Conversely, the Vancouver Police Department argues for the value of forensic evidence. Their main argument is that DNA evidence and now the DNA bank will enable the police to catch the guilty, even long after the crime was committed,[45] and that the innocent will be exonerated. To highlight the issue, they focus on the psychological profile of rapists, as is demonstrated by an SOS officer:

"Without the evidence taken in a timely fashion, we won't be able to identify in a relatively fail safe manner the perpetrator of this type of vicious assault, and the second part that goes along with that is that perpetrators are not stupid people generally. And if they became aware that their victim was unconscious and hospitals won't gather the DNA evidence against them, they may change their *modus operandi* to ensure that the victim is unconscious when they leave them, knowing that the DNA will not be collected. And it may create a series of events by which a serial rapist leaves a victim unconscious if not dead."

In summary, it depends on the perspective of the discussant and his or her professional affiliation as to how she/he values forensic evidence. However, the statistics gathered by Kee (1996) and Herbert and Wiebe (1989) suggest that even when forensic evidence is admitted in court, it is rarely of significance to the outcome. McGregor et al. (1999) demonstrate that there may be other characteristics of the victims which are significant in the bias of the courts to use the evidence. Further research of other variables surrounding the process of evidence collection, through charge laying and on to conviction are necessary. Future studies will assist in determining if the current SAS policy is the most expedient.

XI

Conclusion

This report, which illuminates knowledge and gaps in knowledge of forensic evidence collection and unconscious patients, is intended to better inform B.C. Women's Sexual Assault Service policy for care of the unconscious patient.

The report suggests that it is important to examine the characteristics of women who are admitted into hospital in an unconscious state, and whether different groups of women are dealt with in a different manner by institutions, such as hospitals, police and the justice system. It is vital to track the circumstances under which forensic evidence is admissible from collection in hospital, through the police investigation and into the courts and finally to conviction of an assailant. More research is needed to establish if victims who are the spouses, daughters and sisters (often perceived as "good girls") of privileged, usually white, middle class educated men, are stereotyped in an advantageous manner and receive better representation, respect and outcomes in the court process, while those women who are stereotyped as poor, women of colour, street people (conversely, often perceived as "bad girls"), are viewed as less deserving of equal rights and needs.

At the very heart of the question of conducting a medical-legal examination and the collection of forensic evidence from a victim/patient who is unconscious as a result of an alleged sexual assault, is lack of consent. Regardless of whether or not it is lack of consent to a medical procedure or lack of consent to engage in sexual activity, both relate to the extreme abuse of power; both are associated with the violation of bodily integrity and acts of disempowerment, which undermine the dignity and control that women have for self-determination, agency and autonomy.

Following a sexual assault, it is important to reinforce a woman's right to consent to each and every stage of a medical and legal investigation. Only by being provided with as many options as possible, can a woman determine what is best for her, both in the short term and into the future, which is where the powerful DNA testimony releases its silent confirmation. As society moves into the new deterministic genetic age of reveal-

ing the blueprint of each and every human being, it is important to recognize that new loci of power and control are emerging in the cartography of human relations, as well as federal policies. Until we have better evidence about all women's wishes regarding consent to medical-legal services in the case of sexual assault, it is prudent that a women-centred approach continues to assert the rights of those most marginalized and subjugated in society. Given the proximity of the SAS to Vancouver's Downtown Eastside, where women are particularly vulnerable, it is important that the needs of these particular women are heeded.

Therefore, the metaphor of the violated, voiceless victim is a good place to centre the continuing struggle for reasserting the rights of the victim who has been sexually assaulted; most importantly, in the case of the mute unconscious patient/victim, who cannot state her wishes and must rely on others to safeguard her present and future well-being.

Appendix 1 – Participant Questionnaire

SEXUAL ASSAULT AND COLLECTION OF FORENSIC EVIDENCE FROM UNCONSCIOUS PATIENTS
A RESEARCH PROJECT FUNDED BY THE BRITISH COLUMBIA CENTRE OF EXCELLENCE FOR WOMEN'S HEALTH AND THE SEXUAL ASSAULT SERVICE OF BRITISH COLUMBIA'S WOMEN'S HOSPITAL AND HEALTH CENTRE

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Dear Participant,

In order to obtain as much information as possible about the above research issue, I am piloting a preliminary questionnaire, which I hope you will agree to complete and return to me. In order to respect confidentiality of data, there is no need to identify yourself. However, if you wish to include your name and YOUR affiliation, it would be of additional help in organizing the data analysis in order to write a position paper. If there are other associates in your office/institution/service, who you think would like to fill out a questionnaire, please feel free to copy it and have them return it to me. The questionnaire is also available on disk.

If you have agreed to meet with me personally for a discussion of the issues that you consider pertinent to this study, some of the questions asked below may have already been addressed or may be of limited interest to you. You may perhaps have comments you would like to add on further reflection or because anonymity has been established.

I have left room at the end for any additional information you may wish to discuss. As you fully understand, this subject matter is both sensitive and complex, and therefore any comments you may wish to raise, which can further our thinking on this matter, would be much appreciated.

If you have any further questions about this project please feel free to call me at [redacted], e-mail me at patlee@interchange.ubc.ca or leave a message at the British Columbia Centre of Excellence for Women's Health, 604-875-2633.

Please fill out your responses to the following questions. If insufficient space is provided, please extend the space provided. (Note: Several blank lines were included after each question in the original document.)

1. Were you involved in any of the discussions groups organized by the Sexual Assault Service at British Columbia's Women's Hospital and Health Centre last year? If so, in what way?

2. Please explain what you think are the significant issues relating to the collection or non-collection of forensic evidence from a woman, who has been admitted to hospital in an unconscious state and is unable to give consent to examination and collection of evidence by a sexual assault examiner.

3. If you have ever been involved in any case where there has been a dilemma about whether or not to collect forensic evidence from an unconscious woman, would you please explain the circumstances and what decision making informed the final outcome.

4. If the answer was 'yes' to question 3, were you satisfied with the outcome? If so, why were you satisfied? If not, why not?

5. Is a sexual assault examiner likely to be charged with battery if she collects evidence from an unconscious patient? Please explain.

6. What are some of the issues that you envisage could disadvantage a woman if evidence was collected and handed over to the law enforcement agency without her consent?

7. What are some of the issues that you envisage could advantage a woman if evidence was collected and handed over to the law enforcement agency without her consent?

8. Inconsistencies between various Sexual Assault Programs exist presently, leading to a patchwork of policies about collection, storage, release, collection and non-release, as well as non-collection of evidence. Do you think guidelines should be instituted to streamline policies provincially and nationally, or should an ad hoc system be maintained? Please explain your reasoning.

9. How do the above issues affect the serving of a warrant for release of evidence?

10. Should physician or nurse examiners, as frontline personnel, be expected to make an arbitrary decision about collection of forensic evidence, when faced with a patient, who they do not know if or when she may regain consciousness? If not, who should make this type of decision and why?

11. Do you consider this subject to be a medical practice issue, a legal issue, an ethical dilemma, or a feminist issue? Or is it a combination of several of the above? Please comment.

12. Presently, there appears to be a lack of consensus about the interim policy of non-collection of evidence at Vancouver Hospital among health providers, such as Emergency, ICU, Gynaecology and sexual assault service providers. What could be done to improve potential discord?

13. If you were called tomorrow to attend an unconscious patient, would you collect forensic evidence?

14. What would you do with that evidence?

15. Any further comments you may have would be greatly appreciated.

Thank you for taking the time to complete this questionnaire. Your contribution will remain anonymous, unless you wish to be identified either by name or profession. Before any individualized opinions are included in the final report you will be contacted to review a draft and discuss with me any amendments you see fit.

Name (print):

Affiliation (e.g. professional):

Telephone or other contact method:

Please return by February 26th, 1999 in the stamped envelope or drop off to the Sexual Assault Service of British Columbia's Women's Hospital and Health Centre

Appendix 2 - Tables of Statistics

Table 1 - One-Year Victimization Rates of Sexual assault and Wife Assault per 1000 Adult Female Population, Produced by Crime Victim Surveys

From Johnson, H. (1996). Dangerous domain: Violence against women in Canada (Table 2.2). Toronto: Nelson Canada.

Survey	Year	Sexual assault	Wife assault
	Rate per 1000 female population		
Canadian Urban Victimization Survey	1982	6[1]	4
General Social Survey	1988	–[2]	15
General Social Survey	1993	29[3]	19
U.S. National Crime Victimization Survey	1987-92	1[4]	5
U.S. National Crime Victimization Survey	1992-93	5[5]	9

– not statistically reliable
[1] Includes rape, molesting, and attempts against women age 16 and older
[2] Includes rape, molesting, and attempts against women age 15 and older
[3] Includes sexual assault, molesting, and attempts against women age 15 and older
[4] Includes rape and attempts against women age 12 and older
[5] Includes rape, attempted rape, sexual attacks, and unwanted sexual acts against women age 12 and older

Sources: Solicitor General Canada, Female Victims of Crime, Canadian Urban Victimization Survey, Bulletin 4 (1985); Canadian Centre for Justice Statistics, "Conjugal Violence Against Women," Juristat Service Bulletin 10(7) (1990); Statistics Canada, General Social Survey, Microdata File, Ottawa (1993). Ronet Bachman, Violence Against Women: A National Crime Victimization Survey Report, Washington, D.C.: Bureau of Justice Statistics (1994); Ronet Bachman and Linda Saltzman, Violence Against Women: Estimates from the Redesigned Survey, Washington, D.C.: Bureau of Justice Statistics (1995).

Table 2 - Number of Sexual Assaults Against Adult Women in 1993 Recorded by Police, the General Social Survey, and the Violence Against Women Survey

From Johnson, H. (1996). Dangerous domain: Violence against women in Canada (Figure 2.4). Toronto: Nelson Canada.

Police	15,200
General Social Survey	316,000
Violence Against Women Survey	572,000

Police statistics and the General Social Survey count the number of incidents of sexual assault. The Violence Against Women Survey counts the number of women who have been sexually assaulted.

Sources: Canadian Centre for Justice Statistics, Revised Uniform Crime Reporting Survey, Unpublished data, Statistics Canada (1994a); 1993 General Social Survey, Microdata File, Statistics Canada, Violence Against Women Survey, Microdata File.

Table 3 – Table of Results

From Kee, J. (1996). Collection, storage and use of medical forensic evidence in sexual assault investigations in British Columbia. A research paper. (p. 20). B.C. Ministry of Attorney General, Community Justice Branch, Victims Services Division.

	Dispositions All Files[1]	Medical/Forensic Evidence – All Locations[2]	Medical/Forensic Evidence – Vancouver Supreme Court Only[3]
Total	499	35	15
Convictions	147	7	5
Acquittals	83	15	8
Orders to Stand Trial	96	8	n/a
Stays of Proceedings	155	n/a	n/a
Guilty of Lesser Included Offence	15	1	–
Other	3	4	2

It is also worth noting that of the 452 files searched, only 230 included court proceedings; that is, in only 230 of the files either a trial or a preliminary inquiry was held. It is only those cases in which medical forensic evidence could have been introduced.

[1] A total of 452 court files pertaining to sexual assaults were located and searched. A single court file almost always relates to a single accused person but often documents the proceedings against that person on more than one charge. It is very common to lay more than one charge concerning the same event in the expectation that only one of those charges could successfully proceed. This table counts each different disposition of a sexual offence (conviction, stay of proceeding, acquittal, etc.) appearing on the file once only, even where the disposition related to more than one charge.

[2] This column and the next set out the dispositions of proceedings where medical forensic evidence was introduced.

[3] As the results of the study of files in the Vancouver Registry of the Supreme Court of British Columbia differed significantly from the overall results, this information is provided in this column.

Endnotes

[1] Whereas the Victim Service Division, Community Justice Branch, Ministry of Attorney General uses the term victim/patient, this document reverses the designation to patient/victim to recognize that the victim of a sexual assault is primarily a patient, like any other patient in the health care setting. This report focuses on the subject of sexual assault as being predominantly female, while acknowledging that many of the issues discussed could apply to a male subject.

[2] Qualitative data was collected from a preliminary analysis of 15 completed questionnaires (40 were circulated), as well as discussions raised in personal interviews with 24 people. The latter group was comprised of representatives from the Vancouver Police Department (2), the Crown Counsel Office (1), lawyers concerned with sexual assault (3), the Attorney General Office (2), the Public Trustees Office (1), SAS health care providers (6), B.C. Women's Hospital and Health Service Administration (2), Sexual Assault Nurse Examiners in B.C. (2), victim service workers (4), and a hospital ethicist (1). In most cases people who took part in an interview also filled out a questionnaire. Four identified themselves on the questionnaire.

[3] A Nurse Clinician/Nurse Examiner (SANE), Emergency Sexual Assault Nurse Examiner Program, at Surrey Memorial Hospital, is the Western Canadian representative to the International Association of Forensic Nurses (IAFN) Sexual Assault Nurse Examiner's Council. She has provided names, addresses, and e-mail addresses of all the programmes that are affiliated with IAFN. These programmes could be polled for their experiences with formulating guidelines with respect to the unconscious patient. A SAS SANE has begun to collect e-mail correspondence from other SANEs, which she has kindly shared with the researcher. Current research from a Toronto programme by J. Du Mont & D. Parnis, which documents similar findings to the report by McGregor et al. (1999), has been published in Medicine and Law (2000).

[4] Several interviews with sexual assault victims who are also victim service workers paint a graphic portrait of the victim's unique perspective.

[5] It is commonly argued that policing, legal, and medical institutions continue to portray patriarchal and paternalistic values, which exert mechanisms of power and control over their clients. This does not mean that the people who work within these institutions, whether male or female, do not act in a sensitive manner to promote and defend the best interests of the vulnerable.

[6] Its counterpart in medicine is iatrogenic.

[7] A notable recent addition is the edited volume by Sherwin, S. (1998). The politics of women's health: Exploring agency and autonomy. Philadelphia: Temple University Press.

[8] See a list of useful references at footnote 44 of Morgan, K.P. (1998). Contested bodies, Contested knowledges: Women, health, and the politics of medicalization. In Sherwin, S. (Ed.), The politics of women's health: Exploring agency and autonomy (pp. 83-121). Philadelphia: Temple University Press.

[9] Rodgers (1995) at footnote 20 cites many useful references including Todd, A. (1989). Intimate adversaries: Cultural conflict between doctors and women patients (p. 70). Philadelphia: University of Philadelphia Press and Sherwin, S. (1992). No longer patient. (p.223). Philadelphia: Temple University Press.

[10] There has been considerable media coverage of increased efforts by the police to discover what happened to 31 missing women, many from the Downtown Eastside of Vancouver, as well as the suspicion that the human remains of four women known to be sex trade workers (which were found in remote places in B.C.) may be linked to a serial rapist. One man, presently in prison for sexual assault in B.C., has had his geographical movements over the last few years re-examined in order to correlate where he was when some these women disappeared. The unsolved files date back to 1978, although 22 women have gone missing in the last four years, including four reported in 1999. An episode on July 31, 1999 of the popular American show "America's Most Wanted" profiled these disappearances and deaths, which led to a series of new tips to VPD. Recently, a Toronto woman sued the police for not advising the public of a serial rapist in her community.

[11] A co-founder of the Vancouver SAS argues that medical-legal examinations are not a necessary part of provision of health care services, and as adjunct services, should be viewed as elective and

subject to particular scrutiny in terms of consent (Interview, February 17, 1999).

[12] Malette v. Shulman (1990). 67 DLR (4th) (OntCA) at p. 338. Cited in Etchells et al. (1996). Bioethics for clinicians: 1. Consent. Canadian Medical Association Journal, 178.

[13] SAS was provided with a copy of Freedman, B. (1981). Competence, marginal and otherwise: Concepts and ethics. International Journal of Law and Psychiatry, 4, 248-260. In an outdated discussion of the two-fold nature of rights to consent, Freedman argues "for the incompetent – the voiceless – we are forced to look elsewhere than at their desires, in giving expression to their rights. One approach to this is to have us making decisions in terms of the incompetent's 'best interests' as determined by his biological and psychological being, on the one hand, and, on the other, by a community consensus concerning the good for man" (p. 248).

[14] The following people were invited and attended the first meeting: Megan Ellis, Civil Lawyer, one of the founders of WAVAW RCC, Elizabeth Burgess, Crown Counsel, Director of Special Justice Programs, Judith Milliken, Crown Council, Geramy Field, SOS Vancouver Police, Dr. Liz Whynot, cofounder of SAS, Harjit Kaur, WAVAW and Monika Fisher, a forensic economist and advocate for people with brain injuries.

[15] Most women neither seek medical attention or report to the police. Since most women the SAS examine have been brought in by the police, they are more likely to file a report with them. When the service tracked the conviction rate of women who had been through SAS, they were appalled to see that only 10 out of 100 cases ended up with a conviction (Correspondence with SAS coordinator).

[16] Originally labeled the "interim policy," it was decided that the term "interim" be removed from the record during the February 1999 discussion between SAS and hospital communications department, following communications between the assistant police chief and hospital administration. At this time the Vancouver Police Department was pressing strongly for changes to the policy and threatening to go public about the issue.

[17] Rambow et al. (1992) found that there was a significant association between evidence of genital or nongenital trauma and conviction, while a Finnish study by Pentilla and Karhumen (1990) found little correlation. In a later Scandinavian study, Schei et al. (1995) found that conviction was significantly associated with occurrence of severe violence,

documentation of genital injuries and presence of sperm at the time of examination (quoted in McGregor, 1999, p. 1565). See also another Canadian study by Du Mont and Parnis (2000).

[18] Four physicians from the Sexual Assault Service including authors Drs. McGregor and Wiebe designed a clinical injury score to apply to the 95 cases reviewed. This was rated from 0 to 3: 0 (no injury); 1 (mild injury) where redness or tenderness only or minor injuries with no expected impact on physical function was seen; 2 (moderate injury) consisting of injuries expected to have some impact on function and/or more than redness or tenderness of the genitalia, e.g., lacerations, bruising, abrasions and/or injuries requiring treatment and/or bruising of the head and neck expected to result in significant headache; 3 (severe injury) resulting in head injury with concussion and/or evidence of attempted strangulation and/or other major injuries, e.g., fracture, internal organ contusion.

[19] Based on further communications with Dr. McGregor, a clearer understanding of the significance of the medical-legal report on the visualization of sperm and genital injuries at the time of examination, as opposed to the later DNA typing to identify an assailant, is important. Lengthy delays in obtaining forensic laboratory reports at the time of charge laying may imply that the specifically documented details in medical-legal reports are taken note of in the absence of conclusive DNA data.

[20] Other variables emerging from the research are socioeconomic factors influencing charge laying and the possible bias of the justice system towards certain characteristics of victims who are poor, sex trade workers, substance abusers, or uncooperative with the police.

[21] The Adult Guardianship Act is one of four statutes which was proclaimed effective in B.C. legislature on February 28, 2000. The other statutes are the Health Care (Consent) and Care Facility (Admission) Act RSBC 1996 c. 181, the Representation Agreement Act RSBC 1996 c. 405, and the Public Guardian and Trustee Act RSBC 1996, c. 131. There is also an Adult Guardianship Statutes Amendment Act RSBC 1999, c. 25.

[22] Some useful texts which discuss how women's bodies have been subjected to control by an increasingly powerful medical system are Ehrenreich and English, 1979 and Mitchinson, 1992.

[23] Quoted in Appendix 3 of Flaherty, David H. Collection and disclosure of personal information between health

care providers and policing agencies under the B.C. Freedom of Information and Protection of Privacy Act. September 1, 1998, p. 17.

[24] Malette v. Shulman (1990). 67 DLR (4th) (Ont CA) at p. 338.

[25] Reibl v. Hughes (1980). 2 SCR 880.

[26] This perception is probably unfounded given the lack of legislation surrounding this particular issue. It requires further examination and legal advice.

[27] "Palliative care" means a qualified medical practitioner, or person acting under the general supervision of a qualified medical practitioner, administering medication or other treatment to a terminally ill patient with the intention of relieving pain or suffering even though this may hasten death. This conduct, when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution (Crown Counsel Policy Manual, Active Euthanasia and Assisted Suicide, Ministry of Attorney General, p. 2).

[28] The substantial likelihood of a conviction was addressed in the document Active Euthanasia and Assisted Suicide in Crown Counsel Policy Manual, Ministry of Attorney General, Criminal Justice Branch. It references Mr. Justice Sopinka's reasoning in Rodriquez v Attorney General of Canada et al., Supreme Court of Canada, September 30, 1993. He stated the distinction based on "intention" – the intention to ease pain, which has the affect of hastening death. In his view, "distinction based upon intent are important and in fact form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear…" (p. 34). In a recent Nova Scotia case, respiratory physician Dr. Nancy Morrison, was cleared of the charges of hastening the death of her patient with oesophageal cancer who was in extreme pain. She was, however, castigated by the College of Physicians and Surgeons (Toughhill, 1998). Intent was clear in the case of American habitual euthanist Dr. Jack Kevorkian, who videotaped his administration of a lethal injection. He was convicted and sentenced to 10-25 years (Johnson, 1999, p. 14).

[29] It was not until 1993 that revised surveys showed the correlation between assault and spouses or common law partners (Canadian Centre for Justice Statistics, 1993)

[30] The definition of assault is set out in three parts in Section 265 of the Criminal Code. Sections 271-273 set out level I, II and III for sexual assault.

[31] Author Dr. Carol Herbert, along with Dr. Liz Whynot, was one of the co-founders of SAS, and co-author Dr. Wiebe has been an active and longstanding member of SAS.

[32] For a further illustration of this reality, see Appendix 2, Table 3.

[33] See also papers by Mary Addison and Gail Robinson in the same METRAC publication for similar commentary.

[34] The Supreme Court of Canada in Seaboyer "held that the provisions of the Criminal Code that restricted the use in sexual assault trials of a complainant's prior sexual history with anyone other than the accused were an unconstitutional violation of an accused's right to a fair trial" (Sampson, 1998, p. 4).

[35] The accused Bishop O'Connor was charged with sexually assaulting several Aboriginal women at a residential school in B.C. The defense counsel in the case requested the complainants' medical, therapeutic, education and employment records, which the accused himself had generated.

[36] The complainant in the Mills case is a 15-year-old girl who was 13 at the time Mills assaulted her. Under Bill C-46 the Alberta court judge held that the accused's rights under sections 1 and 7 of the charter were infringed.

[37] Ironically, McClung is the grandson of the renowned feminist Nellie McClung.

[38] L'Heureux-Dube's husband had committed suicide 20 years ago (Editorial in Vancouver Sun, February 27, 1999, pp. A3 and A22).

[39] The use of the term "mystique" is attributed to Dr. Whynot. She reminisces about how in the early days when they used the Seattle Harbour View model for taking and collecting evidence, they decided not to use the rape kit provided by the police because it was too complex and came with a mystique that there was something complicated about the examination. Examiners stocked up their own standard cart. The kits are really only paper bags.

[40] As yet, it is unclear what will happen to the DNA of a victim which is collected at the same time as the assailant's DNA from her body. In the absence of regulation to protect privacy rights, her DNA sample could well be stored in the impending federal government DNA data bank, where profiles of individuals may well be constructed from the individual DNA blueprint for reasons other than those for which it was collected.

[41] Since 1985, survival of DNA in evidence samples in sufficient quantity and quality has made it possible for genetic analysis directly

at the gene level. In relation to sexual assault, specimens in the vagina may last up to seven days, in the mouth for several hours, and in the anal canal for 24 hours (Sensabauh, D. and E. Blake 1994, p.417). In August 1999, for the first time in a Canadian criminal trial, mitochondrial DNA evidence, which makes identification of older remains possible, will be used to implicate a suspect. The Forensic Sciences Laboratory in Birmingham, England has matched the mitochondrial DNA found at the murder site of Mindy Tran, an eight- year-old Kelowna girl killed in 1984, with the blood sample of Shannon Murrin, who is charged with her murder. This evidence is expected
to far outweigh other inconsistent witness testimony (Hogben 1999, pp.A1-2).

[42] Miller quotes from an article by Kirk Makin, "Ontario expanding DNA testing unit at crime lab." Globe and Mail, Tuesday, May 14, 1996, p. A8.

[43] This is the first study using Canadian data to link medical findings in sexual assault cases with legal outcomes. It is the first time odds ratio factors associated with positive legal outcomes in sexual assault has been modeled and any attempt has been made to describe the demographics of a cohort of police reported rape victims with respect to socioeconomic factors (McGregor et al., 1999, p. 12).

[44] The study concluded that other variables which predict the laying of charges should be studied.

[45] Proponents argue that Paul Bernardo would have been convicted sooner if they had used his DNA. In reality, the police did not bother to check it, because they stereotyped the white, educated, well-groomed male as not "the criminal type" (Miller, 1996, p. 1).

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En l'absence de consentement

l'agression sexuelle, l'inconscience et la preuve médico-légale

Centre d'excellence de la C-B pour la santé des femmes

Vancouver, C.-B.
CANADA

Ce rapport de recherche sur la santé des femmes est offert en français et sous des formes utilisables par les personnes handicapées. Pour plus de détails, veuillez communiquer avec le Centre d'excellence de la C.-B. pour la santé des femmes

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