An Examination of Legal and Ethical Issues Surrounding Male Circumcision: The Canadian Context

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Despite shifts in the discourses adopted and reinforced within the Canadian medical community and indeed the international community, routine neonatal male circumcision remains fairly normalized. Focusing on the Canadian context, this paper outlines the health-based and legal arguments against elective infant male circumcision. Part one provides an overview of routine neonatal male circumcision and deals with the crucial distinction between therapeutic and nontherapeutic intervention. It locates elective neonatal male circumcision within the nontherapeutic category. Part two outlines the theoretical underpinnings for medical consent in the Canadian context and discusses the legal requirements for "informed consent." The work of part three is to tease out issues of parental consent and whether parents should be entitled to substitute consent for nonmedically necessary, routine, neonatal circumcision.

Keywords: male circumcision, medical consent, Canadian medical community, parental consent

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On August 22, 2002, five-week-old Ryleigh McWilis died from complications resulting from of an elective circumcision. Two days after the procedure, his parents found his diaper soaked with blood and rushed him to a hospital in Penticton, British Columbia (Fournier, 2004). A Coroner's Report (2004) revealed that Ryleigh's lungs showed severe hemorrhage and areas of hyaline membrane disease, which can arise from asphyxia, shock, and acidosis.

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It is interesting to note that, after almost three decades of explicit cautioning against routine circumcision of newborn male infants by the Canadian Paediatric Society (1975, 1996) and only weeks before Raleigh's death, the Canadian Medical Protective Association (CMPA) issued a statement (CMPA 2002) that there existed no unanimity within medical or legal communities about the justification for circumcising infant males. Six months before that, Saskatchewan's College of Physicians and Surgeons and the College of Physicians and Surgeons of Manitoba circulated memos to its members warning against routine circumcision of newborn boys (CPSS, 2002; CPSM, 2002). This was part of a broad-based educational strategy to raise professional and public awareness about the risks of routine circumcision. Shortly thereafter, the College of Physicians and Surgeons of British Columbia began its own review of the procedure. It determined that infant male circumcision is ultimately a matter of parental choice (based on tradition, culture, religion, or personal preference) and that the procedure should be regarded as "cosmetic" (2002, p. 2). Even so, the College Council has not identified any need to place restrictions on the availability of elective infant male circumcision. However, it issued a notice that circumcision should be considered only after detailed discussion with the parents, explaining that neonatal circumcision is not a medical necessity, that currently the majority of boys are not circumcised, that a number of pediatric associations do not recommend the procedure, and that there are potential short- and long-term risks resulting from the procedure.

Despite shifts in the discourses adopted and reinforced by the Canadian medical community and the international medical community (American Academy of Pediatrics, 1999; Australian College of Paediatrics, 1996; British Medical Association 1996; Canadian Paediatric Society, 1996), routine neonatal male circumcision remains fairly normalized. Focusing on the Canadian context, this paper outlines the health-based and legal arguments against elective infant male circumcision. Part one provides an overview of routine neonatal male circumcision and deals with the crucial distinction between therapeutic and nontherapeutic intervention. It locates elective neonatal male circumcision within the nontherapeutic category. Part two outlines the theoretical underpinnings for medical consent in the Canadian context and discusses the legal requirements for "informed consent." The aim of part three is to tease out issues of parental consent and question whether parents should be entitled to substitute consent for medically unnecessary, routine neonatal circumcision.

With this in mind, an important caveat is in order. The debate surrounding both male *and female* circumcision demonstrates the struggle between respect for cultural differences and universal human rights (i.e., Braver Moss, 1991; Slack, 1988). Without doubt, a more thorough analysis of the balancing of ethnic and cultural traditions and the protection of individuals from harmful cultural practices is needed. However, such an endeavour is beyond the scope of this paper. For this reason, the discussion will focus on nonritual, nontherapeutic neonatal circumcision. Nevertheless, the discussion is framed in such a way as to acknowledge the cultural dynamics at play and respectfully listen to multiple perspectives in order to better grapple with this complex issue.

PRELIMINARIES: LOCATING NEO-NATAL CIRCUMCISION

Routine neonatal circumcision is the most common nonmedical surgical intervention carried out in the United States (Cendron, Elder, & Ducket, 1996). In Canada, elective neonatal circumcision is performed as a primary procedure on less than 10% of the male population (CIRP, 2004). While in the past circumcisions were routinely performed without the consent of the infant's parents or guardians, today "routine" neonatal circumcision is an *elective* procedure that requires parental consent (Le Bourdais, 1995; Oh & Merenstein, 1997). Traditionally, the procedure did not include anaesthesia, due to the belief that infants did not feel pain because their nerves were not completely myelinated (Cope, 1998). Today, however, most medical practitioners will inject a local anesthetic into the penis or use a topical anaesthetic cream (AAP, 1999).

The procedure generally unfolds as follows. The fully conscious newborn is restrained while tissue is incised from the tip of the penis using instruments such as probes, clamps, and scalpels (Cohen, 1992; Gelbaum, 1993). Circumcision entails an incision over the circumference of the tip of the penis and the removal of the penile foreskin (prepuce), which exposes the gland underneath (Boyd, 1998; Boyle et al., 2002). The method most often used is direct surgery whereby the foreskin is held away from the glans with a clamp. Then

> [one] blade of a scissor (or a scalpel) is inserted between the foreskin and glans and the foreskin is first cut along its full length.... The incision is spread apart to expose the glans. Then, using a scalpel or scissors, the foreskin is completely cut off close to the groove. (Romberg, 1985, p. 91)

Some parents justify the procedure for aesthetic reasons (Chessler, 1997) or to spare their sons from "feeling embarrassed" for looking different from others (Patel, 1996, p. 5). However, most proponents of circumcision see it as a preventative healthcare measure; namely, it does not allow for smegma (a sebaceous secretion that collects under the prepuce) to accumulate under the foreskin (Schoen et al., 2000). Circumcision is also believed to reduce the likelihood of urinary tract infections (Canadian Paediatric Society, 1996; Herzog, 1989; Schleupner, 1997; Schoen et al., 2000). Some researchers have found that circumcision decreases the spread of HIV/AIDS and other sexually transmitted diseases. They found that mini-abrasions of the foreskin during intercourse increase the risk of uncircumcised men acquiring certain STIs (Cardwell & Cardwell, 1996; Weiss et al., 2000). There is evidence that it provides protection against penile cancer as well as cervical cancer in female sexual partners (Rivet, 2003; Schoen et al., 2000). Moreover, there are a number of researchers who have found that the risks of circumcision are remote and insufficient to override a parent's decision to have their son undergo the procedure (Ottem, 1996).

Note that circumcision in adulthood is a more complex procedure than surgery upon infants because the infant's foreskin is approximately half the size of what it will be in an adult male's penis (Cuckow, Rix, & Mouriquand, 1994). In Canada at

least one man who has suffered grave injuries as a result of circumcision sought compensation in tort but was unsuccessful (*Sanzana* v. *Wiggens*, 1998). At trial, the judge found that "unhappiness with the cosmetic results in the circumstances" was not a compensatable injury (1998, p. 2391). Further, Mr. Sanzana had not established a causal connection between the pain alleged and the circumcision. However, in *Voorthuyzen* v. *Orovan* (1988), the plaintiff underwent a circumcision to relieve paraphimosis, a condition whereby the foreskin becomes trapped behind the corona and forms a tight band of constricting tissue. He argued that the doctor had removed an excess amount of penile skin, and as a result the patient's penis was foreshortened and he suffered considerable sexual dysfunction and depression. The Ontario High Court found that the physician had met the standard of a reasonably competent urologist. The court nevertheless awarded the plaintiff $15,000 in general damages for loss of income and $5,000 to his spouse under Ontario's *Family Law Reform Act* for loss of care, guidance, and companionship.

With this in mind, the circumcision of adult men will not be the focus of this discussion. Suffice it to say, a competent adult can give "informed consent" to the deliberate infliction of actual bodily harm such as tattooing (Bibbings & Alldridge, 1993) so long as it does not offend public policy. For instance, female genital mutilation was found to be against public policy, and the *Canadian Criminal Code* was amended to include section 268(3). In addition, adults may not consent to have nontherapeutic and harmful interventions carried out on their children. What follows then are the arguments that locate neonatal elective circumcision within the type of procedure to which adults may not legally provide consent by proxy. The issue is important given the potential health risks to infant males when circumcision is performed on them.

ROUTINE NEONATAL CIRCUMCISION: A HARMFUL AND NONTHERAPEUTIC PROCEDURE

> Circumcised penises are not normal. They are mutilated. (Lewis, 2003, p. 1)

There has been increased international interest among lawyers, human rights activists, children's rights proponents, mental health practitioners, ethicists and men directly affected by the procedure in the legal and ethical issues surrounding male circumcision (i.e., AAP, 1999; AAPS, 1996; Boyle et al., 2002; INTACT, 2002; International Circumcision Information Reference Centre, 2004; Somerville, 2000; Svoboda et al., 1999). Apart from a few sociological analyses of the procedure (Boon, 1994; Campbell, 1991; Sweiden, 1996), however, most often the debate is approached from a medical perspective (Harrison, 2002, p. 301). At the core of the discussion is whether or not routine neonatal circumcision should be viewed as therapeutic ("treatment") or nontherapeutic. This distinction is crucial when addressing circumcision because it touches upon the issue of consent.

To begin, a working definition of treatment may be helpful. Section 2(1) of the *Ontario Consent to Treatment Act* (1992), which reflects other similar provincial legislation, defines treatment as "anything that is done for a therapeutic, preventive,

palliative, diagnostic, cosmetic or other health-related purpose, and includes a course or a plan of treatment." On the other hand, nontherapeutic treatment is surgery for *other than* standard medical purposes (Butterworth's Medical Dictionary, 1978, p. 1700; *J.W.B.* v. *S.M.B.*, 1992, p. 226). Although common law once prescribed that only a therapeutic aim could justify "wounding" through medical intervention (Somerville, 1981), today nontherapeutic intervention is legal so long as the subject is capable of giving and has given informed consent and that the intervention does not offend public policy (*Attorney-General's Reference,* 1981). To this end, a number of authors have concluded that elective neonatal male circumcision is in fact a form of nontherapeutic procedure (Boyle et al., 2002) that is not justifiable by law (Somerville, 1981, 2000).

CIRCUMCISION IS HARMFUL

Routine neonatal circumcision continues despite increasing ethical concerns about consent as well as medical concerns about its physical and psychological consequences. It is the latter that is the focus of this next section.

To recognize the significance of the potential harm of this procedure, it is helpful to discuss some anatomical and physiological issues. The foreskin is a highly vascular and sensitive piece of body tissue that covers the glans of the penis. It contains mucosal glands, which secrete lubricants and protective antibodies, and enhances sexual stimulation because of the extensive concentration of nerve endings in the foreskin and its wide range of skin movement during intercourse (Taylor et al., 1996). Removal of the foreskin destroys the gliding action of the penis, and the overall effect of circumcision is the removal of highly erogenous tissue (Crawford, 2002; Gairdner, 1949; Goodwin, 1990; Harrison et al., 1997; Taylor et al., 1996).

Complications from the procedure occur in approximately 2 to 10% of cases (Williams & Capilla, 1993). Romberg (1985) suggests that when the harm done is viewed in terms of the individuals and families concerned, "the risks seem quite significant" (p. 89). They range from relatively minor complications such as bleeding and scarring (Kaplan, 1983) to severe long-term aftereffects such as sensory pain behaviour (Anand & Scalzo, 2000; Fitzgerald, 1998; Taddio et al., 1997), consistent pain in the genital area (Anand & Hickey, 1987), amputation of the glans (Gluckman et al., 1995), acute renal failure (Eason et al., 1994), ruptured bladder (Jee & Millar, 1990), heightened physiological pain responses (Bigelow, 1995; Taddio et al., 1997), and sometimes even death (Sullivan, 2002).

There is growing opposition to the practice on the grounds that it is medically unwarranted (Boyle et al., 2002; Gairdner, 1949), scientific accounts of its benefits are often methodologically and analytically flawed (Australian College of Paediatrics, 1996), and it is in and of itself harmful (Somerville, 2000).

A few Canadian decisions have dealt with complications resulting from circumcision, although none has gone before the Supreme Court of Canada. First, in *Gray* v. *LaFleche* (1950), a circumcision performed by a doctor was so unskillfully done that the six-day-old infant sustained severe and permanent injuries to the glans. A second doctor examined the infant. The penis was covered with granulated tissue, was slightly retracted and flattened, and had no tip. The Manitoba court of Queen's

bench found that the child was entitled to damages for having to go through life with a deformed penis that could decrease his pleasure during coitus and diminish his chances of marriage. In *Bera* v. *Marr* (1988), a young man's penis was left "deviated" following circumcision. The court held that the doctor had not exercised the skill required by a physician for this procedure. In awarding damages, the trial judge considered the psychological trauma that resulted from years of humiliation and teasing. General damages were assessed at $40,000.

Moreover, since the early 1990s, there has been a burgeoning of anti-circumcision groups throughout the West, including the Association for Genital Integrity (which is currently challenging Section 268 of the *Criminal Code* as failing to protect male children), the National Organization to Halt the Abuse and Routine Mutilation of Men (NOHARMM, a direct-action men's network concerned with circumcision), the International Coalition for Genital Integrity (which publishes a news feed for research on the issue of genital integrity), the National Organization of Restoring Men (NORM-UK, a British group engaged in public education about the foreskin and alternative treatments for foreskin problems), and the National Organization of Circumcision Information Resource Centers (NOCIRC). There is also vocal opposition from various professional associations such as Doctors Opposing Circumcision (DOC), Attorneys for the Rights of the Child, and Nurses for the Rights of the Child. The lack of medical indication of the procedure has been acknowledged by provinces such as Nova Scotia (1997) and Saskatchewan (1996), where it has been removed from the list of publicly insured medical services (*Cameron* v. *Nova Scotia,* 1999).

The harm caused by routine neonatal circumcision is outside the *de minimis* range (Somerville, 2000), and the procedure should not fall within the exceptions justifying nontherapeutic medical intervention. This is particularly important given that a male infant himself cannot provide consent.

CIRCUMCISION AND ISSUES OF CONSENT

The following section outlines the law of informed consent in Canada as it pertains to medical treatment. It begins with a consideration of the theoretical underpinnings of Canada's approach to issues of consent. It goes on to examine the exceptions to consent, such as when a patient is unable to provide informed consent on her or his own behalf. In thinking about elective neonatal male circumcision, a situation in which an infant cannot possibly provide consent himself, it is also important to understand when consent can or cannot be substituted by a parent or guardian. An overview of this law is provided. Finally, the interplay between parental rights to give consent and a child's security of person as guaranteed under the *Canadian Charter of Rights and Freedoms* is considered in the context of routine neonatal circumcision.

THE THEORETICAL UNDERPINNINGS OF CONSENT IN THE MEDICAL CONTEXT

According to the Supreme Court of Canada, essential to the idea of consent is the principle that individuals have the right to determine what is to be done with and to their bodies. As Laskin J. states in *Hopp* v. *Lepp*, "[t]he underlying principle is the

right of a patient to decided what, if anything should be done with his [or her] body (1980, p. 661). In *White* v. *Turner*, Linden J. adds that "the law . . . requires that patients be treated as intelligent, mature, and rational individuals" (1982, p. 764). Moreover, in *Norberg* v. *Wynrib*, Justice La Forest wrote that consent is based on notions of liberty, autonomy, and individualism: "It is presumed that the individual has freedom to consent or not to consent" (1992, p. 247). This was confirmed in *Ciarlariello* v. *Schacter* (1993), where Justice Cory held that:

> [E]very patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will not be accepted. Everyone has the right to decide what is to be done to one's own body.... This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient. (1993, p. 106)

To this end, the concept of consent and especially informed consent is at its core intended to protect the individual's right to "security of the person" as contained in Section 7 of the *Canadian Charter of Rights and Freedoms*, which reads: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." Canadian medical law is fundamentally concerned with the issue of consent. It is a well-known common-law rule that a physician or healthcare provider may not engage in medical treatment or even touch a patient without his or her consent (*Re "Eve,"* 1986). It is also well established that a competent adult has the *right to refuse* consent for "medically necessary" treatment (*Malette* v. *Shulman,* 1990). As Justice Linden of the Supreme Court of Canada explained in *Allan* v. *New Mount Sinai Hospital*:

> Our law is clear that the consent of a patient must be obtained before any surgical procedure cam be conducted…. This is not a mere formality; it is an important individual right to have control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed, where it will be done, when it will be done and by whom it will be done. (1980, p. 364)

Moreover, a patient can withdraw consent at any time during a surgical procedure (*Ciarlariello* v. *Schacter*, 1993). That said, there is an exception to the general rule of respect for individual's autonomy and bodily integrity, the medical emergency. Physicians are privileged to provide medical attention if required to save the life or preserve the health of a patient where the consent of that patient or her or his substitute decision maker is not readily available (Linden & Klar, 2001, p. 77). For instance, Section 45 of the *Canadian Criminal Code* provides that "everyone is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person" as long as

(a) the operation is performed with reasonable care and skill; and
(b) it is reasonable to perform the operation, having regard for the state of health of the person at the time the operation is performed and to all the circumstances of the case.

However, once the patient has expressly refused treatment, emergency treatment as well as continued treatment constitutes a battery (*Fleming* v. *Reid*, 1991; *Malette* v. *Shulman*, 1990). Let us now examine more closely the doctrine of "informed consent."

THE LAW OF INFORMED CONSENT: AN OVERVIEW

In Canada, the common-law rule is that no legal wrong is done to an individual who consents to the intentional invasion of his interests (Linden & Klar, 2001, p. 65). Consent provides permission to engage in conduct that would otherwise result in liability for an intentional tort. As such, explicit or implied consent is a full defense to intentional torts. Consent is implied, for instance, when a court authorizes a medical procedure against the wishes of the patient. This was the case, for example, in *Institut Philippe Pinel de Montreal* v. *Dion* (1983), where the Québec Superior Court implied consent to a patient found to be unfit to stand trial. The patient was being forced to undergo drug therapy determined by health professionals to be needed in order to prevent mental deterioration. In order to give valid explicit consent, the following criteria must be met: consent must be voluntary and genuine and is vitiated if

- obtained under duress or pressure,
- obtained by fraud or deceit as to the very nature of the intervention, or
- it would go against public policy to allow the defendant to rely on it.

Moreover, the person consenting must also have the legal or factual capacity to do so. In short, consent must be informed, that is, in accordance with accepted standards for disclosure of information by a physician to the particular patient (Dickens, 1999; *Norberg* v. *Wynrib*, 1992; *R.* v. *Cuerrier*, 1998; Rozovski, 1997).

Certain legal issues arise when establishing whether consent is truly informed. In *Hopp* v. *Lepp* (1980) and *Reibl* v. *Hughes* (1980) the Supreme Court of Canada clarified the law of consent and established the foundation of a new doctrine: "informed consent." This doctrine has proven to be of fundamental importance in the context of legal liability of doctors to their patients. The Court established principles relating to (1) the proper cause of action, (2) the standard of disclosure, and (3) the means of determining causation. In *Reibl*, the Supreme Court of Canada established that, in most cases of medical failure to inform, the cause of action will be framed in terms of negligence rather than battery. The elements of negligence are as follows: (1) a wrongful conduct (a legal duty and a breach of that duty) on the part of the defendant, (2) causation of harm by the wrongful conduct, and (3) real harm to the plaintiff (Linden & Klar, 2001, p. 36). The tort of battery, on the other hand, protects an individual's interest in her or his bodily security from unwanted physical interference that is harmful or offensive to her or his reasonable sense of dignity (*Malette* v. *Shulman*, 1990;

Norberg v. *Wynrib,* 1992). This cause of action is confined to cases where there is no consent due to fraudulent misrepresentation or a misrepresentation that goes to the very nature of the procedure (as opposed to incidental risks).

Canadian courts have determined that the tort of battery is exceptionally serious. Unlike negligence, a defendant will be found liable for all consequences of a wrongful conduct, whether intended or not, and regardless of foreseeability or lack thereof (Linden & Klar, 2001, p. 45; *Bettel* v. *Yim,* 1978). To this end, an action framed in negligence deprives a plaintiff of the procedural advantages of battery. That is, the onus is on her or him to establish all the required elements of negligence; namely, that the defendant physician failed to properly inform her or him of the material risks involved and that there has been an actual harm to a legally recognized interest. Essentially, the plaintiff must establish that, *had she been properly informed, she would not have consented to surgery* and therefore *would not have suffered damages*.

In terms of the standard of disclosure, the Supreme Court of Canada restated its previous decision in *Hopp* (1980) that a patient has the right to decide what will be done to her or his body and a doctor must fully disclose all material risks of the procedure. To this end, a patient must be informed about what a reasonable person would be required to know concerning the procedure in order to enable her or him to decide whether to undergo treatment. This is a question of fact, therefore to be determined by a trial judge rather than by the medical profession (Klar, 1980, p. 76).

The Canadian Supreme Court has adopted a "modified" objective test for causation: *would a reasonable person in the patient's position have consented to the operation where proper disclosure (of the material risks of the proposed treatment) had been made?* The patient's subjective circumstances are not to be ignored, so long as his or her concerns are reasonably based. As then Chief Justice Laskin states:

> In obtaining the consent of a patient for the performance upon him [or her] of a surgical operation, a surgeon should generally answer any specific question posed by the patient as to the risks involved and should without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. (*Hopp,* 1980, p. 210)

The test is difficult to apply, however. With this review of informed consent law in the Canadian context, consider parents' right to provide consent by proxy in the case of routine circumcision.

PARENTAL OR SURROGATE DECISION MAKERS' CONSENT FOR MINORS IN THE MEDICAL CONTEXT

Our society presumes that parents will exercise their freedom of choice in a manner that does not offend the rights of their children (per La Forest, J., in *B (R)* v. *Children's Aid Society* [1995, p. 373]). Whereas an adult may consent to medical procedures, a child is often not in a position to do so or simply lacks the capacity to make such a decision.

Many jurisdictions have circumscribed a minor's rights to consent to medical treatment. For instance, a Washington court determined that a minor was not capable of consenting to having a vasectomy (*Smith* v. *Seibly*, 1967). However, in *Planned Parenthood of Mo.* v. *Danforth*, the American Supreme Court held that a minor did not need parental consent to procure an abortion. There is a growing movement advocating the right to children's self-determination and their right to decide whether to undergo treatment (Shield & Baum, 1994). That said, the basic legal framework in Canada is one that gives broad legislative and judicial deference to parents since they are most often the primary caregivers of children and, as such, are responsible for a child's rearing, protection, and education.

Parents are usually given the responsibility for their children and have the right to make fundamental decisions regarding their health. Specifically, the Supreme Court of Canada has determined that:

> [t]he common law has always, in the absence of demonstrated neglect or unsuitability, presumed that parents should make all significant choices affecting their children, and has afforded them a general liberty to do as they choose. (*Sheena B.,*1995, p. 372)

More recently, the Court relied upon Professor Nicolas Bala's argument that, due to children's limited personal capacity, society temporarily confers on them only a limited legal capacity. This limited legal capacity is not arbitrary and does not stigmatize children. It is, rather, a reflection of their actual need, capacity, and circumstances (cited in *Law v. Canada,* 1999, p. 37). In the medical context, this means that a parent or guardian can provide informed consent in place of a child for medical interventions *in cases of imminent and serious danger to the child's life or a vital organ disease, requiring immediate treatment*. The law clearly indicates, however, that parental authority is limited to "therapeutic treatment," and thus a parent cannot, for example, consent to nontherapeutic sterilization of his or her child (*Re "Eve,"* 1986).

The State maintains a right to intervene when it considers it warranted to safeguard a child's autonomy or health or when a procedure is contrary to "the best interest of the child." This is referred to as *parens patriae,* a common-law concept founded upon necessity, namely that the State will act on behalf of those who cannot care for or protect themselves (*Re "Eve,"* 1986). The main agent for the protection of children is the Children's Aid Society, a group of quasi-governmental, local organizations. They are regulated under provincial legislation. In Ontario, the *Child and Family Services Act* (1990) sets the formal legal standard for intervention as a "child in need of protection." In *Catholic Children's Aid Society of Metropolitan Toronto* v. *M(C)* (1994), the Supreme Court of Canada developed an interpretation of the "best interest of the child." Madame Justice l'Heureux-Dubé, writing for a unanimous bench, found that the best interest of the child encompasses "concerns arising from emotional harm, psychological bonding and the child's desires" (1994, p. 201).

The "best interests of the child" test was tightened by Madame Justice McLachlin in *Gordon* v. *Goertz* (1996). In that decision, she outlined the factors to be considered, limiting them to all relevant circumstances relating to the child's needs and

the ability of the respective parents to satisfy them, and expressly cited the views of the child as a factor to consider (1996, p. 61). To this end, a parent or substitute decision maker making decisions based on the child's "best interests" will be guided by the following considerations:

- Is the condition of the child likely to be improved by the treatment?
- Will the child's condition deteriorate without the treatment?
- Are the anticipated benefits from the treatment outweighed by the risks of harm to the child?
- Is the treatment the least restrictive and least intrusive treatment that meets the first three criteria? (*Fleming* v. *Reid [Litigation Guardian],* 1991)

PARENTAL CONSENT IN THE CONTEXT OF CIRCUMCISION

Where a parent or substitute decision maker has deemed that it is in the child's best interest to undergo a treatment, there may be some conflict between that privilege and the fundamental right to security of the person protected under Section 7 of the *Charter*. Because the State's power to intervene is broad and can be permanent, parental decision making has been protected under the *Charter*. Nevertheless, the Court has determined that parents' rights are not absolute and that the State will intervene when necessity is demonstrated.

Section 7 of the *Charter* provides everyone with a certain degree of autonomy in decisions concerning their private lives, including those concerning medical treatment. The protection of the security of the person is so fundamental that medical treatment administered without a patient's informed consent may amount to battery. In the context of circumcision, if a medical practitioner performs routine neonatal circumcision without an infant's parental consent, that practitioner may be liable for criminal assault as well as for damages for any harm that resulted from her or his negligence (Somerville, 2000).

Given that a portion of the medical community has agreed that routine male circumcision is nontherapeutic and that it may be in and of itself be a harmful practice, it is arguable that when performed on neonates for nontherapeutic reasons, it amounts to a violation of the child's Section 7 rights. As stated at *the Declaration of the First International Symposium on Circumcision,* "parents and/or guardians do not have the right to consent to the surgical removal or modification of their children's normal genitalia." The *Declaration* adds that the only person who may consent to medically unnecessary procedures upon herself or himself is *that* individual, having reached a stage in life where she or he can consent and *only upon* being fully informed about the risks and benefits of the procedure. Note, however, that the *Declaration* is not a binding legal instrument.

In the United States, a case challenging the institution of routine neonatal circumcision was brought before the Superior Court of California. The plaintiff attempted to invoke protections similar to the rights protected under Section 7 of the *Canadian Charter*. In that case, the mother had signed a consent form which expressly stated that the procedure was of no medical purpose. The issue was whether *a parent was capable at law to consent to a surgical procedure without*

medical purpose. The California Superior Court found for the defendant, and this was upheld upon appeal.

The mother of Adam London began a suit *ad litem* for her son against the physician who performed the circumcision and the medical facility where it was performed. The plaintiff alleged eight separate causes of action among which include: (1) *common-law battery*, (2) *violation of willful cruelty statute* (Penal Code 273a), (3) *violation of The Infliction of Pain Statute* (Penal Code 273d), (4) *violation of the Willful Cruelty Statute* (Health and Safety Code 11165; Penal Code ss.273(a)(1) and 273 (a)(2), and (5) *violation of the Child Abuse Statute* (Health and Safety Code 11165). The few Canadian cases dealing with circumcision have been equally unfavourable.

For example, in *Oliver* v. *Paras* (1993), an infant's penis was horribly disfigured after a circumcision was performed at his parent's request. The parents were not informed of the possible risks or of the substantial body of opinion against circumcising neonates. The action for malpractice was dismissed, however, because having taken into account "the popularity in our society of what D. Paras refers to as a semi-medical procedure," Justice McLellan was "unwilling to hold that the usual rules for informed consent for surgery apply to the circumcision of the baby" (1993, p. 60).

CONCLUDING THOUGHTS

> Since circumcision is medically unwarranted mutilation and disfigurement, it would appear to be a clear case of child abuse. (Brigman, 1985, p. 343)

Only in rare circumstances can it be said that circumcision has a therapeutic aim. In fact, in many cases, circumcision can be considered "the antithesis of therapy" (Somerville, 1980, p. 85). Where there is doubt as to the medical benefits of circumcision, that is, where the physician cannot justify medical wounding, it should not be performed. Therefore, the burden is on the person who causes the wounding to establish justification for carrying out the procedure. Unless the physician can establish this, even with the parents' "informed consent," she or he should not proceed. Postponing the procedure until a time when the infant can be more active in the decision-making process seems a viable solution. As the College of Physicians and Surgeons of Saskatchewan has recently stated:

> Informed consent to a surgical procedure rests on an assumption that the decision maker possesses full and accurate information about the benefits and risks of the procedure. The issue becomes whether surgeons are providing parents with accurate and sufficient information about the benefits and the risks involved with the routine circumcision in order to allow them to provide meaningful and informed consent. (2002, p. 12)

To this end, nonreligious circumcision that is not medically necessary should be put off until the boy is mature enough to understand all the material risks and provide his

own "informed consent." In the interim, however, as Smith (1998) argues, parents should be fully informed about the function of the foreskin, the pain and possible risks involved in the procedure, and arguments for and against circumcision in order to make the best possible decision for their child. Moreover, education and dialogue are essential to the circumcision debate. Public awareness is increasing, as evidenced by the numerous parents, health practitioners, children's rights activists, ethicists, lawyers, and concerned citizens who have voiced their opinion. Insofar as male circumcision is the removal of healthy erogenous flesh without medical purpose and without the consent of the child and given that it is a painful procedure, neonatal circumcision is unnecessary and may well violate a child's bodily integrity.

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