

TITLE: ARTICLE: ENFORCING IMPAIRED DRIVING LAWS AGAINST HOSPITALIZED DRIVERS: THE INTERSECTION OF HEALTHCARE, PATIENT CONFIDENTIALITY, AND LAW ENFORCEMENT

AUTHOR: Erika Chamberlain & Robert Solomon+*

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BIOGRAPHY:

* Dr. Erika Chamberlain is an Assistant Professor at the Faculty of Law, University of Western Ontario. She has published in the areas of tort law, impaired driving law, and alcohol policy, with a particular interest in the powers and liability of police.

+ R. Solomon, Professor, Faculty of Law, The University of Western Ontario, and National Director of Legal Policy, MADD Canada. Professor Solomon has been engaged in research and teaching on alcohol and drug policy, and tort and health care law for over 35 years. He has published widely in these fields, and has served as a consultant with government and non-government agencies in Canada and abroad.

HIGHLIGHTS:

ABSTRACT

Many impaired drivers who are taken to hospital following a crash escape conviction under the *Criminal Code*. This is due, in large part, to the legal and practical difficulties of gathering evidence of blood-alcohol concentration in the hospital setting. This article examines the *Criminal Code's* existing blood sample provisions and their interpretation by the courts. The law, as it currently stands, creates an unworkable situation for both law enforcement and hospital personnel. The courts have imposed stringent and narrow requirements for the demand and seizure of blood

samples, without adequately accounting for the equally stringent requirements of patient confidentiality. The result is that many impaired drivers are never appropriately sanctioned. Using models of blood sample provisions from comparable democracies, this article proposes a solution where the rights and obligations of all parties are more clearly defined, scarce resources are used more effectively, and credible evidence is preserved in a greater number of cases.

RESUME

Beaucoup de conducteurs aux facultés affaiblies qui sont conduits à l'hôpital après un accident de voiture échappent souvent à une condamnation sous le code criminel. Cela est dû en grande partie aux difficultés juridiques et pratiques de récolter des preuves de concentration d'alcool dans le sang dans le milieu hospitalier. Cet article examine les possibilités d'échantillon sanguin selon le code criminel et leur interprétation par les tribunaux. La loi actuelle, crée une situation irréalisable pour la police et le personnel hospitalier. Les tribunaux ont imposé des exigences sévères et étroites en ce qui concerne la saisie des échantillons sanguins, sans prendre en compte les exigences strictes du droit de confidentialité sur le patient. A cause de cela, beaucoup de conducteurs en état d'ébriété ne sont pas sanctionnés de façon appropriée. En utilisant des modèles d'échantillons sanguins provenant d'autres démocraties, cet article propose une solution où les droits et les obligations de toutes les parties sont plus clairement définies, les ressources sont mieux utilisées et les preuves crédibles sont préservées dans la plupart des cas.

TEXT:

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INTRODUCTION

Impaired driving is the leading criminal cause of death in Canada, accounting for approximately 1,278 deaths, 75,374 injuries, and as much as \$12.7 billion in financial and social costs.¹ Ironically, the impaired drivers responsible for these statistics are the least likely to be charged and convicted of a criminal offence. In large part, this is a result of the legal and practical difficulties of gathering evidence of blood-alcohol concentration (BAC) from hospitalized impaired drivers. In many cases, these difficulties prevent the collection of credible BAC evidence, and the driver escapes criminal liability altogether. In many cases, the difficulties of obtaining credible BAC evidence allow the impaired driver to escape criminal liability.

This situation is frustrating to law enforcement and to the victims of impaired driving. Furthermore, it thwarts the purpose of the 1985 *Criminal Code* amendments, which created the offences of impaired driving causing bodily harm and death.² The amendments introduced the authority to demand blood samples, instead of breath samples, from injured impaired drivers. These provisions were introduced in response to concerns that impaired drivers who caused crashes were either escaping criminal liability altogether, or were being convicted of lesser offences that did not reflect the seriousness of their conduct. Parliament recognized the difficulties in obtaining evidence against

impaired driving suspects who were physically incapable of providing breath samples due to injuries suffered in a crash.³ It was also acknowledged that many impaired drivers were able to successfully avoid breathalyser testing by feigning illnesses, injuries, or even by simply demanding that they be taken to a hospital.⁴ In an effort to address these problems, the 1985 amendments authorized the police to demand blood samples from suspected impaired drivers who were incapable of providing breath samples or whose physical condition made it "impracticable" to obtain breath samples.⁵

Similar concerns arose with respect to impaired driving suspects who were unconscious or otherwise incapable of responding to a police demand for a breath sample. Except in rare circumstances, the police previously had no means of establishing an unconscious suspect's BAC or of determining if he or she was impaired by alcohol.⁶ In response to these problems, the amendments gave police authority to request a judicial warrant authorizing the taking of blood from suspects who are unable to respond to a demand for a sample. However, the right is restricted to motor vehicle crashes involving death or personal injury.⁷

The blood sample amendments were central to another political and social concern, namely, that impaired drivers who killed or injured others were only being convicted of impaired driving, instead of the more serious offences of manslaughter or criminal negligence causing bodily harm or death.⁸ Parliament specifically created the offences of impaired driving causing bodily harm and impaired driving causing death to ensure that such conduct was subject to appropriate sanctions. These new indictable offences were intended to be easier to prove and prosecute than either manslaughter or criminal negligence.⁹ To better reflect the gravity of their consequences, these new offences also carried lengthier maximum driving prohibitions and terms of imprisonment than the original impaired driving sentences.¹⁰

Unfortunately, as this paper will discuss, the 1985 amendments have not had their intended effect. The blood-testing provisions have been interpreted in such a way that it remains exceedingly difficult to obtain BAC evidence from hospitalized impaired driving suspects. As a result, the vast majority simply escape criminal charges.¹¹ For instance, a 2004 British Columbia study reported that only eleven percent of drivers with BACs above 0.08 percent (the *Criminal Code* limit) who were hospitalized following an auto accident were convicted of any *Criminal Code* impaired driving offence.¹² Similarly, only sixteen percent of injured alcohol-impaired drivers, admitted to an Alberta tertiary care trauma centre between April 1, 1995 and March 31, 2003, were convicted of any federal impaired driving offence, even though their mean BAC was 0.19 percent, almost two and a half times the *Criminal Code* limit.¹³ By contrast, in Sweden, where the police have broader powers to demand blood samples, it was reported that eighty-five percent of hospitalized drinking drivers were convicted of impaired driving.¹⁴

The failure of the blood-testing provisions is also apparent in the charge and conviction rates for the more serious offences of impaired driving causing death and bodily harm. While there were 1,278 deaths attributable to impaired driving in 2006, there were only 137 charges and 36 convictions for

impaired driving causing death.¹⁵ Similarly, there were an estimated 75,374 impaired driving injuries in 2006, but only 842 charges and 233 convictions for impaired driving causing bodily harm.¹⁶ Even discounting for impaired drivers who kill or injure only themselves, and for multi-casualty crashes, the fact remains that relatively few surviving impaired drivers who kill and injure others are charged, let alone convicted, of impaired driving causing death or bodily injury.¹⁷

This paper attempts to explain the "enforcement gap" in impaired driving law and suggests potential reforms. In particular, it explores the confused and troubling interaction of healthcare and law enforcement professionals that is necessitated by the current blood-testing provisions in the *Criminal Code*. This interaction is complicated by the common law rules governing patient confidentiality, as well as the increasingly complex requirements of federal and provincial privacy legislation. For instance, police cannot make a valid blood sample demand without some information about the suspect's medical condition; however, this information typically cannot be released without the patient's consent. Other confidentiality issues arise when medical professionals are aware that a patient has been involved in a crash and has a high BAC. Can they inform police of the patient's likely impairment? Can they take or preserve blood samples for use in a criminal investigation? Finally, it must be remembered that healthcare and law enforcement professionals have different priorities in the aftermath of a crash, and different practical concerns about the use of scarce resources.

Accordingly, this paper takes a more comprehensive approach to the issue than has previously been considered in Canada. The first section explains the current blood-testing provisions in the *Criminal Code*, and the second section explains the interaction of these provisions with the law of patient confidentiality. As will be seen, the apparent conflict between these laws has created an inefficient and largely ineffective means of enforcing impaired driving laws against hospitalized drivers. This paper will then survey how other comparable democracies have addressed this problem, and suggest reforms that are consistent with the unique requirements of the *Canadian Charter of Rights and Freedoms*.¹⁸ Ultimately, the aim is to propose solutions where the rights and obligations of all parties are more clearly defined, resources are used more effectively, and credible evidence is preserved in a greater number of cases.

THE CRIMINAL CODE'S EXISTING BLOOD-TESTING PROVISIONS

Three separate *Criminal Code* provisions allow the police to demand or seize blood samples from suspected impaired drivers. First, under section 254(3)(b), the police may demand blood samples from a person if they have reasonable grounds to believe (i) that he or she committed an impaired driving offence within the preceding three hours; and (ii) that, by reason of the person's physical condition, he or she is incapable of providing a breath sample or it is impracticable to obtain one. Second, the police may apply for a special judicial warrant under section 256 of the *Criminal Code*. This warrant authorizes the police to seek blood samples from a driver if they have reasonable grounds to believe that (i) the driver committed an impaired driving offence within the previous four hours; (ii) the driver was involved in a crash resulting in death or bodily harm; and (iii) a

medical practitioner is of the opinion that the driver is unable to consent to the drawing of blood samples, and that the taking of the samples would not endanger the driver. Third, under section 487 of the *Criminal Code*, the police may apply for a general search warrant authorizing them to search for and seize blood samples that have already been taken from a suspected impaired driver for treatment purposes. However, before issuing such a warrant, the justice must be satisfied by information under oath that there were reasonable grounds to believe that such blood sample evidence would be found on the premises.

Before examining each of these provisions in detail, two general points must be stressed. First, in impaired driving cases the *Criminal Code* creates a clear preference for the taking of breath samples, rather than blood samples. The taking of blood samples is seen as exceptional, and must be justified in accordance with detailed criteria. This preference for breath samples applies even when a suspect is hospitalized, where presumably, it would be much more efficient to take a blood sample. In addition, the Canadian courts have tended, in our opinion, to overstate the invasiveness of taking a blood sample, which in reality is a simple procedure to which many Canadians submit on a regular basis as part of routine medical care. For example, the taking of a blood sample has been referred to as: "an interference of a very intrusive nature,"¹⁹ "a most intrusive measure,"²⁰ and "very intrusive, much more so than a breath sample."²¹ As will be seen, Canada's squeamishness at the taking of blood samples is not shared by other comparable democracies, which use blood sampling as a default measure whenever an impaired driving suspect is hospitalized.

The second difficult feature of the existing *Criminal Code* provisions is that they require the interaction of healthcare professionals and police without any apparent consideration for the laws of patient confidentiality. Both sections 254(3)(b) and 256 require that the police have information about the suspect's physical condition. However, a health professional who releases such information to the police, in the absence of the suspect's consent or legal compulsion (*e.g.* a *subpoena* or warrant), would be in breach of his or her common law, professional, and statutory obligations to maintain the confidentiality of patient information. In addition, if the police wrongfully obtain confidential information, the blood sample demand would be found invalid, or the seizure would be found to violate section 8 of the *Charter*. In either case, the BAC evidence will likely be excluded at trial. Moreover, while section 257(2) of the *Criminal Code* protects medical practitioners from criminal and civil liability for *taking* a blood sample pursuant to a valid demand or search warrant, it does not protect them from liability for breaching confidentiality in assisting police to obtain a valid demand or search warrant.²² Therefore, the existing provisions have created a frustrating and inefficient system for both police and hospital staff.

(A) DEMANDING BLOOD SAMPLES UNDER SECTIONS 254(3)(B)

The police may only demand blood samples under section 254(3) (*b*) if they have reasonable grounds to believe that a suspect has committed an impaired driving offence within the previous three hours. The police must also prove that they had reasonable grounds to believe that, "by reason of any physical condition", either the suspect was incapable of providing breath samples or it was

impracticable to obtain them. The samples must be taken by or under the direction of a qualified medical practitioner, who must be satisfied that the taking of the samples will not endanger the life or health of the person.²³

(I) REASONABLE GROUNDS TO BELIEVE THAT THE SUSPECT COMMITTED AND IMPAIRED DRIVING OFFENCE

This element is common to both evidentiary breath and blood sample demands but is considerably more difficult to establish in blood test cases. In most breath test cases, the police will first demand that the suspect take a test on an approved screening device (ASD), which requires only a reasonable suspicion that the suspect has *any* alcohol in his or her body.²⁴ The manner of driving, the odour of alcohol on the driver's breath, clumsiness in handling over required documentation, and the driver's admission that he or she was just at a bar could all create the required reasonable suspicion. Accordingly, the threshold for demanding an ASD test is relatively low. Since ASDs are typically calibrated to register a "fail" at a BAC of 0.10 percent or higher, a fail on an ASD test clearly gives the police the requisite reasonable grounds to make a demand for an evidentiary breath test on an approved instrument.

In contrast, the police will rarely have the benefit of ASD evidence in cases involving blood tests, where the driver is often incapable of providing a breath sample, or has already been transported away from the scene of an accident. Nevertheless, the police must still prove that they had reasonable grounds to believe that the suspect committed an impaired driving offence. This requires them to provide independent evidence of a suspect's impairment; a difficult task, given that blood sample cases routinely involve drivers who are injured and whose behaviour may arguably be attributable to their injuries or to the shock of being involved in a crash.

For example, the blood sample evidence was excluded in *R. v. Hanet* for lack of reasonable and probable grounds.²⁵ Shortly after midnight, a civilian witness observed the accused driving his truck in the median ditch between the lanes of the highway. There was no evidence as to why his truck had left the roadway. The accused's truck then "struck an access way, vaulted and became stuck."²⁶ The witness, who came to the aid of the accused, noted that he was dazed and slow to respond, and thought that he had consumed "a few drinks". A highway patrol officer who arrived shortly thereafter noted a "slight" odour of alcohol on the accused's breath, as did the paramedic who loaded the accused on a spinal board.²⁷ However, because the patrol officer was only responsible for commercial vehicle enforcement, he left the scene when an RCMP officer arrived to take over the investigation. The RCMP officer testified that the accused had bloodshot eyes, slurred speech, and a moderate to strong odour of liquor on his breath. Porter J. rejected this testimony, commenting, "[t]his evidence is surprising as it had not been noticed by three other witnesses".²⁸ In concluding that the RCMP officer did not have reasonable and probable grounds to believe that the accused had committed an impaired driving offence, Porter J. stated, "I have considerable doubt in my mind about the symptoms he said he saw and, even if they did exist, it is unclear whether these resulted, nearly two hours later, from pain, shock, treatment administered in the hospital or any

other cause."²⁹ Porter J. did not comment on the accused's bizarre driving behaviour, for example, driving in the ditch in between traffic lanes.

As *Hanet* illustrates, it may be extremely difficult, in the absence of objective ASD evidence, for police to persuade the court that they had the requisite reasonable and probable grounds to demand blood samples. The injured driver may have limited mobility, and may be suffering from the shock of the crash. Although the officer may detect alcohol on the driver's breath, this evidence on its own is unlikely to create sufficient reasonable grounds for the demand of a blood sample. Moreover, if other individuals were involved in the crash, the police will appropriately focus on providing first aid, getting the victims to hospital and securing the scene. In such emergencies, the officer's first priority is not to carefully scrutinize the driver for signs of impairment. As a result, the police can only be frustrated when what seems like reasonable and essential evidence of impairment is rejected by a trial judge, particularly in cases where their evidence is consistent with the testimony of other witnesses and there is no other explanation for the crash.

(II) REASONABLE GROUNDS TO BELIEVE THAT THE SUSPECT IS INCAPABLE OF PROVIDING BREATH SAMPLES

As indicated, under section 254(3)(b)(i), the police must also have reasonable and probable grounds to believe that, because of the suspect's physical condition, he or she is incapable of providing breath samples. In the absence of an accident, this provision might be invoked if the suspect had asthma, emphysema or some other respiratory or debilitating illness that would prevent him or her from providing an adequate breath sample. In crash situations, this might occur if a suspect has suffered broken ribs, a collapsed lung or a serious facial injury. For example, in *R. v. Dorn*, police made a valid blood sample demand from a driver who suffered a fractured cheekbone and lacerations to the head.³⁰ Similarly, in *R. v. Dunning*, the court upheld the blood sample demand toward an accused that was strapped to a spinal board at the crash scene, complained of neck pain, and was incapable of providing a deep lung breath sample.³¹

The courts have generally held that police should not make decisions about the driver's inability to provide breath samples unless they have consulted a medical professional. For instance, in *R. v. Brooke*, the court excluded the blood sample evidence because the officer had not made specific inquiries of the attending physician about the accused's physical condition.³² When the officer arrested the accused at the crash scene, he was strapped down, wearing a neck brace, and in the process of being transported to hospital. The officer demanded a blood sample; however, David J. held that the officer should have first inquired about the extent of the accused's injuries, and ruled that the blood sample demand was invalid.³³

(III) REASONABLE GROUNDS TO BELIEVE THAT IT IS IMPRACTICABLE TO OBTAIN BREATH SAMPLES

The second possible basis for demanding a blood sample is that, by reason of the suspect's physical condition, it is "impracticable" to obtain breath samples. Initially, it would appear that the mere fact

that the suspect is in a hospital provides the necessary impracticability. While the task of drawing a blood sample is a relatively simple and quick procedure in a hospital, attempting to administer evidentiary breath tests in a hospital is a daunting task. First, the approved breath-testing instrument and a "qualified technician" must be brought to the hospital.³⁴ Next, the instrument must be set up and calibrated. In a busy hospital, administrators may have difficulty setting aside or even finding an appropriate room in which to conduct the tests.³⁵ Finally, other impaired driving suspects may escape liability because the approved instrument and technician are tied up at the hospital.

In *R. v. Lipka*,³⁶ a former breath technician explained his experience with conducting breath tests in hospitals:

I find it a very awkward situation in that normally you are interfering with the medical people and that your [*sic*] taking up space. Sometimes you're welcome by them, depending on who you're dealing with, but normally I find that you actually are interfering. You're getting in their way, you are taking up a little table and they want to work on [the suspect], and that's right where you are.³⁷

In the face of these challenges, it is understandable that the police have routinely demanded blood samples, rather than attempting to arrange for evidentiary breath testing, when suspects are taken to the hospital.

Before proceeding further, it is important to understand the complexities of the time limits for demanding evidentiary breath or blood samples. The 1999 amendments to the *Criminal Code* extended the time limit for demanding samples from two hours to three hours, meaning that an officer can only make a demand if he or she believes that the suspect has committed an impaired driving offence within the previous three hours.³⁸ However, the 1999 amendments did not make parallel changes to the time limits in sections 258(1)(c) and (d), which contain what is known as the presumption of temporality or "identity".³⁹ These sections presume that the accused's BAC at the time of testing reflects his or her BAC at the time of the alleged offence, but only if they are taken within two hours.⁴⁰ If the tests are taken after two hours, the Crown will lose the benefit of this evidentiary shortcut, and will be required to call a toxicologist to relate the suspect's BAC at the time of testing back to the time of driving. This is time-consuming, expensive, and provides the defence with additional opportunities to raise technical challenges to the evidentiary breath or blood test results. Thus, for all intents and purposes, the police are still required to administer the evidentiary breath or blood tests within two hours of the alleged offence.

In addition to these complex time constraints, there are conflicting judicial interpretations of when a suspect's physical condition makes it "impracticable" to obtain a breath sample. The case law establishes that police concern over the time limit does not, by itself, render the taking of breath samples impracticable. However, it is unclear what combination of additional factors will be sufficient to make it so. Judges have interpreted the requirement that the impracticability stem from the suspect's condition with varying degrees of strictness. These conflicts among lower court

decisions have not yet been squarely addressed by the appellate courts.

In *R. v. MacMillan*, McQuaid J. held that a police officer's belief that it is impracticable to obtain a breath sample "must relate directly to the physical condition of the person at the time, and not otherwise."⁴¹ Thus, the judge held that a police officer was not justified in making the demand for blood samples merely because he was concerned that he could not administer the breath test within the *Criminal Code's* time constraints.⁴² The suspect sustained only a sore neck, which did not, in the judge's view, make it impracticable to obtain breath samples. McQuaid J. stated that the fact that it is time-consuming to transport, set up, and calibrate the equipment is inherent in the approved instrument itself, and does not flow directly from the accused's physical condition.⁴³

Other cases have held that it may be "impracticable" to demand breath samples if the delay required to administer the evidentiary breath test would interfere with the suspect's medical treatment. For example, in *R. v. Campeau*, the suspect required surgery and the approved instrument and qualified technician were temporarily unavailable.⁴⁴ Since the police did not know how long the surgery would take or when the approved instrument would become available, they were justified in demanding blood samples. McTurk J. stated that "impracticability" must be viewed in light of the particular circumstances that were present at the time. Although the "running of the clock" would not alone justify a demand for blood samples, it was one of several factors to consider.⁴⁵

This principle is supported by *R. v. Pearce*, where the accused suffered cuts on his scalp in a single vehicle crash and requested to be taken to the hospital.⁴⁶ Since the officer expected lengthy treatment, he believed that a blood sample demand would be appropriate. The court agreed, stating that the word "impracticable" should not be confused with the word "impossible". Hirschfield J. explained, "[t]he former connotes a degree of reason and involves some regard for practice, while the latter word is absolute and connotes a matter which is out of the question or something no person can do or perform."⁴⁷ Similarly, the same judge held in *R. v. Wytiuk* that the phrase, "by reason of any physical condition of the person" is meant to give the police flexibility in determining the impracticability of obtaining a breath sample.⁴⁸ In that case, the accused was getting stitches for a laceration in the forehead, and could not have provided a breath sample within the time limit.

Nevertheless, the fact that a suspect's physical condition has put him or her in the hospital has not, in itself, been viewed as making it "impracticable" to obtain breath samples. In *Lipka*, the Ontario District Court held that the police officer was not justified in making a blood sample demand, and acquitted the accused on charges of refusing to provide them.⁴⁹ When the officer arrived at the crash scene, the accused was strapped to a spinal board, wearing a cervical collar, and had his leg splinted. The officer arranged for a blood sample kit to be taken to the hospital, and made a blood sample demand on arrival. However, after being examined, it was found that the accused's only serious injury was to his leg, and was not life threatening. The court noted that, according to the dictionary, "impracticable" means "impossible in practice", or "unmanageable", and reasoned that it would have been practicable to administer the evidentiary breath test while the accused waited for

x-rays.⁵⁰ More importantly, the court was critical of the officer's approach to assessing whether arranging for an evidentiary breath test would be impracticable.⁵¹ Specifically, the officer had not requested an approved instrument from the police station, nor had he asked the medical staff about the possible impact of delaying the accused's treatment to organize an evidentiary breath test.⁵² The court attempted to discourage the routine resort to blood sample demands whenever an accused is hospitalized.

Conversely, in *R. c. Paradiso*, Discepola J. took a much more realistic view of what constituted impracticability under section 254(3)(b)(ii).⁵³ The accused had been injured in an auto accident and was taken to the emergency room. She required x-rays but her injuries were not life threatening. The police officer admitted that he demanded a blood sample out of concerns for the time limit and the difficulties of transporting the approved instrument to the hospital. Although Discepola J. ultimately found the blood sample demand to be invalid, he was sympathetic regarding the impracticability of conducting breath tests on a hospitalized patient.⁵⁴ He noted that a patient is under the "control" of hospital personnel, not the police, so it might be difficult to move the patient to an appropriate location for testing.⁵⁵ In addition, the approved instrument requires a consistent electrical supply, which may not be readily available. Discepola J. also observed that it would be difficult to conduct the tests in an emergency room, where space is very limited and the volume of human traffic is high.⁵⁶

In summary, the Canadian courts have not authoritatively defined the police right to demand blood samples under subsection 254(3) (b)(ii).⁵⁷ It is clear that the running of the time limit does not, on its own, make it "impracticable" to obtain breath samples; however, it may be considered with other factors to determine if there are grounds to demand blood samples. These other factors may include the nature of the suspect's injury, possible interference with treatment, and the availability of an approved instrument and qualified technician. Nevertheless, the courts have not allowed blood sample demands to become a routine alternative to breath sample demands, merely because of the difficulties of arranging for breath testing at the hospital.

The interpretation and application of this section have failed to fulfil Parliament's objectives in enacting the blood sample amendments in 1985. Parliament was explicitly concerned that many impaired driving suspects were escaping criminal liability because they had or feigned certain illnesses and injuries, and demanded to be taken to the hospital. Typically, these cases arise from motor vehicle crashes that involve serious personal injuries or death, where the officers' first priorities are obtaining emergency treatment for the injured and securing the scene. Moreover, a disproportionate number of these cases arise on Friday and Saturday nights - times when demands on police and emergency rooms are often the greatest.⁵⁸ Given what is entailed, it can be argued that administering evidentiary breath tests to injured suspects at busy public hospitals is not only inherently impracticable, but also needlessly time-consuming, inefficient and wasteful of scarce law enforcement and hospital resources.

Admittedly, the complexity of setting up an approved instrument in a hospital is not directly

attributable to the suspect's condition. However, the legislation merely requires that the suspect's physical condition make it impracticable to obtain breath samples. Since the suspect would have been tested at the police station *but for* his or her physical condition, that condition must be considered a cause of whatever impracticabilities arise from undertaking breath testing at the hospital. It is misleading to state that the impracticability is inherent to the approved instrument. Used as intended at police stations, approved instruments are not impracticable. The impracticability only arises when, because the suspect's physical condition requires hospital care, the machine has to be transported, set up, calibrated, and used in a hospital.

Finally, as will be discussed in Part II of this article, both legislative drafters and the courts have avoided the complex issues of patient confidentiality that arise as a result of this subsection. The blood sample provisions require that the officer making the demand have some knowledge of the suspect's physical condition and ability to provide breath samples. The courts have suggested that this information would normally be obtained from health care professionals. However, this ignores the fact that medical staff are under no obligation to share information about the suspect's physical condition with the police, and may be violating patient confidentiality if they do provide this information. This presents a certain "Catch 22" situation, which is becoming increasingly complicated in light of the recent flurry of federal and provincial privacy legislation.

(B) SPECIAL JUDICIAL WARRANTS AUTHORIZING THE DRAWING OF BLOOD SAMPLES

(I) REQUISITE GROUNDS FOR OBTAINING THE WARRANT

Although section 256(1) of the *Criminal Code* permits the police to obtain a warrant from a justice of the peace to take blood samples from suspected impaired drivers, it narrowly defines the circumstances in which such warrants are available. First, the police must have reasonable grounds to believe that the suspect committed an impaired driving offence within the preceding four hours.⁵⁹ Second, the officer must have reasonable grounds to believe that the suspect was involved in an auto accident resulting in death or bodily harm.⁶⁰ Third, the officer must have reasonable grounds to believe that a medical practitioner is "of the opinion" that, by reason of either alcohol consumption or the crash, the suspect is unable to consent to the taking of a blood sample.⁶¹ Fourth, the officer must have reasonable grounds to believe that a medical practitioner is "of the opinion" that the taking of the sample would not endanger the suspect's health or life.⁶² Typically, warrants are sought when the suspect has been rendered unconscious or has suffered an injury, such as a serious concussion, that prevents him or her from responding to a demand. These provisions are technically complex, and contain various pitfalls for police and justices of the peace who are unfamiliar with them. As discussed in Section II of this article, the special judicial warrant provisions require the police to obtain what seems to be confidential medical information, without explaining how this information can be legally acquired.

(II) GROUNDS TO BELIEVE THAT AN OFFENCE WAS COMMITTED

Perhaps the biggest challenges for officers applying for special judicial warrants is establishing the reasonable and probable grounds to believe that an impaired driving offence was committed. Because the suspect is typically unconscious or incoherent, it may be extremely difficult to detect signs of impairment. Signs that are apparent may be attributed to other factors such as a head injury, shock or some other medical condition. For example, in *R. v. Clark*, Gerein J. commented in *obiter* that the evidence did not provide reasonable and probable grounds to believe that the suspect was impaired.⁶³ The case involved an otherwise unexplained head-on collision that killed the other driver. In addition, an emergency medical technician had informed the police that she could smell alcohol (probably beer) on the suspect's breath. Nevertheless, Gerein J. noted that the odour could have had a different source, such as diabetes, and that there was insufficient evidence of impairment to issue a warrant.⁶⁴

It is difficult to imagine what other evidence of impairment would be available to an officer in a case like *Clark*. Given the smell of alcohol on the driver's breath and the lack of any other plausible explanation for the auto incident, there were ample grounds to believe that the accused's ability to drive was impaired. Roughly forty percent of all motor vehicle fatalities are alcohol-related, and this percentage is much higher during the evening hours, when Mr. Clark's incident occurred.⁶⁵ Furthermore, nothing in the judgment suggests that Clark did, in fact, suffer from diabetes, so there was no reason why the officer, or the emergency room technician, would have suspected that the smell of alcohol on the accused's breath was due to anything other than alcohol. It seems unduly rigorous to require officers seeking special judicial warrants to rule out all other potential explanations for the smell of alcohol before applying for a warrant.⁶⁶

(III) TELEWARRANT PROVISIONS AND TIME LIMITS

Since these "special judicial warrants" must be obtained within four hours of the alleged offence, the police are permitted to obtain them in person, by telephone or by other means of telecommunication.⁶⁷ Thus, a police officer who attends the scene of an accident, travels with the driver to the hospital, and forms the requisite reasonable and probable grounds may be able to obtain a "telewarrant", as it is called, without leaving the hospital. This is particularly crucial in remote areas, where it may take considerable time to travel to a justice of the peace to obtain a warrant. However, the telewarrant provisions impose another burden on the police officer, namely, the obligation to convince the justice of the peace that the circumstances make it impracticable for the officer to appear personally to obtain a warrant in the ordinary manner.⁶⁸ In *R. v. Sattelberger*, the court quashed a telewarrant because the officer had failed to explain why it was impracticable to appear in person before the provincial court judge.⁶⁹ The court noted that the telewarrant provisions provide a "short cut" for police officers, and must be limited to their intended purposes.⁷⁰

Further, even with the telewarrant provisions, the four-hour time limit may be problematic in serious crash situations. By the time police arrive and secure the scene, ensure that the victims receive medical assistance, form reasonable and probable grounds, travel to the hospital, and obtain the necessary medical opinion that the suspect is incapable of responding to a sample demand, there

may be a very small window of opportunity for completing the required forms and obtaining a telewarrant. This may be especially true if the emergency room is busy. For example, in *Dorn*, the court expressed doubts about whether a special judicial warrant would have been available, given the operation of the time limit.⁷¹ There was no evidence of when the single vehicle incident occurred, and the suspect was not examined by a doctor until nearly three hours after what was believed to be the approximate time of the incident. At that time, the suspect was being prepared to be transported to a larger hospital due to the severity of his head injuries.⁷² This would have left the officer with less than one hour to obtain and execute the warrant. Thus, although four hours may initially appear to provide sufficient time, it may be inadequate in serious or complex auto crashes.

(IV) EXECUTING THE WARRANT

Once the police have obtained a warrant, they may ask a qualified medical practitioner to take the blood sample or arrange to have it taken.⁷³ The warrant authorizes the medical practitioner to take only as much blood as is "necessary to enable a proper analysis to be made" (*i.e.*, the minimum amount necessary to determine the suspect's BAC).⁷⁴ Medical practitioners have no legal duty to comply with the request, even though they are immune from criminal and civil liability if they do.⁷⁵ Accordingly, even if police are successful in obtaining a valid warrant, the medical practitioner may still refuse to take the sample.⁷⁶

Given their technical requirements and the potential for conflict between the needs of law enforcement and healthcare personnel, the special judicial warrant provisions have not had their intended effect. In 1983, the Law Reform Commission expressed concern that unconscious drivers "would enjoy an unfair advantage over conscious ones", and that there would be "an inducement for drinking drivers to feign unconsciousness in order to escape blood sample demands."⁷⁷ Although the situation has improved since the time when there were virtually no means of providing an unconscious driver's illegal BAC at the time of the crash, a very large number of impaired drivers continue to escape liability due to the problems in obtaining and executing special judicial warrants.

(C) SEIZING BLOOD SAMPLES PURSUANT TO A GENERAL SEARCH WARRANT

Section 487 sets out the general search warrant provisions of the *Criminal Code*. In most cases, an officer will appear before a justice of the peace and swear an information that he or she believes that a place or premises contains objects relating to a *Criminal Code* offence, provide evidence of an offence, or are intended to be used in committing certain serious offences. The application must clearly set out the basis for the officer's beliefs, the objects to be seized, the place or object to be searched, and the offence to which the evidence relates. If the justice of the peace is satisfied that there are reasonable grounds to believe that the objects sought are on the premises, he or she may issue a search warrant to the officer. The warrant provides the officer with authority to enter the named premises and to search for and seize the wanted objects.⁷⁸

These general search warrant provisions apply when police wish to seize blood samples that have

already been taken by medical staff. They allow police to obtain BAC evidence even after the three or four-hour time limit has expired for demanding blood samples under section 254(3) or for seeking a special judicial warrant under section 256. This may be crucial in cases where the police were not present at the scene of the crash, spent time attending to victims, or did not immediately form the necessary reasonable and probable grounds to demand a sample.

As will be seen, the general search warrant provisions typically involve cooperation between police and medical personnel, only some of which is permissible under Canadian law. Accordingly, the admissibility of blood samples seized under a general search warrant will often depend on the conduct of medical staff. This issue arises in three main types of situations. First, the blood sample evidence will not be admitted if the medical staff took the samples solely to assist the police in the criminal investigation. The staff's violation of the suspect's right to be free from unreasonable search and seizure invariably results in the exclusion of the samples under section 24(2) of the *Charter*. However, the blood samples will be admissible if the staff originally took them for treatment purposes; such conduct does not entail any violation of the suspect's *Charter* rights. Finally, the samples may be excluded if the staff discloses confidential medical information to police, particularly if that information is subsequently used as the basis for obtaining the search warrant.

(I) BLOOD SAMPLES TAKEN TO ASSIST IN THE CRIMINAL INVESTIGATION

This situation arises when blood samples are not needed for medical purposes, and are taken merely to provide evidence of a driver's BAC. For example, in *R. v. Pohoretsky*, the accused was injured in a single-vehicle accident.⁷⁹ Given the circumstances of the crash and the discovery of a case of beer at the scene, the police suspected that the accused was impaired. One officer travelled to the hospital for the express purpose of obtaining a blood sample. The officer directed the attending physician to draw a blood sample from the accused, who was incoherent and delirious and the sample was taken without the accused's consent, and for no medical purpose.⁸⁰ The Supreme Court of Canada held that the doctor had acted as an agent of the police in seizing incriminating evidence from the accused without his consent and without informing him of his legal rights.⁸¹ Consequently, the sample was found to have been taken contrary to section 8 of the *Charter*. Pursuant to section 24(2) of the *Charter*, the blood test results were excluded from evidence, and the accused was acquitted. The court stated that the police had taken advantage of the accused's condition to obtain a blood sample that they could not have obtained without consent, had he been fully conscious.⁸²

Moreover, the courts have sometimes classified blood samples as having been taken for the purpose of assisting in the criminal investigation even when the police were not directly involved. This would be the case if the medical staff took blood samples, on their own initiative, that were not required for treatment purposes. In *R. v. Cochrane*, a medical technician required a doctor's assistance in taking blood samples for standard medical tests.⁸³ The doctor, knowing that the patient was under investigation for a fatal crash, drew an additional sample in a grey-capped vial, used an alcohol-free swab to avoid contaminating the sample, and ordered a BAC test. The doctor

stated that he had taken these steps because he thought that he might be called to testify. He wanted the BAC evidence because his testimony about another suspect's impairment had previously been challenged. The police later seized the sample under a general search warrant. On a *voir dire*, the court held that the doctor had violated the patient's right to be free from unreasonable search and seizure, because the additional blood sample in the grey-capped vial had not been taken for medical purposes. The blood sample was therefore excluded from evidence in the accused's trial for impaired driving causing death.⁸⁴ This case suggests that blood samples taken for any purposes other than the accused's medical treatment will be inadmissible.

(II) BLOOD SAMPLES TAKEN FOR MEDICAL PURPOSES

The Canadian courts have held that the suspect's *Charter* rights are not violated when the police seize, under warrant, blood samples that were initially taken for medical purposes. In *R. v. Carter*, the suspect was seriously injured in a single-vehicle accident that killed his passenger.⁸⁵ A blood sample was taken for medical purposes in the hospital's emergency department. During an interview with the suspect several hours later, the police learned that he had been drinking prior to the crash. They had also found full and empty beer bottles at the scene. When the police learned that a blood sample had been taken in the hospital, they obtained a search warrant and seized the sample. The Ontario Court of Appeal held that this was a reasonable seizure, as it occurred pursuant to lawful authority, and the police had reasonable grounds to believe that the suspect had committed an impaired driving offence.⁸⁶

In such cases, the police must take measures to preserve the continuity of the blood sample. Blood samples taken for medical purposes will not necessarily meet the high standards used in police evidentiary blood sample "kits".⁸⁷ Officers must ensure that the samples are properly sealed and labelled so that the accused cannot challenge the continuity of the sample at trial.⁸⁸ For instance, in *R. v. Katsigiorgis*, a police officer at the scene of the accident had reasonable and probable grounds to believe that the driver was intoxicated, and accompanied him to the hospital.⁸⁹ A nurse took a blood sample, as per the routine medical procedure when a spinal fracture is suspected. The police officer sealed a sub-sample of the blood to preserve continuity and protect it from contamination while he obtained a warrant. The Ontario Court of Appeal found that this seizure was "not unreasonable".⁹⁰ Hospital staff acted reasonably in handling the blood - - the nurse was following standard medical procedure and was not acting under police authority.⁹¹ Moreover, the officer was acting on reasonable and probable grounds and was attempting to preserve the continuity of the sample.⁹²

Katsigiorgis was followed by the Ontario Court of Appeal in *R. v. Tessier*, which was later upheld by the Supreme Court of Canada.⁹³ The Court of Appeal found no unreasonable seizure when a police officer put a seal on a blood sample that had been drawn from the accused for medical purposes, and asked the laboratory technician to keep the sample in the laboratory refrigerator until he could obtain a warrant. The court found that

it is reasonable, in the interests of both the Crown and the accused to take precautions to ensure that the blood samples would not be tampered with, pending receipt of judicial authorization to take the sample away for testing and for submission in evidence against the accused.⁹⁴

Accordingly, it appears acceptable for police to seal a sample of the accused's blood to preserve continuity while obtaining a warrant.

However, even blood samples taken for valid medical purposes may be excluded in some circumstances. In *R. v. Colarusso*, the majority of the Supreme Court of Canada held that blood samples taken for medical purposes may be excluded if the police improperly "appropriate" or "convert" them for their criminal investigation.⁹⁵ The accused had consented to providing blood and urine samples for medical purposes. These samples were subsequently given to the coroner, who had statutory authority to seize them while investigating the fatal crash. The coroner then had the police deliver the samples to the Centre for Forensic Sciences for analysis, as per standard practice. The police made no effort to obtain independent breath or blood samples for their criminal investigation. Instead, the Centre's toxicologist was called to testify at the criminal trial based on the blood-alcohol analysis that had been conducted for the coroner.

LaForest J., writing for a bare majority of the court, held that the police had violated the accused's section 8 rights by appropriating the Centre's results for the criminal prosecution.⁹⁶ The officers knew the incriminatory nature of the samples, and intended from the outset to use them in their criminal investigation. LaForest J. was especially critical of the officers' failure to pursue their own breath or blood sample demands. Although the majority admitted the toxicologist's testimony under section 24(2), it held that the police should not have appropriated the coroner's evidence in order to circumvent the requirements for a reasonable seizure.⁹⁷

While not the focus of this paper, it bears noting that the majority's decision in *Colarusso* essentially negates the distinction between blood samples taken for medical purposes and those taken for investigatory purposes. The blood samples were clearly taken for medical purposes and with the accused's consent. They were seized under the coroner's statutory authority, and were lawfully analyzed by the Centre for Forensic Sciences. However, the samples were considered to have been taken for criminal investigatory purposes once the toxicologist who performed the analysis was called to testify at trial. According to the majority, the initial seizure became unreasonable when it ceased to be used for the coroner's non-criminal purposes.⁹⁸ Taken to its logical conclusion, it could be argued on the basis of the majority's decision that confidential information is "converted" in any case where medical staff are called as witnesses at trial or where medical information is seized under a warrant or sought under *subpoena*.⁹⁹

(III) THE RELEASE OF MEDICAL INFORMATION FOR CRIMINAL INVESTIGATORY PURPOSES

The final category of cases involves situations in which blood samples are properly taken for

medical purposes, but the results of those tests are subsequently released to police in breach of patient confidentiality. The courts have generally held that, while medical personnel are not acting as agents of the state when taking the sample, they may later become agents if they cooperate with the police. The 1988 Supreme Court of Canada decision in *R. v. Dymont* is the leading authority in this area.¹⁰⁰ The accused had suffered head lacerations in a single-vehicle accident. Neither the attending physician nor the investigating officer involved had observed evidence of impairment. However, before suturing the accused's head, the doctor took a sample of free-flowing blood from the wound for medical purposes without the unconscious accused's consent. When the accused subsequently told the doctor that he had consumed alcohol and antihistamines, the doctor recognized that this was a likely cause of the accident. The doctor then spoke to the investigating officer and, following their conversation, gave him the blood sample.¹⁰¹ The officer did not have a warrant for either information about the accused or the blood sample. An analysis of the sample established that the accused's BAC was 0.10 percent.¹⁰²

The court found that, although it may have been reasonable for the doctor to take the blood sample without consent for medical purposes, the subsequent receipt of the sample by the officer constituted a seizure within the meaning of the *Charter*. In addition, the officer did not have reasonable and probable grounds to believe that an offence had been committed, apart from the confidential information that was wrongfully disclosed by the doctor. Given the lack of reasonable and probable grounds, the seizure was unreasonable, and the blood sample was excluded.¹⁰³ In effect, the doctor's release of confidential information and handing over of the sample to the police served to invalidate the reasonableness of his original conduct in drawing the sample from the accused.

Dymont contains a lengthy discussion of the right to privacy and the protection of personal information. LaForest J. stated that "the courts must be especially alert to prevent undue incursions into the private lives of individuals by loose arrangements between hospital personnel and law enforcement officers."¹⁰⁴ LaForest J. emphasized that medical information belongs to the patient, quoting from the Task Force on Privacy and Computers: "This notion of privacy derives from the assumption that all information about a person is in a fundamental way his own, for him to communicate or retain for himself as he sees fit."¹⁰⁵ Moreover, while LaForest J. did not go so far as to prohibit communications between police and medical personnel in all circumstances, he noted that "it is one thing to inform, quite another to supply material which, if used, amounts ... to conscripting the accused against himself."¹⁰⁶

This latter statement prompted some courts to allow medical staff to release limited medical information about the accused to police. In *R. v. Lunn*, the British Columbia Court of Appeal found that there was no *Charter* violation when police investigating a fatal accident called the hospital two days later to inquire if they had blood samples from the suspect.¹⁰⁷ When the hospital replied affirmatively, the police requested that the samples not be destroyed, so that a search warrant could be obtained. Thus, the warrant that was subsequently issued was based in part on the medical information that the hospital released. Hinkson J.A., for the court, stated that the medical staff was

not acting as an agent of the state in responding to the police inquiry about the existence of a blood sample, nor in preserving the sample until a warrant could be obtained. Referring to *Dyment*, Hinkson J.A. note that "[t]he Supreme Court of Canada has not said that a police officer is prohibited from speaking to a potential witness in the course of conducting an investigation into a criminal offence in order to obtain information upon which to base an application for a search warrant before a justice of the peace."¹⁰⁸ This judgment suggests that it would be acceptable for police to inquire about, and for hospitals to release, information about the presence of a blood sample in the hospital.¹⁰⁹

However, subsequent cases have interpreted LaForest J.'s statement in *Dyment* more narrowly, and have restricted the ability of hospital personnel to disclose confidential medical information to police. In *R. v. Erickson*, a doctor informed the investigating officer that the accused was possibly impaired.¹¹⁰ When the officer asked, the doctor admitted that blood samples had been drawn and that an alcohol screen had been completed. At the officer's request, the doctor showed him the result of the screen, which indicated that the accused's BAC was between 0.12 and 0.17 percent. The doctor did not have the patient's consent to release any of this information, and the disclosure was accordingly a breach of the *Alberta Hospitals Act*.¹¹¹ The officer later obtained a search warrant and seized the blood sample. Major J.A. (as he then was) held that the officer's viewing of the test results without the patient's consent constituted an unreasonable search. Because the subsequent warrant was partially based on the information the doctor had wrongfully disclosed to the officer, it was also invalid. Major J.A. stated that the accused "had a reasonable expectation of privacy with respect to the confidential information that was disclosed without his consent."¹¹²

In *R. v. Dersch*, the disclosure of the suspect's blood sample results to the police was similarly criticized.¹¹³ As the doctor was attempting to insert an intravenous line, the suspect objected in strong language and refused to have blood taken in any circumstances. The suspect also refused a police demand for blood samples. Once the suspect was unconscious, the doctor obtained the assistance of a surgeon, who took blood samples for medical reasons. The Supreme Court held that these samples should not have been taken without the patient's consent.¹¹⁴ In addition, the doctor breached his obligation of confidentiality when, in response to a police officer's written request, he disclosed the suspect's BAC, which was estimated to have been between 0.178 and 0.193 percent at the time of the accident.¹¹⁵ Consequently, the blood sample results, which were seized under a warrant based on the information provided by the doctor, were excluded. The charge of impaired driving causing death and three charges of impaired driving causing bodily harm were subsequently dismissed.

Major J., for the majority of the court, held that obtaining the suspect's BAC information was analogous to a search and seizure by police, and that police took advantage of the doctors' improper conduct. The court stressed the "importance of guarding against a free exchange of information between health care professionals and police".¹¹⁶ Thus, *Erickson* and *Dersch* make it clear that section 8 is violated whenever hospital personnel provide police with information about a suspect's BAC. However, Major J. also commented in *obiter* that "there may be instances of doctors and

hospitals releasing *neutral* medical information, such as the presence of the patient in the hospital".¹¹⁷ As discussed in the next section, this distinction between neutral and incriminating medical information is largely illusory, and seems inconsistent with the existing laws governing patient confidentiality.

(IV) THE CONFLICT BETWEEN LAW ENFORCEMENT AND PATIENT CONFIDENTIALITY

The collection of BAC evidence from hospitalized impaired drivers requires the cooperation of law enforcement and healthcare personnel. Police need certain information about a patient in order to make valid demands for blood samples, and the samples must be taken by or under the direction of a qualified medical practitioner. Similarly, police cannot obtain a valid search warrant without, at the very least, knowledge that blood samples are located at the hospital. Nevertheless, neither the drafters of the *Criminal Code's* blood sample provisions nor the judges who have interpreted them have adequately addressed their implications with the law of patient confidentiality. The courts have criticized police officers who seek blood samples without sufficient information about the suspect's physical condition, but, at the same time, warn against a free flow of information between police and hospital personnel. This has resulted in general uncertainty about the rights of the patient and the obligations of police and healthcare practitioners.

This uncertainty is further complicated by the complex and expanding web of statutory, common law, and professional obligations dealing with the confidentiality of health information. There are varying definitions of what constitutes confidential health information, and conditions on when and to whom it may be disclosed. Contrary to what the criminal courts have suggested, there is no clear line between "neutral" and "incriminatory" health information. Moreover, even if disclosure of certain information is considered permissible for the purposes of the *Criminal Code* or the *Charter*, a healthcare practitioner might still be subject to professional discipline, civil claims for breach of confidence, and prosecution for violating statutory confidentiality provisions if certain information is disclosed. In light of these overlapping and sometimes conflicting provisions, it would not be surprising for practitioners to simply refuse disclosure in all cases, unless subject to a *subpoena* or search warrant.

Although confidentiality is typically discussed as if it were a single or unitary concept, most healthcare professionals will be subject to two or more overlapping sets of confidentiality obligations at any one time. First, there are numerous provincial statutes, of either specific or general application, that create confidentiality obligations relevant to healthcare professionals. For example, a physician working in an Ontario hospital would be subject to the specific confidentiality obligations of the *Public Hospitals Act*, as well as the general confidentiality obligations that apply to all "health information custodians" under the *Personal Health Information Act, 2004 (PHIPA)*.¹¹⁸ Second, healthcare professionals are subject to additional sets of confidentiality obligations under the statutes that regulate their profession, as well as their professional codes of ethics. The *Regulated Health Professions Act, 1991* makes a physician's disclosure of any patient information,

"except with the patient's consent or as required by law", a specific basis for a finding of professional misconduct.¹¹⁹ The physician would also be under an ethical obligation of confidentiality under the Canadian Medical Association's *Code of Ethics*.¹²⁰ Third, healthcare professionals who promise, either implicitly or explicitly, to maintain confidentiality, will be required to maintain confidentiality under common law tort and contract principles. This undertaking of confidentiality may be formalized in a contract, set out in a patient information pamphlet, or expressed orally to the client. Indeed, the courts are moving toward viewing confidentiality as an inherent element of any therapeutic relationship.¹²¹

This section attempts to address some of the issues surrounding patient confidentiality in the enforcement of impaired driving laws against hospitalized drivers. Because legislation varies across the provinces, a uniform statement of the law cannot be provided. As indicated, there may be several different and overlapping sources of a healthcare professional's confidentiality obligations, and compliance with some legislation will not necessarily protect the professional against breaches of other statutory provisions or professional standards. For the sake of simplicity, we have selected a few provisions to highlight the conflicts between law enforcement and patient confidentiality.

(A) WHAT CONSTITUTES CONFIDENTIAL HEALTH INFORMATION?

In order to determine what information can and cannot be disclosed to police, it is necessary to define what constitutes confidential health information.¹²² The flurry of legislative activity over the past decade has established a relatively all-encompassing definition. Ontario's *PHIPA* defines "personal health information" as "identifying information about an individual in oral or recorded form" if that information relates, *inter alia*, to the physical or mental health of the individual, or to the providing of health care to that individual.¹²³ Similarly, the Alberta *Health Information Act* defines "health information" as including "diagnostic, treatment and care information", which, in turn, includes information about "the physical and mental health of an individual and the health services provided to that individual".¹²⁴ In the context of an impaired driving suspect who is taken to hospital, these definitions of health information would seem to include information about any injuries sustained, any required treatment, and perhaps even the presence of a given patient in the hospital.¹²⁵ It certainly would include information about any tests performed on the individual and their results.

The relevant legislation also makes it clear that personal health information cannot be disclosed without the consent of the patient, except in certain enumerated circumstances.¹²⁶ That is, personal health information is *prima facie* confidential. Thus, in the impaired driving scenario, personal health information about the suspect should not be disclosed unless either the patient consents or one of the exceptions applies. These exceptions will be discussed in more detail in section II(b).

The above statutory provisions are generally consistent with the common law of patient confidentiality. In *McInerney v. MacDonald*, the Supreme Court of Canada discussed the nature of confidential health information at length, stressing that such information fundamentally belongs to

the patient, and is for the patient to withhold or disclose.¹²⁷ Patients may decide to communicate personal information for the purposes of their medical treatment, but it does not thereby become available for other purposes. Hence in *Dersch*, the doctors were in breach of their common law duty of confidentiality when they shared Dersch's BAC results with the police, in the absence of Dersch's consent or a warrant.¹²⁸

In spite of the broad statutory and common law definitions of confidential health information, in impaired driving cases, the courts have attempted to distinguish between "neutral" and "incriminating" or "specific" medical information. For instance, in *Dersch*, Major J. suggested in *obiter* that doctors and hospitals might, in some circumstances, release neutral information, such as the presence of a particular patient in the hospital.¹²⁹ Further, in *R. v. Day*, the Ontario Court of Appeal indicated that there was nothing improper about the hospital confirming with police that they had taken a blood sample from the accused and had kept it in storage.¹³⁰ The court reasoned:

While the appellant had a reasonable expectation of privacy in respect of the results of any tests that were performed on him, we are not satisfied in all of the circumstances of this case that he had a reasonable expectation of privacy with respect to the mere fact that blood samples were taken by the medical personnel when he was admitted to the hospital in a coma.¹³¹

On the other hand, the courts have consistently found that releasing specific information about the accused's BAC is a breach of confidentiality obligations.¹³²

It is not clear that the distinction between neutral and specific/incriminating medical information is consistent with the common law or the applicable confidentiality legislation. The existence of a blood sample seems related to the "treatment and diagnosis" of a patient, and therefore falls within the respective definitions of personal health information in provincial statutes. Indeed, the very fact that an individual is a patient is likely to be considered confidential information.¹³³ Thus, unless a relevant exception applies, the disclosure of the fact that a blood sample has been taken and is being stored in hospital would seem to be a breach of various confidentiality obligations.

Ironically, this was even recognized by the court in *R. v. Lunn*.¹³⁴ The accused had caused a crash in which his wife was killed. He refused a police officer's request to provide a blood sample, but samples were later taken for medical purposes in hospital. Two days later, an officer called the hospital and asked a doctor whether blood samples had been taken. When the doctor responded affirmatively, the officer asked that the blood samples not be destroyed. The samples were subsequently seized under a general search warrant. The British Columbia Court of Appeal concluded that this exchange of information between the doctor and police was not a breach of the *Charter*, as the doctor was not an agent of the state. Nevertheless, the court conceded that the accused might have a complaint against the doctor for the release of his private information.¹³⁵

Lunn provides a glimpse of the potential conflict between impaired driving investigations and patient confidentiality. The release of so-called "neutral" information by medical professionals

might survive *Charter* scrutiny for the purposes of a criminal trial. However, it is likely a violation of privacy legislation and the common law of patient confidentiality, and may make the doctor susceptible to claims for breach of confidence, prosecution for breach of the privacy statute, and professional discipline. In light of these risks, healthcare practitioners would be well advised not to disclose any information about a patient to police in the absence of consent or a warrant. Obviously, while the refusal to disclose is prudent for the healthcare professional, it makes the investigation of hospitalized impaired driving suspects exceedingly difficult in many cases and impossible in others.

The conflict of healthcare, confidentiality and law enforcement interests has recently reached extremes in Alberta. Authority over ambulance services was transferred from local authorities to Alberta Health Services in April of 2009, and the relevant legislation added ambulance operators to the list of "custodians" governed by the provincial *Health Information Act*.¹³⁶ Accordingly, ambulance operators were informed by Alberta Health Services that any information gathered in the course of treating patients is *prima facie* confidential. In the impaired driving context, this means that ambulance attendants cannot disclose to police that they smell alcohol on a driver's breath.¹³⁷ Furthermore, if the occupants have already been removed from the vehicle before the police arrive, it is the current position of Emergency Health Services that they cannot even disclose to the police which person was in the driver's seat.¹³⁸ Moreover, if the patients have already been transported to the hospital, the police may be unable to learn their identities or confirm their presence at any given hospital.¹³⁹ Without this information, it is impossible for police to investigate a suspected impaired driving accident, let alone gather sufficient information to obtain a warrant for blood samples.

(B) WHEN CAN CONFIDENTIAL INFORMATION BE DISCLOSED?

As indicated, privacy legislation tends to include a rule of *prima facie* confidentiality of personal health information, with a finite list of exceptions. Obviously, such information can be disclosed with the patient's consent.¹⁴⁰ However, in the case of impaired driving investigations, it is unlikely that a patient/suspect will consent to the release of information to police. Instead, the most relevant exceptions will be disclosure to comply with a *subpoena*, warrant, or court order, or if the disclosure is authorized or required by law.¹⁴¹ These exceptions essentially reflect the common law principle that confidentiality is only breached if the defendant *willingly* discloses confidential information. In the case of disclosure that is mandated by law, and which typically provides sanctions for non-compliance, the defendant has not willingly disclosed the information.¹⁴² Thus, for instance, if legislation requires reporting of certain communicable diseases to a public health authority, a medical practitioner who reports a patient is complying with a legal obligation, and has not willingly disclosed the patient's confidential information.

In the impaired driving context, such provisions would apply if police had obtained a warrant to seize the results of a patient's BAC test from the hospital, or if a physician were subpoenaed to testify about the accused's impairment at a criminal trial. In these circumstances, the physician would be required by law to comply with the warrant or *subpoena*, and would face proceedings for

contempt or obstruction of justice if he or she refused. However, these provisions do not allow a medical practitioner to disclose information in the absence of a warrant, *subpoena*, court order, or other legal obligation. Most importantly, they would not authorize disclosure simply for the purposes of assisting with a police investigation.

In the absence of a warrant or *subpoena*, the police cannot force medical practitioners to answer questions about a patient's medical information, and accordingly, any disclosure would be a *willing* breach of confidentiality. Indeed, the Canadian Medical Protective Association, the body that provides physicians with medico-legal advice and risk management education, recently advised physicians as follows: "While physicians may have a desire to collaborate with police to foster public safety and injury prevention, physicians are bound by a duty of confidentiality to their patients. As such, physicians should not provide any patient information to the police unless the patient has consented to this disclosure or where it is required by law."¹⁴³

The disclosure provisions of the relevant health information statute were discussed in *R. v. Lavoie*, where the accused volunteer firefighter had rolled-over his fire truck when responding to a call.¹⁴⁴ Both a fellow fire fighter and an ambulance attendant observed the odour of alcohol on him, and the attendant so informed the investigating officer. However, the officer did not make a formal blood sample demand when the accused was taken to hospital. Instead, she requested that the emergency room nurse inform her of the results of a BAC test that was completed for medical purposes. The nurse complied, indicating to the officer that it was a high reading. The officer then asked for the blood samples to be stored at hospital until she could obtain a warrant for their seizure, which she ultimately did. Williams J., of the Nova Scotia Provincial Court, found that there had been a breach of patient confidentiality, and excluded the BAC evidence from the accused's trial.¹⁴⁵ Williams J. explicitly cited the Nova Scotia *Hospitals Act*, noting that confidential information was not to be released without the patient's consent, and that there was no relevant exception in the case.¹⁴⁶ Although Williams J. stated that information could be released under warrant or *subpoena*, neither was present in the circumstances. The judge concluded that neither the officer nor hospital staff had acted in good faith, and that "the strategy adopted by the police, in collusion with the hospital staff, led to a serious and flagrant violation of s. 8."¹⁴⁷

It is fairly clear that, under the current law of confidentiality, patient information should not be disclosed to police without a warrant or other legal obligation. It is somewhat more complicated, however, to determine whether the blood sample provisions of the *Criminal Code* amount to a legal obligation to disclose information. As previously discussed, police need at least some information about the patient's physical condition to make a demand for blood samples under section 254(3)(b). Similarly, to obtain a special warrant for blood samples under section 256, police must obtain the opinion of a medical practitioner that the taking of blood will not endanger the suspect's health. Nevertheless, there is nothing in the *Criminal Code* that expressly requires medical practitioners to provide this information to the police; there is no duty or obligation to disclose any information at all. Therefore, when a medical practitioner provides information to police, it seems that he or she is voluntarily or willingly disclosing confidential information, and thus, committing a breach of

confidence.

Unfortunately, this issue has not been squarely addressed by the Canadian criminal courts, which often seem to be wilfully blind to the dilemma faced by healthcare practitioners. In *R. v. Porretta*,¹⁴⁸ Eberhard J. suggested that it was "clearly" permissible for a medical practitioner to answer questions about the patient's condition as necessary for the police to obtain a warrant for blood samples under section 256 of the *Criminal Code*:

Clearly, the officer obtaining this information from a medical practitioner does not require a search warrant to do so. No other confidential information was sought or received. Accordingly, it is my view that the officer's knowledge of the blood samples having been taken does not raise a concern for the preservation of confidentiality between doctor and patient, does not represent a free flow of information between medical professionals and police and does not constitute a breach of the accused's *Charter* rights.¹⁴⁹

This interpretation is not as clear as Eberhard J. assumes. The officer's testimony in *Porretta* was that the emergency room physician told him that blood had already been drawn for medical purposes, and that the accused might be suffering from a concussion.¹⁵⁰ This information seems to fall directly within the definition of personal health information, and should not have been disclosed without consent, some form of warrant or court order, or other legal obligation. However, Eberhard J. focused entirely on the disclosure of the information from a criminal justice or *Charter* perspective, and ignored all other sources of the doctor's confidentiality obligations.

It is troubling that the criminal courts have taken such a casual attitude to obligations that are fundamental to the doctor/patient relationship. Doctors are fiduciaries, and patients are vulnerable when they impart personal information to their doctors.¹⁵¹ A doctor's duty of confidentiality, part of the Hippocratic Oath, should be taken every bit as seriously as a lawyer's duty of confidentiality.¹⁵² The criminal courts should not expect doctors to release information about their patients, neutral or otherwise, unless required by law. As discussed in Part IV of this paper, the *Criminal Code* should make it clear that healthcare professionals are required to respond to certain inquiries during an impaired driving investigation, thereby clarifying that such disclosure is "required by law" and, thus, not a willing breach of confidentiality.

(C) WHAT ARE THE CONSEQUENCES FOR IMPROPER DISCLOSURE?

Various legal consequences can follow from an improper disclosure of confidential health information. First, as described in the first part of this paper, the improper disclosure to police will most likely result in the exclusion of the patient's BAC evidence from his or her criminal trial for impaired driving. The blood sample demand or search warrant will be found to have been made or granted on improper grounds, such that the subsequent taking of blood from the patient will be rendered an unreasonable search and seizure under section 8 of the *Charter*. Most often, the BAC evidence will then be excluded pursuant to section 24(2). Blood tests are typically seen as an

intrusive measure, and as self-incriminatory; as a result, their admission is often likely to bring the administration of justice into disrepute.¹⁵³ Without BAC evidence, the Crown will have difficulty proving the accused's impairment beyond a reasonable doubt, particularly if the accused was unconscious or injured in the crash, or if his or her behaviour could be alternatively attributable to shock, head injury or other medical condition.¹⁵⁴ This typically results in the accused being acquitted of the impaired driving charges.

Second, if the disclosure of information was a violation of the relevant privacy legislation, the staff member and/or hospital may be subject to prosecution under that statute. The penalty is most often a fine, and potentially a substantial one. For instance, under the Ontario *PHIPA*, individuals can be fined up to \$50,000 for wrongful disclosure of health information, and hospitals could be fined up to \$250,000.¹⁵⁵ Under the Alberta *Health Information Act*, individuals are subject to a minimum fine of \$2,000 and a maximum fine of \$10,000, and a hospital is subject to a minimum fine of \$200,000 and a maximum fine of \$500,000.¹⁵⁶

Next, the parties responsible for the wrongful disclosure may be subject to a private law action for breach of confidence or, in some jurisdictions, breach of privacy.¹⁵⁷ Breach of confidence originated in the courts' equitable jurisdiction, and plaintiffs may be entitled to a range of remedies depending on the unique factors of the case.¹⁵⁸ In circumstances involving wrongful disclosure of personal information, the most likely remedy would be compensatory and, perhaps, punitive damages. The courts may take a particularly hard line against health professionals who are in breach of confidence, since they are in a fiduciary position with respect to their patients. It is not necessary for the patient to have suffered any loss; the courts have held that wrongful disclosure, itself, is a form of detriment that entitles the plaintiff to damages.¹⁵⁹

Finally, a healthcare professional who wrongfully discloses patient information is susceptible to professional discipline. Ontario regulations indicate that it is professional misconduct to give "information concerning the condition of a patient or any services rendered to a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required by law."¹⁶⁰ Depending on the severity of the violation, the discipline could range from a reprimand to a fine, to the suspension or revocation of the licence to practice.¹⁶¹

Given the range of potential consequences, both civilly and professionally, it is not surprising that health care professionals are hesitant to disclose any information that may be considered confidential to the police. Their caution is only likely to increase as concern for and regulation of patient confidentiality grows.

(D) WHAT ARE THE CONSEQUENCES FOR FAILURE TO DISCLOSE?

While there are numerous potential consequences for medical professionals who disclose personal health information in breach of their obligations, there are essentially no legal consequences for non-disclosure or failure to cooperate with police. The *Criminal Code's* blood sample provisions do

not obligate medical practitioners to answer police questions about a suspect's condition or ability to provide a breath or blood sample. Moreover, section 257(1) states that it is not an offence for a medical practitioner to refuse to take a sample of blood from a patient. Thus, there is no legal risk associated with a refusal to cooperate with a police investigation into a suspected impaired driver. Given the complexity of confidentiality obligations and the degree of disclosure-phobia that they have created, one could hardly blame medical practitioners if they decided never to disclose information about a patient to the police. The most prudent course of conduct, from the view of medical practitioners and hospital administrators, is to refuse disclosure unless subject to a search warrant or *subpoena*.

The problem, as discussed, is that it is exceedingly difficult for police to make a valid blood sample demand or obtain a valid search warrant without at least some information about the suspect's medical condition or the presence of blood samples in the hospital. Accordingly, the primary consequence of hospital staff's failure to disclose personal information about the patient is that impaired driving investigations will be frustrated. This is unfortunate, as situations involving hospitalized impaired driving suspects tend to involve deaths or injuries to other people as well. Ironically, the offenders who commit the most serious offences (impaired driving causing bodily harm or death) are the least likely to be charged and convicted. This is precisely the outcome that the 1985 *Criminal Code* amendments were trying to avoid. It is apparent that more effective blood sample provisions are necessary if injured impaired drivers are to receive a appropriate sanction. The following section outlines the legislation in other Commonwealth jurisdictions, where blood samples are more readily available in crash situations.

(V) APPROACHES IN OTHER COMMONWEALTH JURISDICTIONS

Unlike Canada, most Commonwealth jurisdictions have enacted legislation to facilitate, rather than discourage, the taking of blood samples in impaired driving cases. Perhaps most notably, their laws are designed to ensure that biological samples are taken by the most efficient means possible. In cases involving hospitalized suspects, this means dispensing with the preference for breath samples. They allow for blood to be taken without cumbersome requirements regarding the suspect's physical condition or the impracticability of obtaining breath. This in turn eliminates the need for police to consult with medical staff about the suspect's condition, thereby reducing the risk that confidential patient information will be improperly disclosed. The following is a survey of the most relevant provisions in the United Kingdom, New Zealand and Australia.

(A) THE UNITED KINGDOM

Under the United Kingdom's *Road Traffic Act 1988*, police are authorized to demand a breath-screening test from a person who they suspect was driving, attempting to drive or in charge of a motor vehicle, and who they suspect has alcohol in his or her body.¹⁶² They can also demand screening tests from drivers who they reasonably believe were driving at the time of an accident.¹⁶³ Drivers who refuse to take or who fail the screening test may be arrested without a warrant and

required to provide an evidentiary breath, blood or urine sample.¹⁶⁴ Breath sample demands can only be made at a police station.¹⁶⁵ Thus, if a suspect is taken to hospital, police are not required, indeed are not even permitted, to demand a breath sample. This spares police from the cumbersome tasks of transporting and setting up an approved breath-testing device at the hospital, or of justifying why it is impracticable to obtain a breath sample. Rather, when a suspect is taken to hospital, the police can demand a blood or urine sample.¹⁶⁶ Blood samples can only be taken by a medical practitioner, and the suspect's consent is required.¹⁶⁷ However, it is an offence to fail to provide a sample without a reasonable excuse.¹⁶⁸ Finally, the *Road Traffic Act 1988* does contain some "Protection for Hospital Patients", in that the medical practitioner in charge of the suspect's case must be notified of the demand for a blood or urine sample.¹⁶⁹ The practitioner can object to the taking of a sample, but only on the grounds that it would be prejudicial to the proper care and treatment of the suspect.¹⁷⁰

These provisions strike an appropriate balance between police convenience and a suspect's physical integrity. They ensure that blood samples will only be taken by appropriate personnel, and that they will not endanger the patient's health. Blood samples will not be forcibly taken but, parallel to breath testing provisions, those who refuse to provide a sample will thereby commit an offence. Thus, blood or urine samples should be available from most hospitalized impaired driving suspects. Moreover, there is minimal need for police and hospital personnel to exchange confidential information. Police can demand blood samples without any information about the suspect's physical condition or likely release time from the hospital. Indeed, medical practitioners need not get involved until after a valid blood sample demand has been made. Even then, they are only involved in actually drawing blood from the patient, or in objecting on the grounds of the patient's health.

(B) NEW ZEALAND

In New Zealand, police are authorized to demand a breath screening test from any person driving or attempting to drive a motor vehicle.¹⁷¹ If a suspect refuses to take or fails the screening test, the police may demand an evidential breath test. If an evidential breath test cannot be conducted for any reason, including situations where the suspect refuses to take the test or an evidential breath-testing device is not readily available, the police may demand an evidentiary blood test.¹⁷² Once required to provide a sample, it is an offence for any person to fail or refuse to accompany an officer to undergo a blood test.¹⁷³ The results of the blood test may be used in any proceedings against the suspect.

New Zealand also has special provisions that apply in crash situations. Police may demand a breath screening test from any driver involved in an accident, regardless of whether they think the person has alcohol in his or her body.¹⁷⁴ If the police are unable to determine who was driving, police can demand a breath screening test from anyone they have good cause to believe was driving at the time of the accident. Depending on the results of the screening test, police may demand evidentiary breath or blood samples, as outlined above. Moreover, if a medical practitioner has reason to believe that someone who is under his or her care or treatment in a hospital or doctor's office was

involved in a crash, the medical practitioner may take a sample of blood for evidential purposes, as long as it is not prejudicial to the suspect's proper care and treatment.¹⁷⁵ This applies whether the patient is conscious or unconscious.¹⁷⁶ The legislation also protects the Crown and medical personnel against criminal liability for taking a blood sample without the patient's consent.¹⁷⁷

The above provisions provide much more flexibility to police in demanding breath and blood samples from suspected impaired drivers. Blood samples can be demanded if breath-testing equipment is unavailable "for any reason". Moreover, blood samples may be taken when drivers are taken to hospital following an accident, even if there are no grounds to believe that the driver was impaired. This is particularly helpful in situations in which the driver is unconscious, where police would have obvious difficulty observing signs of impairment. Blood samples can thus be routinely taken in these situations, without the need for a warrant. This helps to ensure that reliable BAC evidence is efficiently taken and preserved in crash situations.

(C) AUSTRALIA

In Australia, each state and territory is responsible for its own highway traffic and criminal laws. Taken together, these traffic and criminal laws give police much broader authority to demand screening tests and evidentiary breath and blood samples than the Canadian law. Random breath testing (RBT) is authorized in all jurisdictions.¹⁷⁸ This means that police can demand a breath screening test from any driver, without any need for suspicion that the driver has consumed alcohol. In most jurisdictions, the police can also demand that a driver take an evidentiary breath test if he or she fails a screening test or refuses to take it.¹⁷⁹ Further, the police generally may demand a blood sample if a driver is unable to provide a breath sample because of a medical condition or physical disability.¹⁸⁰

In accident situations, the general RBT provisions authorize the police across Australia to demand that any driver involved in a crash submit to a test. Furthermore, the police are usually authorized to demand a screening test from anyone they suspect was driving at the time of a crash.¹⁸¹ Some states also permit the police to demand evidentiary breath or blood tests from anyone who was driving or suspected of driving at the time of an accident.¹⁸²

All jurisdictions authorize the police or medical practitioners to demand a blood sample from any driver or suspected driver who was involved in an accident and is taken to hospital for treatment.¹⁸³ Indeed, most jurisdictions impose a positive duty on medical practitioners to take a blood sample from such patients. For example, in South Australia, when a person over fourteen attends at or is admitted to a hospital with injuries suffered in an auto accident, the medical practitioner must take samples of his or her blood and seal them in two containers. The practitioner must then make the samples available to the patient and the police.¹⁸⁴

(VI) THE WAY FORWARD IN CANADA

There is no obvious reason why provisions similar to those in the United Kingdom, New Zealand

and Australia could not be enacted in Canada. First and foremost, the *Criminal Code* should be amended to remove the "preference" for breath samples when suspected impaired drivers are taken to hospital. This amendment alone would eliminate many of the current obstacles to effective enforcement of impaired driving laws. Police would not be required to evaluate whether the suspect's condition is sufficiently poor to justify a blood sample demand. Nor would they be forced to transport a complicated and sensitive breath-testing machine to the hospital, where administrators may or may not have suitable space to conduct the tests. Further, the police would not be required to seek confidential patient information from hospital staff, who would be risking violation of their various confidentiality obligations to provide it. Rather, medical personnel could perform the quick and efficient procedure of drawing a blood sample, thereby providing reliable BAC evidence to ensure that impaired driving suspects do not, by reason of their hospitalization, escape criminal liability.

Obviously, there will be situations where a suspect's physical condition will make it dangerous to draw a blood sample, and any *Criminal Code* amendments should allow for medical practitioners to object to a demand for blood samples on medical grounds. However, given that only a small amount of blood is required for BAC testing, and is often drawn for medical purposes when an accident victim comes into the emergency room, such cases will likely be very rare. There is no need for Canadian legislators or courts to maintain their squeamish stance with respect to blood tests. While they are admittedly more intrusive than breath tests, blood samples are taken from most Canadians on a regular basis as part of routine medical care. They are hardly on par with the strip searches, cavity searches and stomach pumping which are performed on those suspected of some drug offences. Blood tests are quick and relatively painless, and do not subject the patient to any sort of indignity or humiliation. When performed by a qualified technician, they involve exceedingly little risk.

Second, Parliament should remove the requirement for blood samples to be taken by a qualified medical practitioner (*i.e.*, physician).¹⁸⁵ Many physicians do not regularly draw blood samples; instead, this task is delegated to a nurse or other qualified technician. Such personnel draw blood on a regular basis, and are actually more skilled at the task than many physicians. In a busy hospital setting, these other qualified personnel are much more likely to be available to draw blood from impaired driving suspects. Thus, for the sake of efficiency and patient comfort, the *Criminal Code* should allow blood samples to be drawn by anyone who is qualified to do so by the provincial licensing bodies. A medical practitioner should only need to get involved if there is some reason to believe that the taking of blood samples might endanger the suspect's health. However, as noted above, such cases will be rare.

Third, Canada should introduce a modified form of automatic blood testing for hospitalized auto accident victims, as currently exists in New Zealand and Australia. For instance, when someone is brought to hospital and there is reason to believe that he or she was involved in a motor vehicle accident, the *Criminal Code* or provincial highway traffic legislation should require hospital personnel to take a sample of blood for potential BAC testing. Given Canadian constitutional

principles and the courts' concern about collusion between hospitals and law enforcement, we are not advocating that the legislation require medical staff to turn the blood samples over to the police automatically. Rather, the samples could simply be stored at the hospital and only released to the police if they independently established sufficient grounds to obtain a warrant for their seizure. Such a provision would not turn hospital staff into police informants, but would increase the likelihood that BAC evidence is collected in a timely manner and preserved for any criminal investigation that might ensue. In addition, it would relax the current time constraints on the police, who may be busy attending the scene of the accident and unable to form the requisite grounds for a special judicial warrant within the four-hour time limit in section 256.

Finally, both the *Criminal Code* and provincial privacy legislation need to clarify the obligations of healthcare personnel when dealing with police investigations. As suggested by the Supreme Court in *Dyment*, "[i]nvasions of privacy must be prevented, and where privacy is outweighed by other societal claims, there must be *clear rules* setting forth the conditions in which it can be violated."¹⁸⁶ The simplest way to accomplish this is to require healthcare professionals to cooperate with police who are investigating an impaired driving accident. For example, when asked by police, hospital staff should be required by the *Criminal Code* to answer: whether they have taken blood samples from a patient; whether they have performed a BAC test; and whether the taking of blood samples would endanger the patient's health. By requiring them to answer, the *Criminal Code* would make it clear that they are not "willingly" disclosing confidential information, and thereby remove any uncertainty or fear regarding disclosure. This recommendation is relatively modest. It would allow for the minimum necessary disclosure of information. Many courts have already found, albeit without much justification, that such information is "neutral" and available for disclosure to the police.¹⁸⁷ Clear legislative authority would remove any doubt and would protect staff from civil lawsuits or professional discipline for cooperating with the police. It would also help to reduce the fear that currently seems to surround the issue of patient confidentiality.

Before concluding, it is appropriate to address a concern that is sometimes raised in this area, namely, that some people may avoid seeking medical treatment because they fear that hospital staff will report them to police. For instance, in *Dyment*, the Supreme Court expressed concern that the collusion of medical staff and police would undermine public confidence in hospitals. LaForest J. stressed that hospitals are meant to be places where the sick and injured receive treatment, not where they become subject to criminal investigation.¹⁸⁸ Similarly, the *Report of the Commission of Inquiry into the Confidentiality of Health Information* expressed the concern that,

[p]ersons in need of health care might, in some circumstances, be deterred from seeking it if they believed that physicians, hospital employees and other health-care providers were obliged to disclose confidential health information to the police in those circumstances. A free exchange of information between physicians and hospitals and the police should not be encouraged or permitted. Certainly physicians, hospital employees and other health-care workers ought not to be made part of the law enforcement machinery of the state.¹⁸⁹

This concern may be legitimate in some circumstances. For instance, if an abused woman knows that hospital staff may report her, she may avoid seeking treatment in the hospital because she does not want police involved in her domestic situation. However, this is a relatively minor concern in the case of hospitalized impaired drivers. Those involved in serious crashes are typically brought to the hospital by ambulance, and do not make a conscious choice whether to receive treatment. Furthermore, the police are routinely called in accident situations, and will know about the potential criminal charges irrespective of the suspect's treatment in hospital. In fact, if a suspect refuses to go to the hospital to avoid the chances of having a blood test for BAC, he or she will likely be subject to a breath sample demand instead. In short, the potential for some minimal cooperation between healthcare providers and the police at the hospital is unlikely to be determinative, one way or another, in a suspect's decision whether to be treated for his or her injuries.

CONCLUSION

Canada's criminal law does not provide for the effective prosecution of hospitalized impaired drivers. Indeed, among comparable democracies, Canada seems to have implemented the most inefficient system of gathering BAC evidence in auto incident situations. The *Criminal Code's* blood sample provisions are technical, cumbersome, and do not take into account the practicalities of emergency healthcare or law enforcement. Furthermore, as interpreted by the courts, the provisions either do not acknowledge or simply ignore the various duties of confidentiality owed by healthcare professionals to their patients. The resulting situation is confusing and frustrating to both police officers and healthcare personnel. The current blood sample provisions impede criminal investigations against the drivers who commit the most serious offences of impaired driving causing bodily harm and death, of whom only a small portion are charged, and an even smaller portion are convicted.¹⁹⁰ Not only do those drivers escape the penalties and remedial programs prescribed for their conduct, but they are allowed to return to the roads to commit additional impaired driving offences.

This distressing situation could be addressed by some relatively modest changes to the law. In particular, the preference for breath samples should not apply when suspects are taken to hospital. This reform would relieve police of the burden of transporting an approved breath-testing instrument to the hospital, or of justifying why it is impracticable to take breath samples. In addition, it would save police from having to gather information about the suspect's physical condition from hospital personnel, who would be in breach of their confidentiality obligations by responding. The second main recommendation of this paper is that the *Criminal Code* and various privacy statutes should identify what information medical personnel are required to provide to police during the course of an impaired driving investigation. This would help to clarify the rights and obligations of healthcare professionals, patients, police, and ensure that confidentiality obligations are taken seriously. Taken together, these recommendations should increase the likelihood that reliable, admissible BAC evidence is available in even severe crash situations. While hospitals must remain places of treatment, they cannot be allowed to remain a safe haven for impaired drivers.

FOOTNOTES :

1 G. William Mercer, *Estimating the Presence of Alcohol and Drug Impairment in Traffic Crashes and their Costs to Canadians: 1999 to 2006* (Vancouver: University of British Columbia, 2009) at 8, 11 [Mercer]. In contrast, there were only 605 homicides in Canada in 2006, including first and second degree murder, manslaughter and infanticide; Geoffrey Li, *Homicide in Canada, 2006* (Ottawa: Canadian Centre for Justice Statistics, 2007) at 2.

2 *Criminal Law Amendment Act*, 1985, S.C. 1985, c. 19, ss. 238-241.

3 *House of Commons Debates* (20 December 1984) at 1388 (Mr. Crosbie) and 1396 (Mr. Waddell) [*Debates*].

4 *Ibid.*

5 *Criminal Code*, R.S.C. 1985, c. C-46, s. 254(3) (b).

6 For example, the police might have been able to obtain BAC evidence if blood samples had been taken for medical purposes, the police were aware that samples had been taken, and they were later able to seize them under the general search warrant provisions of the *Criminal Code*.

7 *Criminal Code*, *supra* note 5, s. 256(1).

8 *Debates*, *supra* note 3 at 1384. Then Justice Minister John Crosbie was frustrated with the "anomaly that driving offences should explicitly condemn conduct that creates a grave risk to public safety but fails specifically to condemn the conduct when the risk results in bodily harm or death."

9 See Department of Justice, Policy Sector and Legislative Services Branch, *Impaired Driving Case Study* (Ottawa: Department of Justice, 2000).

10 *Criminal Code*, *supra* note 5, ss. 255(2) and (3). At that time, the maximum sentences for impaired driving causing bodily harm and death were ten and fourteen years' imprisonment, respectively. There was a maximum ten-year driving prohibition for both offences. In 2000, the maximum sentence for impaired driving causing death was increased to life imprisonment, and the driving prohibition was opened to any period that the court considers proper: *An Act to amend the Criminal Code (impaired driving causing death and other matters)*, S.C. 2000, c. 25, s. 2.

11 The situation is similar in the United States. See Jeffrey W. Runge *et al.*, "Enforcement of Drunken Driving Laws in Cases Involving Injured Intoxicated Drivers" (1996) 27:1 *Annals of Emergency Medicine* 66; Rita K. Cydulka *et al.*, "Injured Intoxicated Drivers: Citation,

Conviction, Referral and Recidivism Rates" (1998) 32:3 *Annals of Emergency Medicine* 349; Kevin R. Krause *et al.*, "Prosecution and Conviction of the Injured Intoxicated Driver " (1998) 45 *Journal of Trauma* 1069; William L. Biffel *et al.*, "Legal Prosecution of Alcohol-Impaired Drivers Admitted to a Level I Trauma Centre in Rhode Island" (2004) 56 *Journal of Trauma* 24. However, charge and conviction rates appear to be higher in states with so-called "implied consent" laws, which allow blood to be drawn from injured drivers to measure their BACs. See Steven Chang, James G. Cushman & Michael D. Pasquale, "The Injured Intoxicated Driver: Analysis of the Conviction Process" (2001) 51 *Journal of Trauma* 551.

12 Roy Pursell *et al.*, "Proportion of injured alcohol-impaired drivers subsequently convicted of an impaired driving criminal code offence in British Columbia" (2004) 6:2 *Canadian Journal of Emergency Medicine* 80 [Pursell I]. The mean BAC of alcohol-positive drivers was 0.15 percent, or nearly twice the *Criminal Code* limit.

13 See Michelle Goecke *et al.*, "Characteristics and conviction rates of injured alcohol-impaired drivers admitted to a tertiary care Canadian Trauma Centre" (2007) 30:1 *Clinical & Investigative Medicine* 26 at 26, 29.

14 S. Mattsson, A. Eriksson & H. Sjögren, "Conviction rates among hospitalized DUI/DWI drivers" (2000) 28 *Journal of Traffic Medicine* 21. The comparable conviction rate in the state of Victoria, Australia is reported to be over ninety percent. See Pursell, *supra* note 12 at 86-87.

15 See Mercer, *supra* note 1 at 8; Statistics Canada, *CANSIM Table 252-0014, Adult and youth charged ... annual* (Ottawa: Statistics Canada, 2008) [CANSIM].

16 Mercer, *ibid.* at 8; CANSIM, *ibid.*

17 Canadian impaired driving charge and conviction data are difficult to obtain and interpret. The data are often incomplete in terms of the years covered and the number of jurisdictions reporting. Further, the charge and conviction are difficult to reconcile, as charge data are reported by calendar year, while conviction data are reported by fiscal year. As a result, the figures provided should be seen as only a general illustration of enforcement patterns.

18 Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [Charter].

19 *R. v. Pavel* (1989), 53 C.C.C. (3d) 296 at 310, 74 C.R. (3d) 195 (Ont. C.A.) [*Pavel* cited to C.C.C.].

20 *R. v. Hanet*, 182 A.R. 30, [1996] A.J. No. 210 at para. 20 (Prov. Ct.) (QL) [*Hanet* cited to A.J.].

21 *R. v. Darlington*, 2001 ABPC 141, 296 A.R. 167, [2001] A.J. No. 1095 at para. 24 (Prov. Ct.) (QL) [*Darlington* cited to A.J.].

22 This stands in contrast to the various mandatory reporting statutes, which explicitly protect healthcare facilities and physicians for the disclosure of required information. See e.g. *Mandatory Gunshot Wounds Reporting Act, 2005*, S.O. 2005, c. 9, s. 4; *Child and Family Services Act*, R.S.O. 1990, c. C.11, ss. 72(7), 72(9).

23 *Criminal Code*, *supra* note 5, s. 254(4). In making the demand, the police officer must provide assurances to this effect (*i.e.* that a medical practitioner is satisfied that the suspect's life or health will not be endangered by the taking of blood samples; *R. v. Green*, [1992] 1 S.C.R. 614, [1992] S.C.J. No. 18 (QL) (failure to provide such assurances provides the suspect with a reasonable excuse to refuse to provide samples); but see *R. v. Knox*, [1996] 3 S.C.R. 199, 139 D.L.R. (4th) 1 at para. 18 [*Knox* cited to S.C.R.] (if an accused provides a blood sample in the absence of such assurances, the evidence may be admissible).

24 *Criminal Code*, *supra* note 5, s. 254(2).

25 *Supra* note 20.

26 *Ibid.* at para. 8.

27 *Ibid.* at paras. 10, 12.

28 *Ibid.* at para. 14.

29 *Ibid.* at para. 17. Porter J. clearly disapproved of the officer's conduct in this case, stating on three separate occasions in the judgment that the officer was on a "fishing expedition" (at paras. 17, 19 and 29).

30 [1999] S.J. No. 580 (QL), 46 M.V.R. (3d) 69 (Q.B.). This section also applies when injuries render drivers generally incapable of providing a breath sample, even if there is no specific injury that directly prevents them from doing so. See e.g. *R. v. Hiltz* (1988), 82 N.S.R. (2d) 387, 4 M.V.R. (2d) 84 (N.S. S.C.) (the driver was found unconscious and slumped over the steering wheel of this car. Although he regained consciousness on the way to the hospital, the officer did not know the extent of his injuries and demanded a blood sample. The trial judge found that this was a valid demand, as the driver was "in no condition to give breath samples"); see also *R. v. Reutov*, [1992] A.J. No. 292 (Q L), 38 M.V.R. (2d) 189 (Alta. Prov. Ct.).

31 [1995] O.J. No. 646 (QL), 26 W.C.B. (2d) 494 (Prov. Div.) (the accused was thus convicted of refusing to provide a blood sample, even though he had offered to provide breath samples instead).

32 1999 ABPC 9, 239 A.R. 339, [1999] A.J. No. 56 (Prov. Ct.) (QL) [*Brooke* cited to A.J.].

33 *Ibid.* at para. 16.

34 See *Criminal Code*, *supra* note 5, s. 254(1). Qualified technicians are usually specially-trained police officers. They must be officially designated by the Attorney General of the province as being qualified to operate a n approved instrument.

35 The accused must also be informed of his or her legal right to counsel and must be given a reasonable opportunity to consult with counsel before the evidentiary breath test is administered. This requirement applies as well to blood tests. See *R. v. Therens*, [1985] 1 S.C.R. 613.

36 (1989), 20 M.V.R. (2d) 298, [1989] O.J. No. 2676 (Ont. Dist. Ct.) (QL) [*Lipka* cited to M.V.R.].

37 *Ibid.* at 303.

38 *An Act to amend the Criminal Code (impaired driving and related matters)*, S.C. 1999, c. 32, s. 2, amending s. 254(3) of the *Criminal Code*.

39 See *R. v. St. Pierre*, [1995] 1 S.C.R. 791, [1995] S.C.J. No. 23 (QL); *R. v. Gibson*, 2008 SCC 16, [2008] S.C.R. 397, [2008] S.C.J. No. 16.

40 Ironically, extending the presumption provides some legal benefit to the accused, whose BAC will typically fall steadily starting thirty minutes after consuming his or her last drink. See J.G. Wigmore & D.M. Lucas, "The Scientific Validity of the Decision in *R. v. Phillips*" (1990) 2 J.M.V.L. 43 at 49; Robert Solomon & Erika Chamberlain, "Calculating BACs for Dummies: The Real-World Significance of Canada's 0.08% Criminal BAC Limit for Driving" (2004) 8 Can. Crim . L. Rev. 219.

41 (1989), 78 Nfld. & P.E.I.R. 163, 19 M.V.R. (2d) 137 at 140 (P.E.I. S.C.) [*MacMillan* cited to M.V.R.].

42 *Ibid.* The judge noted at 141 that, after the suspect's medical examination, there "would then have remained a 29 minute window during which the accused could well have been driven two one of the two RCMP barracks nearby for the administration of the first breathalyzer test". Frankly, given the time it would take to transport the accused, calibrate the machine, and allow the accused to find and consult counsel, the judge's opinion in this regard seems overly optimistic. Moreover, McQuaid J. simply assumed that the approved instrument was not already being used to test another suspect.

43 *Ibid.* at 140; see also *R. v. Evans*, [1990] B.C.J. No. 921 (QL), 9 W.C.B. (2d) 639 (B.C. Co. Ct.); *R. v. Walkom*, 1998 ABPC 20, 221 A.R. 21, [1998] A.J. No. 1785 (Prov. Ct.).

44 (1990), 24 M.V.R. (2d) 191, [1990] O.J. No. 2714 (Ont. Gen. Div.) (QL) [*Campeau* cited to M.V.R.].

45 *Ibid.* at 195.

46 (1988), 13 M.V.R. (2d) 116, 56 Man. R. (2d) 77 (Man. Q.B.) [*Pearce* cited to M.V.R.].

47 *Ibid.* at 121.

48 (1989), 17 M.V.R. (2d) 18 at 22, 60 Man. R. (2d) 259 (Man. Q.B.) [*Wytiuk* cited to M.V.R.] (emphasis in original).

49 *Supra* note 36.

50 *Ibid.* at 305.

51 *Ibid.* at 304-6.

52 *Ibid.* (the court did not address whether this inquiry would have violated the accused's reasonable expectation of privacy regarding confidential medical information).

53 [2002] J.Q. No. 7999 (C.M.) (QL). Discepola J. suggested that, even though the transport of an approved instrument to the hospital might be possible, it was not easily feasible at para. 65); An interesting issue, beyond the scope of this paper, is whether the French version of the blood sample provision is more conducive to blood sample demands. While the English version requires that obtaining breath samples be "impracticable", the French equivalent is "pas facilement réalisable."

54 *Ibid.* (The blood sample demand was found to be invalid because the officer was preoccupied with meeting the *Criminal Code's* time limits, and had not properly turned his attention to the question of whether, by reason of the suspect's physical condition, it was impracticable to obtain breath samples at para. 78).

55 *Ibid.* at paras. 69, 71.

56 *Ibid.*; See also *R. v. Salmon*, 1999 BCCA 740, [1999] B.C.J. No. 2893, (1999), 141 C.C.C. (3d) 207 (the British Columbia Court of Appeal suggested that it may be impracticable to obtain breath tests if the accused requires lengthy treatment and the approved instrument is located some distance away from the hospital).

57 There is also some confusion in the case law about the process police should follow in determining whether it is impracticable for the suspect to provide breath samples. See *Pavel*, *supra* note 19 (the Ontario Court of Appeal suggested that, in most cases, police should demand a breath sample first, and should only demand blood samples if it later becomes

evident that breath samples would be impracticable at 308); See also *Darlington*, *supra* note 21 (Fraser J. of the Alberta Provincial Court stated that the "normal procedure" would be to demand a breath sample at the scene, and then change to a blood sample demand at the hospital, based on medical advice at para. 18); But see *Salm on*, *supra* note 56 (in 1999, the British Columbia Court of Appeal held that the concept of impracticability was linked to the concept in section 254(3)(a) that breath samples be provided "forthwith or as soon as practicable"; that is, once it appears to the officer that breath samples cannot be provided forthwith or as soon as practicable, a valid blood sample demand can be made at 211-12).

58 National Center for Statistics & Analysis, *Traffic Safety Facts, 2007 Data -- Alcohol-Impaired Driving* (Washington: NHTSA, 2008), Table 2 (the National Highway Traffic Safety Administration reported that, in 2007, forty percent of drivers involved in fatal crashes on weekend nights had a BAC above 0.08 percent. By contrast, only 15 percent of weekday and 9 percent of daytime fatal crashes involved a driver with that BAC.).

59 The value of this four-hour time limit is not as great as it would initially appear. See *supra* note 40 and related text (if the samples are taken more than two hours after the alleged offence, the Crown will lose the benefit of the presumption of identity, making the prosecution more time-consuming, expensive and difficult).

60 *Criminal Code*, *supra* note 5, s. 256(1)(a).

61 *Ibid.*, s. 256(1)(b)(i).

62 *Ibid.*, s. 256(1)(b)(ii).

63 (1995), 135 Sask. R. 103, [1995] S.J. No. 566 (Q.B.) (QL).

64 *Ibid.* at para. 19 (Gerein J. also suggested that the officer seeking the warrant should have informed the Justice of the Peace that an officer who attended the crash scene had not observed the odour of alcohol).

65 Traffic Injury Research Foundation, *Alcohol-Crash Problem in Canada: 2006* (Ottawa: Traffic Injury Research Foundation and Canadian Council of Motor Transport Administrators, 2009) at 14.

66 See also *R. v. Petkau*, 1998 ABQB 365, [1998] A.J. No. 1645 (Q.B.) (the court found that a special judicial warrant had been improperly issued because the officer was insufficiently specific about the grounds for believing that an offence was committed. The officer had indicated that he found a 750 ml. bottle of Gibson's Finest in a paper bag on the seat of the vehicle, but he had failed to explain that the bottle was nearly empty. The accused, whose BAC was 0.17 percent at the time of testing (2.5 hours after the crash), and who presumably had consumed a great deal of Gibson's Finest, was acquitted).

67 *Ibid.*, s. 256(1).

68 *Ibid.*, s. 487.1(4)(a).

69 (1995), 106 Man. R. (2d) 252, [1995] M.J. No. 431(Q.B.) (QL) [*Sattelberger* cited to Man. R.].

70 *Ibid.* at para. 36; See *R. v. Bondy*, [1997] A.J. No. 631 (Prov. Ct.) (QL) (fortunately, for the purposes of the telewarrant provisions, the officer can prove impracticability by showing that the relevant time limits may expire if he or she were required to appear in person).

71 *Supra* note 30 (the police officer had actually made a blood sample demand under s. 254(3)(b), but the court found that the suspect was incapable of consenting to the demand, and ruled the blood sample evidence inadmissible).

72 *Ibid.*

73 *Criminal Code*, *supra* note 5, s. 256(1).

74 *Ibid.*, s. 254(3).

75 *Ibid.*, s. 257(1) and (2).

76 Herb M. Simpson & Robyn D. Robertson, *DWI System Improvements for Dealing with Hard Core Drinking Drivers - Enforcement (Executive Summary)* (Ottawa: Traffic Injury Research Foundation, 2001) (this recent survey of American law enforcement officers found that police encounter resistance from medical staff in about one quarter of impaired driving cases involving medical attention, and that 20% of the officers experienced refusal in more than half of such cases at 7).

77 Canada, Law Reform Commission, *Investigative Tests: Alcohol, Drugs and Driving Offences*, Report No. 21 (Ottawa: Minister of Supply and Services Canada, 1983) at 14.

78 As indicated, there are now also general telewarrant provisions, which allow officers to apply for and obtain warrants without having to appear before a justice of the peace. However, the police must explain the circumstances making it impracticable to appear personally before a justice (section 487.1(4)(a)). In cases where police wish to seize blood samples that have already been taken, and thus, where there is no danger that a time limit may expire, the officer will most likely be required to appear personally before the justice.

79 [1987] 1 S.C.R. 945, [1987] S.C.J. No. 26 [*Pohoretsky* cited to S.C.R.].

80 Interestingly, at the time, the Manitoba *Blood Test Act* authorized medical practitioners to take and analyze blood samples from patients when they had reasonable and probable

grounds to believe that the patients had been driving within the past two hours. It also protected them from liability for disclosing the name of the patient or the results of the analysis. See *S.M.* 1980, c. 49, ss. 1 and 2. However, the trial judge found that the doctor in this case lacked the requisite grounds under the provincial statute. In addition, the Supreme Court of Canada was doubtful whether the Act could authorize the taking of samples for the purposes of criminal prosecution, since section 258(2) of the *Criminal Code* provides that no one can be required to provide bodily samples except in accordance with section 254.

81 *Pohoretsky*, *supra* note 79.

82 Since this case arose before the enactment of the 1985 blood sample provisions, the police were not authorized to demand a blood sample from the accused. Given that the accused was not in a condition to provide a breath sample, the police had no authority to gather any evidence of his BAC from him. Consequently, the accused would have escaped criminal liability in any event. This is precisely the type of situation that prompted Parliament to introduce the blood sample amendments in 1985.

83 [1990] B.C.J. No. 1411 (Co. Ct.) (QL) [*Cochrane*].

84 *Ibid.*

85 (1982), 39 O.R. (2d) 439, 144 D.L.R. (3d) 301 (C.A.) [*Carter* cited to O.R.].

86 *Ibid.* at 441.

87 For example, blood sample kits have standard vials and labels, and include features, such as non-alcohol swabs, to ensure that the sample is not contaminated.

88 *R. v. Carter* (1985), 19 C.C.C. (3d) 174, 31 M.V.R. 1 (Ont. C.A.) (in this subsequent decision, the defense successfully rebutted the presumption of accuracy by, *inter alia*, raising a reasonable doubt regarding the continuity of the blood sample).

89 (1987), 62 O.R. (2d) 441, [1987] O.J. No. 937 (C.A.) (QL) [*Katsigiorgis* cited to O.R.].

90 *Ibid.* at 447.

91 Apparently, this procedure is distinguishable from that in *Cochrane*, *supra* note 83, because all of the samples were taken purely for medical purposes. While police seized a sub-sample of the blood, they were not involved in demanding the sample, no additional sample was taken for investigatory purposes, and the nurse did not have the criminal investigation in mind when she drew the sample.

92 Accord *R. v. Woodhouse*, [1992] O.J. No. 3855 (Gen. Div.) (QL), where the police officer asked the doctor whether he would taking a sample from the accused. When the doctor

responded affirmatively, the officer asked for one of the samples to be sealed for police use. In an oral judgment, Forestell J. held that this was not an unreasonable search or seizure. See also *R. v. Mabon*, [1989] O.J. No. 926 (QL), 16 M.V.R. (2d) 223 (Dist. Ct.).

93 (1990), 58 C.C.C. (3d) 255, 23 M.V.R. (2d) 165 (Ont. C.A.) [*Tessier* cited to C.C.C.], aff'd [1991] 3 S.C.R. 687, (1991), 69 C.C.C. (3d) 192.

94 *Ibid.* at 256.

95 [1994] 1 S.C.R. 20, 110 D.L.R. (4th) 297 [*Colarusso* cited to S.C.R.].

96 *Ibid.* (the minority (Lamer C.J., Cory, McLachlin and Major JJ.) found no section 8 violation).

97 *Ibid.*

98 *Ibid.* at para. 92.

99 Conversely, the minority in *Colarusso* held that the police conduct had been appropriate. Given that they knew that blood samples had been taken for medical purposes and were going to be analyzed by the Centre for Forensic Sciences, their decision not to demand further blood samples was reasonable. *Ibid.* at para. 48.

100 [1988] 2 S.C.R. 417, [1988] S.C.J. No. 82 (QL) [*Dyment* cited to S.C.R.]. As with *Pohoretsky*, this case arose prior to the introduction of the 1985 blood sampling amendments. Thus, the only way that police could obtain BAC information was through the general search warrant provisions.

101 *Ibid.* at para. 30 (it is unclear from the decision what was discussed between the doctor and the officer. It is clear only that they had a conversation, at the end of which the doctor gave the officer the accused's blood sample. LaForest J. expressed doubts as to whether the doctor handed the sample over voluntarily).

102 *Ibid.* at para. 7.

103 *Ibid.* at para. 40. In a dissenting judgment, McIntyre J. held that, if there had been a wrongful seizure, it was by the doctor, not the officer. The officer had not acted in bad faith. In fact, having come into the possession of decisive real evidence, the officer had a duty to tender it into evidence. McIntyre J. would have allowed the appeal and restored the accused's conviction.

104 *Ibid.* at para. 29.

105 *Privacy and Computers -- The Report of the Task Force Established by the Department*

of *Communications/Department of Justice* (Ottawa: Information Canada, 1972) at 13.

106 *Dyment*, *supra* note 100 at para. 30.

107 (1990), 61 C.C.C. (3d) 193, 26 M.V.R. (2d) 209 (B.C.C.A.) [*Lunn* cited to C.C.C.].

108 *Ibid.* at 197.

109 *Ibid.* With respect, the Court of Appeal appears to have avoided the central issue in *Lunn*. The decision seems to rely too heavily on the conclusion that, since the doctor was not acting as an agent of the state, the *Charter* did not apply to his actions. In our view, the court did not adequately explore the consequences of the doctor's breach of confidentiality, stating simply, "while the appellant might complain that Dr. Metcalf revealed information of a private nature, the consequence is not that it constituted a breach of the *Charter*".

110 (1992), 125 A.R. 68, 72 C.C.C. (3d) 75 (Alta. C.A.) [*Erickson* cited to C.C.C.], *aff'd* [1993] S.C.R. 649, (1993), 81 C.C.C. (3d) 447.

111 *Ibid.* at 79, referring to R.S.A. 1980, c. H-11, s. 40(3).

112 *Ibid.* at 81 (although there was a breach of s. 8, Major J.A. allowed the Crown's appeal based on the good faith of the police officer and the discoverability principle. Major J.A. ordered a new trial, in which the blood sample evidence would be admissible).

113 [1993] 3 S.C.R. 768, 85 C.C.C. (3d) 1 [*Dersch* cited to S.C.R.].

114 *Ibid.* at para. 29.

115 *Dersch*, *supra* note 113 at para 9 (the doctor testified at trial that he was unaware that he could not disclose this information to police against the express wishes of the suspect. This type of inquiry by police was criticized by the Ontario Court of Appeal in *Re Inquiry into the Confidentiality of Health Records in Ontario*(1979), 240 O.R. (2d) 545, 98 D.L.R. (3d) 704 [cited to D.L.R.], *rev'd* on other grounds (1981), [1981] 2 S.C.R. 494, 128 D.L.R. (3d) 193).

116 *Ibid.* at para. 29.

117 *Ibid.* at para. 23 (emphasis added).

118 R.S.O. 1990, c. P.40, s. 14(1); *Hospital Management*, R.R.O. 1990, Reg. 965, ss. 22-23.2; S.O. 2004, c. 3 [*PHIPA*].

119 See *infra* notes 160 and 161.

120 *Code of Ethics* (Ottawa: Canadian Medical Association, 2004), online: CMA Online

<www.cma.ca/index.cfm/ci_id/43892/la_id/1.htm>.

121 See generally Barney Sneiderman, John C. Irvine & Philip H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses and other Health Care Professionals*, 3d ed. (Scarborough: Thomson Carswell, 2003) at 212 -218; Gilbert Sharpe, *The Law and Medicine in Canada*, 2d. ed. (Toronto: Butterworths, 1987) at 182-83.

122 Although statutory language varies across jurisdictions, we use the terms "confidential health information," "health information," and "personal health information" interchangeably in this section of the paper.

123 *PHIPA*, *supra* note 118, Sch. A, s. 4(1).

124 R.S.A. 2000, c. H-5, s. 1(1) [*HIA*].

125 The presence of a patient relates to the "providing of health care to that individual."

126 *HIA*, *supra* note 124 s. 34(1); and *PHIPA*, *supra* note 118, s. 29.

127 [1992] 2 S.C.R. 138 at para. 18, 93 D.L.R. (4th) 415 [*McInerney* cited to S.C.R.]; see also *Dyment*, *supra* note 100 at para. 22.

128 *Supra* note 113 at para. 22.

129 *Ibid.* at para. 23.

130 (1998), 40 W.C.B. (2d) 84, [1998] O.J. No. 4461 (Ont. C.A.) (QL).

131 *Ibid.* at para. 4; see also *Lunn*, *supra* note 107.

132 See e.g. *Erickson*, *supra* note 110; *R. v. Lavoie*(2002), 205 N.S.R. (2d) 252, 34 M.V.R. (4th) 140 (Prov. Ct.) [*Lavoie* cited to N.S.R.].

133 A patient's presence in a hospital relates to the provision of healthcare services to an individual, which is specifically enumerated as personal health information in the relevant statutes. See *supra* note 124. (However, some legislation allows for a hospital patient's name to be released, unless the patient specifically objects to the release of that information. See *PHIPA*, *supra* note 118, s. 38(3). The courts have not directly addressed this issue in terms of the common law confidentiality principles. A court may not be particularly concerned that a dentist disclosed to a patient's insurance company that he or she was a patient. A court might hold that there was no reasonable expectation of privacy regarding such a mundane matter, or that the dentist had the patient's implied consent to share such information. However, neither of these approaches is likely to be adopted in regard to a psychiatrist, sex therapist, or addictions counsellor confirming that a person is a patient).

134 *Supra* note 107.

135 *Ibid.*

136 See *Emergency Health Services Act*, S.A. 2008, c. E-6.6, s. 52(1)(b), adding s. 1 (1)(f)(ii.1) to the *HIA*.

137 See e.g. *R. v. Lachappelle*(2003), 49 M.V.R. (4th) 298 at para. 42 (Ont. S.C.J.) (it was found to be a breach of confidentiality for the emergency room nurse to show the investigating officer a note she had made on the accused's medical chart, indicating that he smelled like alcohol).

138 Personal correspondence with B. Bokenfohr, Director, Legal Services and Risk Management Branch, Edmonton Police Service (24 July 2009, 8 August 2009).

139 See Bonnie Bokenfohr, "Police Experience with the *Health Information Act*: The Edmonton Police Service's Submissions to the Select Special *Health Information Act* Review Committee" (2005) 14 *Health Law Review* 9.

140 *HIA*, *supra* note 124, s. 34(1); *PHIPA*, *supra* note 118, s. 29.

141 *HIA*, *ibid.*, ss. 35(1)(i) and 35(1)(p); *PHIPA*, *ibid.*, s. 41(1)(d).

142 See *Re Inquiry into the Confidentiality of Health Records in Ontario*, *supra* note 115 at 714 (Dubin J.A.).

143 General Counsel, The Canadian Medical Protective Association, "Reporting of gunshot and stab wounds" (April 2009); See also K. Evans, *A Medico-Legal Handbook for Physicians in Canada* (Ottawa: The Canadian Medical Protective Association, 2005) at 18.

144 *Supra* note 132.

145 *Ibid.*

146 R.S.N.S. 1989, c. 208, s. 71.

147 *Lavoie*, *supra* note 132 at para. 75.

148 (1995), 15 M.V.R. (3d) 289 (Ont. Gen. Div.).

149 *Ibid.* at para. 34.

150 *Ibid.* at para. 26.

151 *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, 92 D.L.R. (4th) 449 [*Norberg* cited to S.C.R.].

152 Modern translations vary, but the essence is as follows: "Whatsoever things I see or hear concerning the life of man, in any attendance on the sick or even apart there from, which ought not to be noised abroad, I will keep se cret thereon, counting such things to be as sacred secrets." See Clinton DeWitt, *Privileged Communications Between Physician and Patient* (Springfield: C.C. Thomas, 1958) at 23.

153 See *supra* notes 19-21; see generally Jack Watson, "Blood Samples: Are They Real or Not?" (1990) 2 J.M.V.L. 173. The main exception to this is where blood samples had already been validly taken for medical purposes. If the section 8 violation related only to the search warrant used to seize those samples, the court might find that the blood samples were real evidence that was discoverable even in the absence of the *Charter* violation. See *Erickson*, *supra* note 110 at 81-82; *Colarusso*, *supra* note 95 at para. 121.

154 See *Hanet*, *supra* note 20.

155 *PHIPA*, *supra* note 118, s. 72(2).

156 *HIA*, *supra* note 124, s. 107(7).

157 This action exists by virtue of legislation in some provinces. See *Hollinsworth v. BCTV*(1996), 34 C.C.L.T. (2d) 95, [1996] B.C.J. No. 2638 (B.C.S.C.) (QL), aff'd [1999] 6 W.W.R. 54 (B.C.C.A.) (a plaintiff successfully claimed under the British Columbia *Privacy Act*, (now R.S.B.C. 1996, c. 373, s. 1(1)), against a company that provided a video of his hair grafting surgery to a television station without his consent).

158 *Cadbury Schweppes Inc. v. FBI Foods Ltd.*, [1999] 1 S.C.R. 142 at paras. 24, 25, [1999] S.C.J. No. 6 (QL) [*Cadbury* cited to S.C.R.].

159 *Ibid.* at para. 53; see also *Attorney-General v. Guardian Newspapers (No. 2)*, [1990] A.C. 109 (H.L.) at 256 (Lord Keith).

160 *Professional Misconduct*, O. Reg. 856/93, s. 1(1), para. 10.

161 *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Sch. 2, s. 51(2); See *Hasan v. College of Physicians and Surgeons (N.B.)*(1994), 152 N.B.R. (2d) 230, [1994] N.B.J. No. 389 (C.A.) (a physician who wrong fully disclosed confidential information for non-medical purposes was suspended for four months).

162 *Road Traffic Act 1988* (U.K.), 1988, c. 52, s. 6(1).

163 *Ibid.*, s. 6(2).

164 *Ibid.*, s. 7(1).

165 *Ibid.*, s. 7(2).

166 *Ibid.*, s. 7(4) (generally, the police officer decides whether the suspect must provide a blood sample or a urine sample. However, if a medical practitioner believes that a specimen of blood cannot or should not be taken for medical reasons, a urine sample will be required).

167 *Ibid.*, s. 11(4) (if these requirements are not met, the evidence must be disregarded); *Road Traffic Offenders Act 1988* (U.K.), 1988, c. 53, s. 15(4) (the requirement of consent would seem to preclude the taking of any samples from an unconscious or incoherent suspect).

168 *Road Traffic Act 1988*, *ibid.*, ss. 6(4) and 7(6).

169 *Ibid.*, s. 9(1).

170 *Ibid.*, s. 9(2).

171 *Land Transport Act 1998* (N.Z.), 1998/110, s. 68(1) (a).

172 *Ibid.*, s. 69(1).

173 *Ibid.*, s. 72(5).

174 *Ibid.*, s. 68(1)(c).

175 *Ibid.*, s. 73(5).

176 *Ibid.*, s. 73(5)(c) (however, if the patient is conscious, he or she must be informed that blood is being taken for evidential purposes).

177 *Ibid.*, s. 73(7).

178 See e.g. *Road Transport (Alcohol and Drugs) Act 1977* (ACT), s. 8 [ACT]; *Road Transport (Safety and Traffic Management) Act 1999* (NSW), s. 13(1) [NSW]; *Road Traffic Act 1961* (SA), s. 47E [SA]; *Road Traffic Act 1974* (WA), s. 66(1) [WA].

179 See ACT, *ibid.*, s. 22; NSW, *ibid.*, ss. 14(1) and 15(1); SA, *ibid.*, s. 47E.

180 See SA, *ibid.*, s. 47F; *Road Safety Act 1986* (Vic), s. 55(9A) [Vic].

181 See ACT, *supra* note 178, ss. 9(a) and (b); *Traffic Act 1987* (NT), s. 29AAC(1)(b).

182 See *Road Safety (Alcohol and Drugs) Act 1970* (Tas), s. 197, s. 8(3) (Tas); SA, *supra* note 178, s. 47E(1)(d); NT, *ibid.*, s. 23(1)(b)(ii); WA, *supra* note 178, s. 66(2)(d).

183 See ACT, *supra* note 178, s. 15AA(1); See NSW, *supra* note 178, s. 20; Tas, *ibid.*, s.

10A(1).

184 SA, *supra* note 178, s. 471. For similar provisions, see ACT, *supra* note 178, s. 15AA; *Road Safety Act 1986 (Vic)*, s. 56.

185 *Criminal Code*, *supra* note 5, s. 254(4).

186 *Supra* note 100 at para. 23 (emphasis added).

187 See *supra* note 113.

188 *Dyment*, *supra* note 100 at para. 38.

189 *Report of the Commission of Inquiry into the Confidentiality of Health Information* (Toronto: Queen's Printer, 1980), Vol. II at 91.

190 See *supra* notes 14-15.