

Genital Integrity Policy Statement

A statement of position

by

Doctors Opposing Circumcision

Seattle, Washington
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Chapter One: Introduction

Doctors Opposing Circumcision (DOC) is a non-governmental, non-profit, educational organization, organized by medical doctors who support genital integrity and who oppose non-therapeutic genital cutting of infants and children. Female circumcision already is recognized generally as a harmful operation and a violation of human rights. Laws have been passed to protect girls, but boys have not been protected. This statement, therefore, will concentrate on the protection of the genital integrity of male infants and children.

Several medical societies in English-speaking nations have issued position statements regarding the circumcision of male children. These societies are composed of members, many of whom perform circumcision. The first duty of medical societies appears to be to protect and advance the financial and legal interests of their members. (The practice of non-therapeutic child circumcision generates about \$1.2 billion annually for the American medical community.¹) Under these circumstances, there is a *conflict of interest* that hampers honest discussion of the issues.

Goldman argues that medical society circumcision policy statements are biased in favor of circumcision for a variety of emotional and social-political factors.² Emotional factors include the avoidance of the emotional discomfort of questioning one's own circumcision by circumcised doctors, and the protection of self-esteem by those who have performed hundreds or thousands of circumcisions.² Social-political factors include a division of opinion and a desire to avoid an appearance of religious intolerance.² Goldman observes that discussions of sexual, psychological, human rights, ethical, and legal issues frequently are excluded from medical society circumcision policy statements.²

DOC agrees that medical society position statements often are incomplete, inadequate, and tend to ignore discussion of the structures, functions, development, and care of the normal penis and, instead, tend to over-state the so-called “potential benefits,” while minimizing the inherent injury, risks, complications, and disadvantages of circumcision. In some position statements, medical science is tainted with religious/cultural bias. Such bias perpetuates the practice of male circumcision for the benefit of the society members, some of who profit personally from the performance of child circumcision. The discussion of the bioethics of circumcision is often superficial and inadequate. In some cases, the statements appear to have been drafted by lawyers, not medical doctors, so as to protect medical practitioners from liability. These statements fail to meet the needs of the public for accurate information and are a disservice to the infant boys who need protection. (See Chapter Six.)*

* The American Academy of Pediatrics (AAP) is a case-in-point. The media generally regard the AAP as the nation's authority on what is best for the health and well-being of children. The Academy usually does, in fact, give sound advice on child health and well-being. In the matter of male circumcision and genital integrity, however, a quite different situation prevails.

The practice of male circumcision creates two kinds of men — those who enjoy genital integrity and those who do not. Some of those men who do *not* enjoy genital integrity have various emotional issues relating to their deprivation of a whole penis by a traumatic operation.^{1,4} Many circumcised doctors have an emotional need to defend their culture of origin and to rationalize their personal deprivation by the creation of medical literature asserting prophylactic benefits of circumcision.⁴ On the other hand, it appears that most non-circumcised doctors and some circumcised doctors oppose circumcision. The AAP has both kinds of doctors within its membership. Consequently, there is an ongoing tug-of-war between the two opposing forces who seek to dominate the AAP's circumcision policy.² The medical literature relating to male circumcision is polarized by the 130-year-old debate between the circumcised doctors and the others;¹ the AAP may

DOC has no such conflict of interest and, therefore, has determined to issue its own statement regarding the genital integrity of male children. This statement will consider the anatomy, histology, and physiology of the prepuce; the alleged advantages of circumcision, the complications, harms, and disadvantages of circumcision; the inherent injury to the penis and its proper physiological function; the psychological sequelae of circumcision, and their social consequences. This statement will also review the position of the circumcision of male children under international human rights law, domestic law, and contemporary bioethics. Genital integrity is most likely to provide the highest state of health and well-being,³ so this statement will propose actions to support and defend the genital integrity of America's children.

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be equally polarized with respect to non-therapeutic male circumcision because of the presence of so many circumcised doctors within its fellowship.² Furthermore, Goldman (2004) observes that doctors who have performed circumcisions in their medical practice have an emotional need to defend the practice,² so they may "deny some of the evidence against circumcision."²

The AAP claims that its circumcision policies (all four of them) are evidence-based. The reality, however, is quite different. Thompson (1983) reported great controversy within the *ad hoc* committee that produced the 1975 *Report of the Ad Hoc Task Force on Circumcision* and a necessity to compromise the evidence.⁵ The dissension in the task force that produced the 1989 AAP *Report of the Task Force on Circumcision* erupted into open warfare in the pages of the May 3, 1990 issue of the *New England Journal of Medicine*, with Edgar J. Schoen, MD, FAAP, representing the circumcision party⁶ and Ronald L. Poland, MD, representing the genital integrity advocates.⁷

Goldman (2004) reports the Task Force that produced the 1999 AAP *Circumcision Policy Statement* also was filled with controversy and dissension.² George C. Denniston, MD, MPH, the president of Doctors Opposing Circumcision, compared the 1999 AAP *Circumcision Policy Statement* produced by that task force with other AAP statements of good medical practice and the American Medical Association's *Principles of Medical Ethics*.⁸ In a letter to the then-president of the AAP, Louis Z. Cooper, M.D., FAAP, *et al.*, he pointed out numerous variances from good medical practice and ethics as reported in other statements by the AAP and AMA.⁸ Apparently, these variances were necessary to satisfy the male doctors who represented the circumcision party.

Gollaher (2000), discussing the 1999 statement, writes:

“As in the past, the new policy was a compromise meant to reconcile the AAP’s hawks and doves.”⁹

AAP circumcision policy statements are compromises that have scant relationship to the real evidence. Even after being informed of the variances by Denniston,⁸ the AAP took no action to bring its *Circumcision Policy Statement* into conformity with good medical practice and ethics. The need to provide a compromise acceptable to the circumcised male doctors who appear to dominate AAP circumcision policy, therefore, takes precedence over the health, well-being, human rights, best interests, and genital integrity of America's children.

Chapter Two: The Prepuce

One must understand the nature and function of the structure that is amputated by circumcision in order to properly evaluate the effects of male circumcision. This chapter provides that information.

General Description

The prepuce traditionally has been described as a simple fold of skin,¹ for which the purpose and function are unknown. This is inaccurate. In reality, the prepuce is a complex structure with multiple anatomical and physiological functions.²

The prepuce is a portion of the entire covering of the penis. It is specialized tissue, composed of skin, mucosa, nerves, blood vessels, and muscle fibers.² It is anchored by the abdominal wall at the proximal end of the penis and at the proximal end of the glans penis. It is not attached to the shaft of the penis, so, after puberty, it is free to slide back and forth, everting and inverting as it does.³ The sliding/rolling back and forth is called the *gliding action*.^{3,4}

A frenulum is found on the ventral side of the penis. The frenulum serves to tether a movable structure to a non-movable structure. The penile frenulum returns the foreskin to its normal protective forward position.² Most men report that the frenulum is highly erogenous tissue.

Peripenic Muscle

In the skin of the penis, there is a sheath of dartos fascia muscle fibers — the *peripenic muscle*.^{2,3,5} The muscle fibers keep the prepuce snug against the glans penis.³ The fibers of the peripenic muscle sheath form a whorl at the tip of the prepuce, which act as a sphincter,³ especially in infants and children. The sphincter also serves to prevent inadvertent retraction of the prepuce. The peripenic muscle gives the prepuce great elasticity, allows it to stretch, and helps to return the prepuce to its forward, protective position after retraction.² The elasticity of the prepuce plays an important role in the erogenous and sexual functions of the prepuce.

Immunology

The prepuce covers and protects the glans penis and urinary meatus. In most males, the prepuce protects the sterile urinary tract environment in infancy and maintains the moistness — beneficial to good health — of the mucosal surface of the glans penis throughout life.⁶ Fleiss *et al.* (1998) have identified immunological functions that help to protect the body from pathogens:⁷

- sphincter action of the preputial orifice functions like a one-way valve, allowing urine to flow out but preventing the entry of infectious contaminants;
- apocrine glands of the inner prepuce, which secrete lysozyme, an enzyme that breaks down cell walls of pathogens (and also acts against HIV⁸);
- sub-preputial moisture that lubricates and protects the mucosa of the glans penis; and
- high vascularity to bring phagocytes to fight infection.

The epidermis of the prepuce contains Langerhans cells that secrete cytokines,² hormone-like low-molecular-weight proteins, which regulate the intensity and duration of immune responses.⁹ de Witte and

colleagues (2007) report that the Langerhans cells produce *langerin*, a substance that provides a barrier to HIV infection.¹⁰

Innervation

The prepuce of the newborn male has extensive innervation. Winkelmann (1956) reported, “[t]he principal form of innervation of human newborn prepuce consists of a deep and superficial network of nerve fibres in the dermis.”¹¹ Moldwin & Valderrama (1989) reported an extensive neuronal network in the prepuce.¹²

The prepuce of adult males is even more extensively innervated. Winkelmann (1959) described the prepuce as a specific erogenous zone with nerves arranged near the surface in rete ridges.¹³ Taylor et al. (1996) also found nerves near the surface in rete ridges and further described a concentration of nerve endings in a ring of ridged tissue just inside the tip of the prepuce near the mucocutaneous boundary, which he named the ridged band.¹⁴ The nerve endings in the ridged band are Meissner's corpuscles and Krause's end-bulbs.

The nerves of the penis, including the preputial nerves, supply sensory input to both the somatosensory and autonomic nervous systems by different routes.² The sensory input to the somatosensory nervous system is supplied through the dorsal nerve of the penis, and the autonomic nervous system is supplied through the parasympathetic nerves, which run adjacent to and through the wall of the membranous urethra.

The prepuce is provided with an extensive vascular network to bring oxygen to support the heavy innervation.^{2,7,14}

Several writers have commented on the sensitivity of the prepuce. Winkelmann (1956) wrote, “...it is a region of great sensitivity and possessed of an abundant nerve supply,”¹¹ and later (1959) identified the prepuce as a specific erogenous zone.¹³ Falliers (1970) noted the “sensory pleasure associated with tactile stimulation of the foreskin.”¹⁵ A landmark study by Sorrells et al. (2007) of the fine-touch sensitivity of the penis finds that the areas most sensitive to fine touch are on the foreskin.¹⁶ Circumcision, therefore, amputates the most sensitive areas of the penis.

Sexual Function

The prepuce is primary, erogenous tissue necessary for normal sexual function.² In adult life, the gliding action facilitates introitus⁴ and reduces friction and chafing during coitus.⁵ The movement and stretching of the prepuce during coitus stimulate the nerve endings in the prepuce, produce erogenous sensation, and eventually ejaculation.^{18,19} The presence of the prepuce tends to protect the corona of the glans penis from direct stimulation, helps to prevent premature ejaculation^{20,21} and contributes to female satisfaction.²² (See Chapter Six for a discussion of the sexual harm of prepuce excision.)

Natural Development

The great majority of newborn infant boys are born with the inner surface of the prepuce fused with the glans.² In addition, the tip of the prepuce at birth usually is too narrow to allow retraction. The duration of these conditions vary with the individual but can last until the completion of puberty or

longer. For these two reasons, the non-retractile foreskin is normal in childhood and adolescence and cannot be considered a disease requiring treatment.

The first data on development of the retractile prepuce was provided in 1949 by British pediatrician Douglas Gairdner.²² Gairdner said 80 percent of boys have a retractable foreskin by the age of two years, and 90 percent of boys have a retractable prepuce by the age three. His erroneous information²³ has been incorporated into medical textbooks and medical school curricula for decades, and it still is repeated in medical literature today.²⁴

Gairdner's data are inaccurate²³⁻²⁵ and, unfortunately, most healthcare providers have been taught this inaccurate information,^{24,25} which contributes to improper diagnosis of "pathological phimosis" in the healthy, normal, non-retractile foreskin. Retractability usually occurs much later than previously believed.^{2,24,25} About 44 percent of boys have a fully retractable prepuce by age 10-11^{2,27,28,29} and about 95 percent have a fully retractable prepuce by age 18.^{2,27} Non-retractile foreskin is the more common condition until 10-11 years of age. Thorvaldsen & Meyhoff (2005) report that the mean age of first foreskin retraction is 10.4 years.²⁹ Non-retractile foreskin in childhood and adolescence is not a disease and does not require treatment.

Ballooning of the prepuce in childhood during urination is harmless and self-limiting. Babu *et al.* (2004) have shown that ballooning does *not* cause obstructed voiding.³⁰ Ballooning disappears with increasing maturity. No treatment is required.³¹

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Chapter Three: Alleged Medical Benefits of Circumcision

An infant boy is born with a healthy foreskin that is not diseased. Consequently, there are no medical indications for circumcision in the newborn period.^{1,2}

Infant circumcision is a painful, stressful, and traumatic procedure that leaves the infant exhausted and debilitated to the extent that some are unable to suckle at the breast.³ Medical authorities accordingly recommend that circumcision be performed only on *healthy and stable* infants. In the absence of any medical indication, and with the surgical operation being performed only on healthy and stable infants, the Council on Scientific Affairs of the American Medical Association (AMA), therefore, properly describes elective infant circumcision as a “non-therapeutic” procedure.⁴ (Infant circumcision was downgraded from *routine* to *elective* in 1997, in a joint statement issued by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.⁵)

Claims for any health or medical benefit are restricted to a possible prophylactic benefit in later life. Circumcision of the newborn, in the opinion of a few, may prevent phimosis, infection with sexually transmitted diseases, urinary tract infection in the first year of life, penile cancer, and cervical cancer in sexual partners. These claims date from the era of opinion-based medicine, when, in the absence of any scientific evidence, medical doctors relied on the opinions of one another rather than on evidence. (e.g.⁶) We shall examine each of these claims.

Phimosis

Phimosis is the term used to describe the condition of being unable to retract the prepuce (foreskin).

Almost every newborn infant boy has a non-retractile foreskin. The condition of non-retractability occurs because 1) the foreskin is fused with the glans penis in the newborn, 2) because the foreskin of the newborn is too narrow to retract over the glans penis, or 3) frenulum breve. Non-retractable foreskin is *not* a disease but a *normal* developmental physiological stage in boys. The foreskin gradually becomes retractable between infancy and 18 years of age.⁷ Only about 1 percent of males, aged 18 and older, have a non-retractile foreskin. The fusion of the foreskin with the glans penis spontaneously separates and no treatment is necessary. Frenulum breve, a rare condition, may be relieved by a minor incision in the frenulum (frenuloplasty).

Phimosis is not a life-threatening condition, and usually requires no treatment. When treatment is deemed necessary, phimosis may be treated by application of topical steroid ointment without surgical risk.^{8,9} Older boys and men may treat non-retractile foreskin with manual stretching to accomplish permanent tissue expansion.^{10,11} (See Chapter Seven)

Neonatal circumcision frequently results in a phimotic condition, as the cicatrix caused by circumcision may contract in front of the glans penis, trapping it behind a phimotic ring. Blalock *et al.* (2003) report that phimosis occurs in 2.9 percent of circumcision patients.¹² This exceeds, by a factor of three, the incidence of non-retractile foreskin reported by Øster (1968) at the end of puberty. It is clear, therefore, that circumcision cannot be recommended to prevent phimosis. The AAP statement of 1975 correctly noted that incomplete removal of the foreskin can result in post-circumcision phimosis.¹³ The AAP statement of 1989 misleadingly reported that circumcision “properly performed” prevents phimosis.¹⁴ By properly performed, the task force meant that sufficient skin must be removed to make it impossible for a circular scar to form in advance of the glans penis. Unfortunately, when that much tissue

is removed, the patient is likely to suffer painful erections because insufficient skin is left to accommodate the expansion of the penis with tumescence. Circumcisions frequently are improperly performed because they are delegated to the most junior members of the staff.¹⁵ Also, knowledgeable physicians are aware that skin tissue must be left to accommodate erections, so post-circumcision phimosis is not an uncommon complication. The use of male circumcision to prevent/cure phimosis is outmoded.

Sexually Transmitted Diseases

Abraham Leo Wolbarst, M.D., was an ardent defender and promoter of the practice of circumcision. After Holt (1913) criticized ritual circumcision because of the large number of cases of tuberculosis resulting in death acquired through infection of the open wound,¹⁶ Wolbarst (1914) came to the defense of ritual circumcision by extolling the alleged sanitary benefits of circumcision.⁶ Wolbarst did this by collecting opinions from other medical doctors, which he then published in an article in the *Journal of the American Medical Association*. He solicited opinions that circumcision prevented the venereal diseases of syphilis and chancroid. He then cited these opinions as evidence of the value of circumcision. Controlled studies were not available in that long-ago day. The United States military services, on the basis of such flimsy evidence, circumcised large numbers of men to prevent sexually transmitted diseases during two world wars.

Modern evidence-based medicine, however, is unable to support Wolbarst's overblown claims. Cook *et al.* (1994) was unable to show a definite benefit for circumcision—finding a slight tendency for non-circumcised men to have more syphilis and gonorrhea, but less tendency to have genital warts.¹⁷ Donovan *et al.* (1994) reported no significant difference between non-circumcised and circumcised men.¹⁸ Van Howe (1999) found circumcised men may be slightly more likely to have urethritis and uncircumcised males may be more prone to genital ulcer disease (GUD).¹⁹ Dickson *et al.* (2008) found more STD in circumcised men but the difference was not statistically significant.²⁰ The Fetus and Newborn Committee of the Canadian Paediatric Society found that “circumcision had no significant effect on the incidence of common STDs.”²¹ The AAP Task Force (1999) reported that “behavior factors appear to be far more important than circumcision status.”²² The medical evidence does not support the practice of neonatal circumcision to prevent STDs.

de Vincenzi & Mertens (1994) performed a meta-analysis of the then-existing literature, regarding circumcision and HIV infection. They concluded, at that time, there was insufficient evidence to recommend male circumcision to prevent HIV transmission.²³ The Council on Scientific Affairs of the AMA (1999) concluded that “behavioral factors are far more important risk factors for acquisition of HIV and other sexually transmissible diseases than circumcision status, and circumcision cannot be responsibly viewed as “protecting” against such infections.”²⁴ The Cochrane Library review of the medical evidence (2003) concluded that there is insufficient evidence to recommend circumcision to prevent HIV infection.²³ Thomas (2004) found no evidence that circumcision is protective against HIV in a U.S. Navy population.²⁵ Talbott (2007) reports that it is the percentage of female sex workers in the female population, not the incidence of male circumcision, that determines the level of HIV infection.²⁶ Dowsett & Couch (2007) examined the results of three randomized controlled trials (RCTs), but they still found insufficient evidence to recommend circumcision to prevent HIV infection.²⁷ Green *et al.* (2008) reviewed the evidence regarding circumcision to prevent HIV infection and found “insufficient data” as well as countervailing data. They concluded:

“The world community must cautiously review and carefully consider the long-term consequences of mass circumcision campaigns, from the risk of increasing deaths and infections to human rights violations. In the rush to save lives, many may instead be lost

and human rights trampled in the stampede. Circumcision is not the panacea the world has been waiting for in the battle to stem the HIV crisis.”²⁸

The Lancet published two coordinated randomized controlled trials (RCTs) on February 24, 2007.^{29,30} One should note that the lead authors of these RCTs are natives of Australia, Canada, or the United States, all of which, now or formerly, are or were circumcising cultures. These men may well have suffered circumcision as infants. Siegfried *et al.* (2003) comment that such men are likely to carry “strong beliefs and opinions” in favor of circumcision.²⁴ They may be compelled, therefore, to produce literature to support their culture of origin. (See Chapter Six for discussion of the effect of circumcision upon medical literature.) These authors wrote papers advocating male circumcision to prevent HIV infection *prior* to undertaking these RCTs. The severe criticism that these papers have received suggests that something other than pure medical science is at work. Researcher bias cannot be ruled out.

The epidemic of HIV infection in the United States is concentrated among men who have sex with men (MSM). Two studies find that male circumcision is ineffective at preventing HIV among MSM.^{31,32}

Moreover, RCTs carried out among *adults* in *Africa* are not relevant to *children* in *North America*. Children do not engage in vaginal sexual intercourse so they are not at risk of HIV infection by sexual transmission.

Condoms are an effective means of preventing sexually transmitted disease, including HIV.³³

Urinary Tract Infections

Ginsburg & McCracken (1982), who studied urinary tract infection (UTI) in male infants at Parkland Hospital in Dallas, noted that 95% of the infant male UTI patients were not circumcised.³⁴ They speculated that lack of circumcision may have contributed to the infection in some way. However, Parkland Hospital, a public hospital, did not perform neonatal circumcisions, even if patients demanded it,³⁵ so most of the client population at Parkland must have been noncircumcised—a fact apparently overlooked by Ginsburg & McCracken.

This observation prompted Wiswell *et al.* to produce retrospective studies regarding UTI in circumcised infant males as compared with uncircumcised males. The studies all have serious methodological flaws, including failure to control for confounding factors, which include maternal infection, perinatal anoxia, high or low birthweight, prematurity of birth, rooming in, method of urine sample collection, type of hygienic care, and breastfeeding. The Fetus and Newborn Committee of the Canadian Paediatric Society (1989) examined data provided by Wiswell *et al.* and reported that they found Wiswell’s data to be “not sufficiently compelling to justify a change in their existing policy that circumcision is unnecessary and should not be performed.”³⁶ Altshul (1990) pointed out that the studies had only shown association, not cause and effect.³⁷ Thompson (1990) found that “unequivocal proof that lack of circumcision is a risk factor for increased urinary tract infection is currently unavailable.”³⁸ Chessare (1993) compared the alleged advantage of preventing UTI with the disadvantages of complications and found that, even if Wiswell was correct in his claims, non-circumcision would still produce the highest medical utility.³⁹

Evidence from Israel establishes a compelling association between ritual circumcision on the eighth day and immediate post-circumcision UTI.⁴⁰⁻⁴²

Mueller *et al.* (1997) reported no difference in the incidence of UTI in circumcised and non-circumcised boys with normal urinary tract anatomy.⁴³

To put this matter into perspective, a Swedish study by Marild *et al.* (1998), where infant circumcision is not practiced, found that, in the first six years of life, the incidence of UTI in boys was 1.8 percent, but in girls it was 6.6 percent.⁴⁴ UTI infection in boys was rare after the first year of life. When UTI does occur, it is easily treated medically. McCracken (1989) and Larcombe (1999) report UTI infections respond rapidly to anti-microbial therapy.^{45,46}

The Task Force on Circumcision of the American Academy of Pediatrics, in their evidence-based statement, reported serious methodological flaws in all existing studies, and declined to recommend circumcision to reduce UTI.²² The Royal Australasian College of Physicians (RACP) says routine non-therapeutic circumcision “cannot be justified on the basis of preventing a UTI.”⁴³

The consensus of medical opinion is that circumcision is of little, if any, value in reducing UTI. Risk, complications, and disadvantages of circumcision outweigh any reduction in UTI. The notion that neonatal male circumcision can prevent UTI increasingly is being viewed as a medical myth – one started by Ginsburg & McCracken’s failure to recognize that the client population at Parkland Hospital in Dallas was mostly noncircumcised.

Medical authorities now recommend breastfeeding, not circumcision, to reduce UTI in infancy.^{48,49} Moreover, Hansen (2004),⁵⁰ and Mårild & others (2004)⁵¹ report that breastfeeding continues to have a protective effect even after weaning.

Kwak *et al.* (2004) report that circumcision after anti-reflux surgery to prevent UTI is not effective.⁵²

Penile Cancer

Abraham L. Wolbarst, the noted early 20th-century circumcision promoter, started the myth that neonatal circumcision absolutely prevented penile cancer, at a time (1932) when the etiology of cancer was not well understood.⁵³ His claims were accepted as fact, and unfortunately, one still finds such statements in the medical literature today. It was not long, however, until doctors started to report cases of cancer in circumcised men that did not fit with Wolbarst’s claims.⁵⁴ Wolbarst’s report was incorrect. Maden *et al.* (1993) reported 41 cases of penile cancer in circumcised men.⁵⁵ Certainly, it was becoming clear that circumcision did not prevent penile cancer.

True risk factors did not emerge until the 1980s. DNA from human papillomavirus (HPV) was identified in penile cancer cells.⁵⁶ Infection with HPV (which is contracted by sexual intercourse) is an important risk factor. The use of tobacco is another important risk factor.⁵⁷

Maden *et al.* (1993) improperly claimed that lack of circumcision was a risk factor,⁵⁵ but Cold *et al.* (1997) discovered that Maden had not adjusted his data for age.⁵⁸ When Maden’s data were properly adjusted for age, there was no difference in the risk for circumcised and non-circumcised men.⁵⁸

Circumcision is ineffective for the prevention of penile cancer. Bissada *et al.* (1986) report that penile cancer forms on the circumcision scar.⁵⁹ The American Academy of Family Physicians (AAFP) says 600 to 900 circumcisions would be necessary to prevent one case of penile cancer.⁶⁰ The AAP says the risk of penile cancer in a non-circumcised man is “somewhat” higher than a circumcised man but remains low.²² The AMA says, because the disease is rare and occurs later in life, the use of circumcision as a preventive measure is not justified.⁴

Cancer of the Cervix in Partners

The risk factors for cervical cancer are infection with human papilloma virus (HPV)⁶¹ and smoking.⁶² Risk of infection with HPV is increased by early onset of sexual intercourse and multiple sex partners.⁶³ There is no clear evidence that male circumcision decreases the risk of infection.

Male circumcision cannot be shown to prevent cervical cancer in female partners. The Royal Australasian College of Physicians (RACP) points out that vaccines are being developed to prevent infection with HPV. The RACP found no data to suggest that circumcision would be of additional benefit.⁴³ When HPV vaccine comes into general use, it should nearly end the threat posed by cervical cancer.

Human papillomavirus vaccine to protect against HPV cervical cancer is now a reality and is being given to pre-teen girls.⁶⁴

Conclusion

The claims of “potential benefits”, allegedly provided by medically unnecessary, non-therapeutic circumcision, lack any real support from medical science. United States medical literature, as compared with the medical literature of other nations, is highly biased in favor of male circumcision.⁶⁵ The word “potential” means to exist in possibility but *not* in actuality. The scientific literature that supports such “potential” benefits is written mostly by a few doctors who were reared in circumcising cultures.^{66,67}

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Chapter Four: The Immediate Complications of Circumcision

The immediate complications of circumcision may be classified as hemorrhage, infection, surgical mishap, other miscellaneous complications, and death.

Bleeding

The foreskin is highly vascularized,¹ so hemorrhage is a particular problem and risk when the foreskin is cut. An artery that passes through the frenulum to provide blood to the glans penis is in danger of being severed.² Williams & Kapila (1993) report bleeding to be the most common problem associated with circumcision.³

Special clamps are used to crush the skin to provide hemostasis. Old clamps may be worn, deformed, and fail to provide adequate crushing and hemostasis.⁴ When using the Plastibell® device, failure to tie the string tightly may result in bleeding.⁵

When a newborn is circumcised, there is great danger from bleeding because the prepuce is highly vascularized and because an infant's body contains only 85ml/kg of blood.⁶ With so little total blood volume, a small loss of blood may cause exsanguination, hypovolemia, hypovolemic shock, and death.⁷⁻⁹ The coroner of Dade County, Florida reported the death of an infant from hemorrhage.⁷ Hiss *et al.* reported a hemorrhage followed by death.⁸ The coroner of British Columbia reported the death of a one-month-old infant from bleeding, exsanguination, hypovolemic shock, and multiple organ failure.⁹

Infection

Infection may range from the trivial to the life-threatening systemic infection.³

Life-threatening infections, including septicemia and meningitis,^{10,11} tuberculosis,^{12,13} wound diphtheria,¹⁴ *staphylococcus*,¹⁵ and *streptococcus*,¹⁶ pyoderma¹⁷, impetigo,^{18,19} and scrotal abscess with *salmonella* infection,²⁰ also have been reported. Scurlock & Pemberton (1977) reported a death from meningitis.¹¹ The coroner of Ontario reported the death of a two-week-old infant from infection with *Escherichia coli*, intravascular coagulopathy, and hypoxic-ischemic encephalopathy.²¹

There are several reports of a significant increase in urinary tract infection (UTI) after ritual circumcision.²²⁻²⁴

Necrotizing fasciitis²⁵⁻²⁷ and Fournier's gangrene (gangrene of the scrotum) have been reported.²⁸ Such infections require extensive debridement (surgical excision) of infected tissue, if the patient is to survive.²⁵⁻²⁸

Circumcision infections may be spread by hospital workers.^{16,29,30,32,33} Hospitals are increasingly infected with antibiotic-resistant pathogens. St. Catherine's Hospital on Long Island experienced an outbreak of methicillin-resistant *Staphylococcus aureus* (MRSA) among circumcised boys in the hospital nursery.³¹ Any invasive procedure increases the risk of MRSA infection in the newborn nursery.³² Boys who are circumcised have a twelve-times greater risk of CA-MRSA infection.³³

Surgical Accident

Circumcision is an imprecise surgical procedure. It is difficult to judge the amount of skin to excise. One problem is the removal of excess skin,³ which may denude the entire shaft of the penis and require an immediate corrective operation by a urologic specialist.³⁴⁻³⁶ Circumcision may also result in injuries to the urethra, including urethral fistula,³⁷⁻³⁹ which requires corrective surgery by a urologic specialist. A case of bivalving the glans penis caused by inserting the scissors into the urethra has been reported.⁴⁰

Due to the difficulty in judging the correct amount of skin to excise, sometimes so little skin is removed that the penis does not appear to be circumcised. This may generate parental complaints and requests for a re-circumcision, although there is no medical indication for the second circumcision. Leith (1970) reported that, in his study of 200 circumcisions, 19 were recircumcisions.⁴¹ There is danger of painful erections if too much skin is removed.

More serious surgical mishaps include excision of part of the penis⁴²⁻⁴⁵ or glans penis,⁴⁶⁻⁴⁸ necrosis of the glans penis,⁴⁸ necrosis of the penis caused by electrocautery devices,⁴⁹⁻⁵¹ and total ablation or amputation of the penis.⁵²

Death

Death may be the result of either bleeding⁷⁻⁹ or infection.^{11,12,15,21} There is no central registry of circumcision deaths, so the incidence of death from circumcision is controversial. Williams & Kapila (1993) characterize death as “rare.”³ Gairdner (1949), however, reported 16 deaths annually in Britain in the 1940s.⁵³ Circumcision deaths may be attributed to bleeding or infection rather than the underlying circumcision. Few doctors are willing to acknowledge death from an elective, unnecessary, non-therapeutic, allegedly “minor,” surgical procedure. Gellis (1978) estimated there are more deaths from circumcision than from cancer of the penis (which would mean more than 200 deaths per year).⁵⁴ (Prevention of penile cancer is not a valid excuse for circumcising. See Chapter 3.) Baker (1979) argued that there are at least 229 deaths per year in the United States from circumcision.⁵⁵

Miscellaneous

Miscellaneous immediate complications of circumcision include life-threatening pulmonary embolism,⁵⁶ apnea and projectile vomiting,^{57,58} tachycardia and heart failure,⁵⁹ pneumothorax,⁶⁰ and gastric rupture.⁶¹

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Chapter Five: Post-operative Complications of Circumcision

The immediate postoperative complications of circumcision may be classified as urinary retention, meatitis, meatal ulceration, meatal stenosis, skin tags, adhesions, skin bridges, concealed penis, phimosis, and miscellaneous complications. These complications are iatrogenic.

Urinary Retention

Circumcision sometimes results in urinary retention¹ with possible obstructive uropathy.² Bandages used in ritual circumcision may cause urinary retention.^{3,4} The plastic ring portion of the Plastibell® may also cause urinary retention,⁵ which may result in a ruptured bladder,⁶ renal failure,⁷ or interruption of circulation in the lower extremities.^{8,9} Urinary retention caused other complications that led to death in one reported case.¹⁰ Urinary retention is not seen in non-circumcised intact boys.

Adhesions and Skin-Bridges

The first step in the genital cutting of newborn boys is separation of the inner surface of the foreskin from the glans penis, to which it is fused at birth. The tearing, which Gracely-Kilgore (1984) compared with “skinning a squirrel,”¹¹ leaves the surface of the glans penis and the inner lining of the foreskin raw. Newborn circumcision wounds are not sutured, so the residual foreskin heals wherever it falls. The residual foreskin may heal together with the glans penis, which results in adhesions that may form a skin bridge,^{11,12} resulting in tethering.¹ Gracely-Kilgore reports that 15 percent of boys seen in her practice had adhesions and three percent required surgical correction.¹¹ Adhesions may require surgical separation by a urologic specialist.¹³ Adhesions are not seen in non-circumcised intact boys.

Meatal Complications

Meatitis, meatal ulceration, and meatal stenosis are pathology only seen in circumcised boys who have been deprived of the protective foreskin. The connection between circumcision and these iatrogenic pathologies has been known at least since 1921.¹⁴ The exposure of the unprotected glans penis to the ammoniacal diaper (nappie) is generally believed to be the cause of inflammation and ulceration.^{14,15} Persad *et al.* (1995), however, have suggested that ischemia of the glans penis, caused by the severing of the frenular artery at circumcision, may be the etiologic factor.¹⁶ The ulceration may eventually result in the formation of scar tissue, restricting the opening of the urethra. Leitch (1970) reported 8 cases of meatal ulcer and 3 cases of meatal stenosis in a series of 200 circumcisions for an incidence of 5.5 percent.¹⁷ A meatotomy may be required to open the urethra.¹⁸⁻¹⁹ Meatal complications are not seen in non-circumcised intact boys.

Urinary Tract Infection

Several studies find that more than 50 percent of urinary tract infections (UTI) occur within 12-14 days after ritual circumcision.²⁰⁻²²

Post-circumcision Phimosis

Oddly enough, circumcision, which is touted to prevent phimosis, actually causes phimosis.^{22,23} When the circumcision scar forms beyond the glans penis, a phimotic ring results, causing phimosis. Blalock *et al.* (2003) reported an incidence of 2.9 percent in circumcised boys.²³ Leich reported that 11 out of 200 required recircumcision to correct post-circumcision phimosis.¹⁷

Inconspicuous Buried, Trapped, or Concealed Penis

This iatrogenic condition occurs secondary to circumcision.²⁴⁻³⁰ A second surgery usually is necessary to effect a repair.²⁸⁻³⁰

Keloid Formation

Keloids are an overgrowth of scar tissue. Keloids are reported after circumcision.³¹⁻³³ They require surgical removal and repair.³¹⁻³³

Circulation Problems, Ischemia, Necrosis, and Gangrene

Circumcision severs arteries and veins including the frenular artery that supplies the glans penis,¹⁶ so it is not surprising that circulation problems are reported after circumcision. Gangrene of the penis,³⁴⁻³⁶ and of the glans penis,^{37,38} have been reported.

Miscellaneous Complications

Miscellaneous post-operative complications include chordee,³⁹ inclusion cysts,^{40,41} lymphedema,^{40,41} neuromas,⁴² sub-cutaneous mass,⁴³ and cancer.⁴⁴

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Chapter Six: Long-Term Adverse Effects of Circumcision

Male circumcision has many adverse effects that do not appear until later in life. These effects usually are overlooked and ignored in most discussions of male circumcision.

Emotional Effects

Memory starts before birth¹ and newborn infants have fully functioning pain pathways.² One would expect, therefore, to find psychological effects associated with the genital cutting operation.

Post-traumatic stress disorder (PTSD) is a normal response to an abnormal event. Neonatal genital cutting is an event in which a newborn infant experiences extreme levels of pain, terror, and helplessness,³ so it fulfills the criteria as a psychogenic for PTSD. Levy (1945) reported that children experience behavior problems, such as night terrors and a fear of nurses and doctors, after surgery, including circumcision.⁴ Cansever (1965) tested boys before and after circumcision and reported that the ego seeks safety in total withdrawal.⁵ Levy found their symptoms to be similar to *combat neurosis*, now known as PTSD.⁴ Taddio *et al.* (1997) studied the behavior of babies at first vaccination. They found that circumcised boys have a much stronger reaction to pain of vaccination than do girls and intact non-circumcised boys, which the authors suggested is an “infant analogue” of PTSD.⁶ Other authors also have reported PTSD in circumcised males. Rhinehart (1999) reported four cases of PTSD secondary to neonatal circumcision in middle-aged men that he encountered in his psychiatric practice.⁷ Ramos & Boyle (2001) reported PTSD in 70 percent of Philippino boys who experienced ritual circumcision and 51 percent of Philippino boys who experienced medical circumcision.⁸

Circumcised males often feel great anxiety regarding their circumcision. This manifests itself in a reluctance to talk about circumcision or an assertion that “I’m circumcised and I’m fine.”⁹ van der Kolk (1989) reports some traumatized males also have a compulsion to reenact or repeat the trauma.¹⁰ These feelings emerge as the “adamant father” syndrome. Typically, a circumcised father will irrationally and adamantly insist that a son undergo circumcision, although this is contrary to contemporary medical advice. Some circumcised doctors also exhibit anxiety by pushing medically unnecessary circumcision on their patients¹¹ or writing medical journal articles to defend the practice.^{12,13} This has caused the medical literature on the subject of male circumcision to become voluminous and polarized because other doctors write letters and articles to refute the false claims of circumcised doctors.¹³

Circumcision of the newborn usually is performed in the first week of life (the perinatal period), and, as reported above, clearly is traumatic for most boys. Several authors report that perinatal trauma causes self-destructive behavior in adult life.^{10, 14-17}

Circumcision is cyclic trauma. Many males, who were circumcised as infants, grow up to become circumcisers themselves, in an unending repetitive pattern of abuse.^{10-13,17,18}

Sexual Effects

Taylor *et al.* (1996) report circumcision removes more than 50 percent of the normal skin and mucosa from the penis.¹⁹ This skin and mucosa is provided by nature to allow for the expansion of the penis during erection. There may not be enough residual foreskin and mucosal tissue after circumcision to allow the penis to expand during erection. The result not infrequently is painful erection or tearing at the scar site, as the residual tissue is stretched to the limit and beyond.^{20,21}

Earlier work by Winkelmann (1956,1959) showed the prepuce to be highly innervated and a “specific erogenous zone.”^{22,23} The foreskin contains the areas of the penis most sensitive to fine-touch.²⁴

Meislahn & Taylor (2004) report an online survey of intact males, in which most of the men identified the foreskin, not the glans penis, as the site of sexual pleasure.²⁵ This study is the first to report “directionality” in the foreskin. That is, the foreskin tends to return to the forward position. The survey found that stretching of the foreskin produces erection in intact males. The survey also reported that stretching of the *ridged band* of the foreskin produces contractions of the *bulbocavernosal muscle*, which produces ejaculation. The intact males who participated in the survey reported the foreskin to be far more important than the glans penis.²⁶

Removal of the nerves of the foreskin by circumcision produces a deficit in sensory input into the central, parasympathetic, and sympathetic nervous systems. One, therefore, would expect to find alteration in sexual response. Several recent studies have found this to be the case. Coursey *et al.* (2001) reported that adult circumcision degrades erectile function.²⁶ Fink *et al.* (2002) also reported worsened erectile function after adult circumcision and, in addition, a degradation of penile sensitivity.²⁷ Pang & Kim (2002) carried out a survey in South Korea, where many adult males have been circumcised, and report that a man was twice as likely to have experienced diminished sexuality rather than improved sexuality.²⁸ Shen *et al.* (2004) surveyed 95 circumcised male patients and reported erectile dysfunction in 28, weakened erectile confidence in 33, prolonged intercourse in 31, and difficult insertion in 41.²⁹ Senkul *et al.* carried out a survey of young adult Turkish males who were circumcised in adult life. They reported increased time to ejaculate.²⁹ Thorvaldsen & Meyhoff (2005) report that young circumcised males have more difficulty in reaching erection and orgasm.³¹ Kim & Pang (2007) reported a decrease in masturbatory pleasure and an increase in masturbatory difficulty in Korean males who were circumcised as adults.³²

Denniston (2004) surveyed 38 men who had experienced sexual intercourse before and after circumcision. Twenty-two of the 38 men (58%) felt that the pleasure of intercourse was lessened and they would not have circumcision again.³³

Circumcision changes male sexual behavior. Laumann *et al.* (1997) reports circumcised males have a “more highly elaborated set of sexual practices.” This includes more frequent masturbation and a greater preference for oral sex.³⁴ The British National Survey of Sexual Attitudes and Lifestyles (Natsal 2000) reports that circumcised males were more likely to report homosexual partners and partners from abroad.³⁵ Richters *et al.* (2006) report that more circumcised men in Australia tend to reach orgasm “too quickly”.³⁶

Female Sexuality

Several studies report that *male* circumcision also adversely affects *female* sexuality. Warren & Bigelow (1994) report the foreskin avoids problems with vaginal dryness.³⁷ Fleiss & Hodges (2002) explain that the lack of gliding action in the circumcised male partner causes the taut shaft skin to drag the vaginal lubrication out of the vagina.³⁸ O’Hara & O’Hara (1999) surveyed women in the United States who had had sex with both circumcised and intact partners. They report the women preferred the partner to be intact by a ratio of 8.6 to one.³⁹ Women reported that they were more likely to be orgasmic and even have multiple orgasms when the male partner is intact.³⁹ Bensley & Boyle (2001) surveyed 35 women in Australia who had sexual experience with both circumcised and intact partners.⁴⁰ Eleven, who had a mean age of 27.3 years, indicated a preference for a circumcised partner. Eleven, who had a mean age of 36.4 years indicated they would choose a genitally intact partner.⁴⁰ They reported that circumcised males are significantly less likely to use condoms because of concern about reduced penile sensitivity. In addition,

the females were significantly more likely to report vaginal dryness with a circumcised partner.^{41,42} The experience reported with a circumcised male partner is similar to the symptoms of “female arousal disorder.” Female arousal disorder may be a normal response to sex with a circumcised male partner.^{41,42}

Social Effects

Laumann (1997) reported that 77 percent of the adult males in the National Health and Social Life Survey (1992) were circumcised.³⁴ The effects of this wounding by circumcision have been discussed above. Goldman (1997) argues extensively that the result of having so many emotionally and sexually injured males in a society would produce undesirable social effects.⁴³

Goldman (1997) suggests that men who were neonatally circumcised would be more likely to suffer from low self-esteem, to avoid intimacy in male-female relationships, and a higher incidence of divorce.⁴³ Moreover, he says neonatal circumcision may cause a higher incidence of unnecessary surgery, and of adult violence, including suicide, rape, and murder.⁴³

Baker (1996) argues that men harbor rage toward their mothers for their circumcision. She also identifies a connection between sexual violence, rape, and neonatal circumcision.⁴³ DeMause (1996) connects perinatal circumcision trauma with increases in teenage suicide and social violence.⁴⁴

Effect on Medical Society Policy Statements

In the United States, where non-therapeutic neonatal circumcision once was a *routine* practice, a nearly totally circumcised male population was created. Medical doctors in the United States are largely a part of this circumcising culture, in which the abnormal appears to be normal. Circumcised men who become medical doctors have no personal experience of the foreskin and may never have seen a human foreskin. As reported above, if the doctor is circumcised himself, he is more likely to recommend circumcision to his patients.¹¹

Medical societies in the United States are composed of men and women from this circumcising culture. Certain medical societies have issued public statements regarding circumcision. These statements inevitably are drafted by committees composed of persons, whether male or female, who are products of the circumcising culture, and who may feel a need to defend their culture of origin.¹²

These committees are faced with the challenge of sorting out the medical literature on circumcision, which as indicated above, has numerous papers written by circumcised doctors, who tend to be biased in favor of circumcision.¹² Doctors from circumcising cultures may be blinded to the bias of published papers.

Moreover, male members of the committee are faced with the uncomfortable task of challenging their own circumcision.⁴⁶ Members may be parents who have had a son circumcised and who may feel a need to defend that decision.¹² Some members conceivably could even have a compulsion to reenact the trauma of their own circumcision on others!¹⁰

Doctors who are appointed to policy committees may have strong opinions on circumcision as a result of their previous experiences in a circumcising culture. Medical doctors, who profit from the performance of circumcision, may be appointed to serve on a policy committee.*⁴⁶

Conflict-of-interest is inevitable. Such conflicted doctors are unlikely to be able to produce a truly evidence-based statement, even if they are able to sort out the bias in the medical literature.^{46,47} Fox &

Thomson (2005) report that medical societies downplay or minimize the risks associated with male circumcision.⁴⁸ For example, one law review article has found serious departures from the evidence in two statements produced by the American Academy of Pediatrics.⁴⁹

American medical societies, thus far, have been unable or unwilling to acknowledge the human rights (see Chapter Nine) and medical ethics (see Chapter Eleven) issues inherent in the non-therapeutic circumcision of children.¹³ Similarly, they have not recognized the long-term adverse effects reported in this chapter.¹³

Foley (1966) reports that circumcised doctors are biased in favor of circumcision.⁵⁰ Circumcision practice of long ago, therefore, has an effect on the policy statements of medical societies today. Such statements are the result of compromises between the bias of the committee members in favor of circumcision and the overwhelming evidence supporting genital integrity as the optimum choice for health and well-being. Such statements tend to perpetuate the *status quo*.⁴⁶ The public, therefore, is poorly served by the apparent inability of circumcised doctors to produce a truly evidence-based statement.¹³

* It is very likely that all of the male members of the three task forces of the American Academy of Pediatrics are circumcised and not one has any personal knowledge of the prepuce. Circumcised doctors frequently need to justify their loss of genital integrity with claims of prophylactic benefits, so their writings tend to be biased against genital integrity.^{12,13}

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Chapter Seven: Conservative Alternatives to Therapeutic Circumcision

Introduction

Male circumcision is an unnecessarily invasive operation that excises and destroys the prepuce¹ and its multiple physiological functions (See Chapter Two.),^{2,3} creates an abnormal physical appearance, leaves an annular scar, and violates the patient's genital integrity. The Medical Ethics Committee of the British Medical Association (2006) advises use of conservative treatment whenever possible.⁴ The goal of conservative treatment should include preservation of the foreskin and its restoration to health.⁵

Phimosis

Phimosis (Greek for "muzzling") is the term that designates a non-retractile foreskin. Circumcision is a traditional treatment for non-retractile foreskin. Non-retractile foreskin, however, is not a disease and does not necessarily require treatment, unless it causes problems.

Non-retractile foreskin is the normal condition in children and some adolescents.⁶⁻⁹ The foreskin usually becomes retractable with maturity, spontaneously and without treatment. (See Chapter Two.) Patiently waiting for nature to make the foreskin retractable is required.¹⁰ Thorvaldsen & Meyhoff (2005) report that the mean age of first foreskin retraction is 10.4 years.¹¹ Physician ignorance of the normal development of the prepuce seems to be a worldwide problem.¹²⁻¹⁶ Physician education about the normal development of the foreskin should end improper diagnosis of pathological phimosis.^{10,13,14}

If treatment of non-retractile foreskin is deemed necessary, there are three non-invasive or minimally-invasive alternatives to circumcision:

1. manual stretching to accomplish tissue expansion
2. topical application of steroid ointment with gentle stretching
3. minimally-invasive preputioplasty

There have been numerous trials in several nations of topical steroid ointment for the treatment of non-retractile foreskin.¹⁷⁻³⁰ Apparently, due to researcher ignorance, most have been carried out on very young boys, when the prepuce still is developing. Nevertheless, the treatment thins the skin²¹ and works in about 80 to 95 percent of cases. The procedure is safe^{20,24,27} and few, if any, complications have been reported. Topical steroid ointment now is the standard treatment of non-retractile foreskin in boys (if treatment is deemed necessary).^{24,27,29,30} Treatment with steroids avoids the psychological trauma of circumcision.³¹

Manual stretching also is effective for creating a retractile foreskin by tissue expansion.³²⁻³⁴ Manual stretching is suitable for adolescents and adults³²⁻³⁴ and is cost-free.

British and European surgeons have used minimally invasive plastic operations with great success for more than a decade.³⁵⁻³⁸ Plastic operations preserve the foreskin and its functions and have an easier and quicker recovery period with less pain.

Waiting for nature and maturity to make the foreskin retractable is the lowest-cost treatment of non-retractile foreskin in children. Manual stretching of the foreskin also is cost-free. After those cost-free treatments, topical steroid treatment costs less than preputioplasty, with circumcision being the most costly treatment for non-retractile foreskin.^{39,40}

Scotland provides an example of what can be achieved. Better physician training on normal development of the foreskin, greater use of steroid medical treatment, and preputioplasty cut the number of circumcisions performed for phimosis in half over a ten-year period.⁴¹ With fuller use of conservative treatment, the number of circumcision operations for phimosis easily could approach zero.

Circumcision now is outmoded as a treatment for non-retractile foreskin and should be discarded, except when a competent adult patient insists on it, after he is completely and thoroughly informed of its certain injury, loss of penile sensation, sexual satisfaction, complications, and risks.⁴²

Balanoposthitis

Balanoposthitis is inflammation of the glans penis and foreskin; *balanitis* is inflammation of the glans penis; and *posthitis* is inflammation of the prepuce. In this discussion, the word “balanitis” refers to all three conditions. Inflammation has many causes, including trauma, environmental irritants, and infection. Before treatment can be prescribed, the attending physician first must determine the cause of the inflammation. Diagnosis may include a patient history, swab and culture, and biopsy.^{43,44} There are many pathogens, including fungus, anaerobes, aerobes, protozoa, and viruses, that may cause infection.⁴³ Each requires different management.

A complete discussion of the diagnosis and treatment of the many causes of balanitis is beyond the scope of this statement. The *British National Guideline on the Management of Balanitis* (2001) provides specific directions and a flowchart for diagnosis of the cause of balanitis.⁴⁵

Rickwood & Escala (1989) suggested that circumcision may be performed in cases of recurring balanitis,⁴⁶ however, this was written before the development of specific guidelines for diagnosis. Balanitis should not recur if accurately diagnosed and appropriate treatment is administered. Recurrence of balanitis suggests that a different diagnosis and treatment is needed. Irritation, inflammation, and infection are treated with topical antibiotic ointment, steroid, or oral antibiotic.³⁰

Fleiss (2000) reports that *Acidophilus* culture restores healthy bacteria and may be applied directly to the foreskin to promote healing.⁴⁷

The foreskin, which has many immunological functions,² is protective against balanitis. The foreskin maintains the subpreputial moisture, which contains oils and anti-pathogenic substances, and helps to protect against irritation and infection.² More penile inflammation is found in circumcised boys,⁴⁸ so circumcision should be avoided. The foreskin should not be retracted in young boys.^{48,50} It should be left in place to protect the penis. Soap may remove the oils from epithelial tissue and cause non-specific dermatitis that is mistaken for balanitis.⁵¹ Soap should be used sparingly or not at all.^{51,52}

Balanitis Xerotica Obliterans/Lichen Sclerosus

Balanitis xerotica obliterans (BXO) is the same disease as *lichen sclerosus et atrophicus* (LSA).^{53,54} Traditionally, the term BXO has been used when the disease affects the male genital organs. The preferred term today, however, is *lichen sclerosus* (LS).

Edwards describes the disease as follows:

“The clinical appearance is of white plaques on the glans, often with involvement of the prepuce which becomes thickened and non-retractile. In active disease haemorrhagic vesicles may be seen. The changes only affect squamous skin, leaving atrophic areas

which cause cicatricial shrinkage leading to urethral stenosis and phimosis. The condition affects all ages and circumcision specimens from children with phimosis often show the characteristic histological appearances. Histology initially shows a thickened epidermis, followed by atrophy and follicular hyperkeratosis. This overlies an area of oedema with loss of the elastic fibres and alteration in the collagen, which in turn overlies a perivascular band of lymphocytic infiltration. Haemorrhagic vesicles occur when the oedema causes detachment of the epidermis with a capillary erosion and extravasation of blood.”⁴³

The disease, which is of unknown origin,⁴³ commonly involves the genital organs.⁵³ In males, the foreskin frequently is the target, but it may also involve the glans penis and the urethra.⁵⁴ It usually is seen in boys from about age 4 to 11.⁵⁶ Frequently, a whitish ring of hardened, non-elastic tissue is seen at the tip of the prepuce that prevents retraction.⁵⁶⁻⁵⁸ Diagnosis should be confirmed with biopsy.⁴³

Rickwood *et al.* (2000) reported an incidence of 0.6 of one percent in British boys with a peak at age eleven.⁵⁹ Kizer *et al.* (2003), who surveyed United States Army adult men, reported an incidence of 5.07 per ten thousand in white men and about twice that in black and hispanic men.⁶⁰

BXO/LS once was considered to be an absolute indication for circumcision,^{57,58} but that is not the case today.⁵⁵

Treatment with the carbon dioxide laser has been successful in removing the lesions of BXO/LS.⁶¹⁻⁶⁵

Several studies have shown treatment with sub-lesional, intra-lesional, or topical steroids to be successful, especially in mild cases.^{17, 57, 66-71} Vincent & MacKinnon (2005) report a 30 percent success rate with topical steroid cream.⁷¹

Treatment with topical steroid cream is now the first treatment for BXO/LS.^{55,56,69-70} Tacrolimus ointment may be a possible treatment option.^{73,74}

Surgery, in addition to medical treatment, may be necessary in some cases. Meatotomy or urethroplasty may be required in severe cases to relieve obstruction and ease voiding.⁴³ Dewan (2003) recommends preputioplasty instead of circumcision to relieve phimosis.⁷² Laser treatment may be useful in the treatment of meatal stenosis.⁵⁵

BXO/LS has been identified as a risk factor for development of squamous cell carcinoma (SCC) in adults.^{43,55} The risk of SCC in children is unclear. Biopsy should be performed to rule out SCC.

Summation

Better understanding of the functions of the prepuce,^{2,3} the advent of the human rights era (see Chapter 9), and advances in medical ethics (see Chapter 11) have increased the demand for conservative alternatives to male circumcision, which preserve the patient’s genital integrity, as a treatment. Advances in medical science make circumcision outmoded and obsolete as a treatment for phimosis and balanoposthitis. Newer medical and surgical treatments make circumcision as treatment for BXO/LS unnecessary in many cases.

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Chapter Eight: The Distribution of Male Genital Integrity

Wallerstein (1985) estimates the overall worldwide incidence of male genital integrity at about 80 percent.¹ The incidence of genital integrity varies enormously from nation to nation.¹

Non English-Speaking Nations

The incidence of genital integrity is very low in Israel, where most boys are circumcised on the eighth day of life.

The incidence of genital integrity also is very low in Turkey² and other Muslim nations, where boys are usually circumcised between ages four and twelve.

Europe has had a very high incidence of genital integrity,¹ however, the increasing immigration of Muslim minorities is lowering the incidence of genital integrity in Europe. Sweden, like other Scandinavian nations, does not usually practice male circumcision. Even among Jews, the incidence of circumcision is relatively low. Hofvander (2002) reports only about 40 percent of Swedish Jews practice ritual circumcision,³ leaving 60 percent with intact genitals.

Latin America does not practice non-therapeutic genital cutting of boys, so the incidence of genital integrity in Latin America is very high.

Russia and China, except for Muslim areas, do not practice non-therapeutic male circumcision, so the incidence of genital integrity is very high.¹

In South Asia, Muslims practice circumcision, but Hindus, Sikhs, Buddhists, and others do not, so those groups have a very high incidence of genital integrity.

The Philippine Islands have a very low incidence of genital integrity because non-therapeutic circumcision (called *tuli*) is a social practice.⁴

South Korea, because of American influence, also has a very low incidence of genital integrity.⁵ Kim *et al.* (1999) report a genital integrity rate of only 16 percent among males aged 16-29.⁵

English-Speaking Nations

The English-speaking nations, alone in the world, have practiced male neonatal circumcision for putative prophylactic purposes for more than one hundred years.¹

The British National Health Service stopped providing non-therapeutic circumcision in 1950, so the incidence of genital integrity has greatly increased in the United Kingdom. The 2000 British National Survey of Sexual Attitudes and Lifestyles (Natsal 2000) placed the incidence of genital integrity among 16 to 19-year-old males at 88.3 percent.⁶ Men of ethnic minorities (except black Caribbeans) were significantly more likely to be circumcised than those described as "white".⁶ Jews in Britain had the lowest incidence of genital integrity at 1.3 percent, but Sikhs, Buddhists, and Hindus had an incidence of genital integrity of 98.2 percent.⁶

Canada has practiced circumcision, but the practice is in decline all across the country. Patel (1965) reported the incidence of circumcision at one hospital in one city to be 48 percent in 1961-2, which would

produce an incidence of genital integrity of 52 percent.⁷ This four-decade-old figure has been improperly used by the American Academy of Pediatrics to represent the incidence of circumcision in all Canada.⁸ In any event, it is inaccurate and outmoded. The Canadian-based Association for Genital Integrity reports that the incidence of genital integrity among boys born in 2003 varied from a high of 100 percent in Newfoundland to a low 70.5 percent on Prince Edward Island.⁹ It estimates the overall incidence of genital integrity among Canadian boys, born in 2003, to be 86.1 percent in 2003, with a trend toward increased genital integrity.⁹

Australia has a high incidence of genital integrity among newborn boys because the official policy of the Australian College of Paediatrics, since 1971, has been to discourage circumcision of newborn boys.¹⁰ Wallerstein (1985) reported the incidence of genital integrity in Australia at about 51 percent in 1973-4 and about 61 percent in 1979-80.¹ In 2000, only about 52 percent of all Australian males were genitally intact because of the previous high incidence of circumcision.¹¹ Darby (2000) reported that the incidence of genital integrity among newborn boys in 1995-6 was 89.4 percent. The incidence of genital integrity among newborn Australian boys has held steady at about 87.2 percent in recent years but varies sharply from state to state, with a low of 82 percent in Queensland and a high of 98 percent in Tasmania.¹²

New Zealand formerly had a low incidence of genital integrity, but in about 1970, the rate of circumcision started to decline sharply, so the incidence of genital integrity has been increasing. New Zealand has increased the incidence of genital integrity among newborn Caucasian boys to more than 99.5 percent.^{13,14} The Polynesian Pacific Island (mostly Samoan and Tongan) people have a low incidence of genital integrity, approaching zero percent.¹⁴ The indigenous Maori people respect and maintain genital integrity.^{13,14}

The United States has the lowest incidence of genital integrity among English-speaking nations,¹ but the trend is toward increased genital integrity. A study carried out in five Pittsburgh hospitals in the early 1960s found that 97 percent of the infants were circumcised, leaving only 3 percent with intact genitals.¹⁵ Laumann *et al.* (1997) reported results from the National Health and Social Life Survey (NHSLS), which surveyed males born from 1932 through 1971.¹⁶ The NHSLS found that the incidence of circumcision peaked at 85 percent in 1965, which would produce a genital integrity incidence of 15 percent. Of males born in the U.S., 23 percent had intact genitals. Among males born outside the U.S., 67 percent had intact genitals.¹⁴ The National Hospital Discharge Survey (NHDS) reports that, in 2006, the overall incidence of genital integrity in the United States among newborn boys was 44 percent.¹⁷ The NHDS also reports the incidence of genital integrity by four census regions. There was substantial regional variation with the incidence of genital integrity ranging from a low of 22 percent in the North Central Region to a high of 66 percent in the Western Region.¹⁷ There has been a year-to-year trend toward increased genital integrity among newborn boys in all four U.S. census regions.¹⁷

Nearly one hundred percent of boys in Islamic nations are circumcised. The circumcision, however, usually occurs at from five to twelve years of age.¹⁸ The United States and Israel are the only two nations that circumcise a majority of boys in the newborn period. The United States is the *only* nation that circumcises a majority of boys in the newborn period for *non-religious* reasons.

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Chapter Nine: International Human Rights Law and the Circumcision of Children

Introduction

The various codes of medical ethics that have been enunciated by the medical societies of western nations require medical doctors to respect the human rights of their patients.¹⁻⁷ It is, therefore, necessary to consider circumcision of children in the light of international human rights law. According to The United Nations Children's Fund (UNICEF):

Human rights are those rights which are essential to live as human beings – basic standards without which people cannot survive and develop in dignity. They are inherent to the human person, inalienable and universal.⁸

This chapter will examine the position of circumcision of children (who are unable to consent to surgery) that was introduced into medical practice in the nineteenth century, under international human rights law, which was adopted by the nations of the world in the twentieth century.

The era of human rights may be considered to have started with the formation of the United Nations at San Francisco in 1945 because the *Charter of the United Nations* requires that body to promote universal respect and observance of human rights for all—without distinction as to race, sex, language, or religion.⁹

Children possess two kinds of human rights:

- General human rights that every human possesses, universally, simply by reason of being a human being.
- Special human rights that every child possesses, universally, simply by reason of minority.

UNICEF explains:

Human rights apply to all age groups; children have the same general human rights as adults. But children are particularly vulnerable and so they also have particular rights that recognize their special need for protection.¹⁰

Doctors who treat child-patients, therefore, have an ethical duty to respect and honour both the general human rights and the special human rights of the child-patient.

General Human Rights

The General Assembly of the United Nations, acting to fulfill its obligations under the Charter, adopted the *Universal Declaration of Human Rights* (UDHR) in 1948.¹¹ The UDHR recognizes the rights of all to security of the person (Article 3), to freedom from inhuman, cruel, or degrading treatment (Article 5), and the rights of motherhood and childhood to special protection (Article 25.2), all of which are applicable to circumcision.

The General Assembly adopted the *Covenant on Civil and Political Rights* (CCPR) in 1966.¹² That Covenant has several provisions, which are applicable to the circumcision of children. Each nation that is

a state-party under the CCPR, which took effect in 1976, pledges to enforce those rights for its citizens. The United States ratified this covenant on 8 September 1992 with various reservations, understandings, and declarations that limit its value. Articles 7 and 24 are applicable to circumcision.

Article 7 provides:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Article 9 provides:

1. Everyone has the right to liberty and security of person.

Article 24 provides:

1. Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.

One must bear in mind that non-therapeutic circumcision is a radical, irreversible operation that excises healthy, functional tissue from the body of the child¹³ without medical justification and without the consent of the child, and which permanently destroys various physiological functions. According to Svoboda:

Reasons for concern with the procedure under human rights principles include a profound loss of highly specialized and sensitive sexual tissue, which also serves important protective functions, loss of bodily integrity, traumatic and highly painful disfigurement, complications with a range of severity up to and including death, and the impermissibility of any mutilation of children's sexual organs performed with neither their consent nor medical justification.¹⁴

Applicable general human rights include *security of the person* and *freedom from cruel or degrading treatment*. In addition, the two instruments recognize the right of the child to special *protection* by reason of his minority.

Additional Particular Human Rights for Children

The General Assembly of the United Nations has acted twice to enunciate and protect the rights of the child. First, in 1959, the General Assembly adopted the *Declaration on the Rights of the Child* (DRC),¹⁵ which expanded and further defined the rights of the child to special protection. The DRC enunciated ten general principles for the protection of children, of which Principles 1, 2, 8, 9, and 10 are applicable to child circumcision:

1. The child shall enjoy all the rights set forth in this Declaration. Every child, without any exception whatsoever, shall be entitled to these rights, without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.

2. The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the

enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.

8. The child shall in all circumstances be among the first to receive protection and relief.

9. The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form.

10. The child shall be protected from practices which may foster racial, religious and any other form of discrimination.

The DRC, however, was binding on no one, so in 1989, the United Nations General Assembly adopted the *Convention on the Rights of the Child (CRC)*,¹⁶ which enunciated specific rights which the states-party were required to implement in their domestic laws. One-hundred one nations have become states-party to the CRC. Two nations are not states-party to the CRC. They are Somalia, which has no functional government, and the United States,¹⁷ where deep opposition exists. The implementation of the CRC varies from nation to nation. In the United States, even though the CRC has not been ratified by Congress, it still sets a benchmark for the protection of children.

The CRC has a number of articles, which are relevant to child circumcision. They include Articles 2, 3, 4, 6, 19, 24(3), 34, 36, 37, and 39. All nations except Somalia and the United States, therefore, have pledged to implement the provisions of the CRC for the protection of children within their respective borders.

Article 2(1)

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

This article establishes the universality of child rights. As UNICEF says:

All children have the same rights.¹⁸

There are no exceptions.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

This article establishes “best interests” as the guidance by which decisions concerning the child are made. The second part establishes the obligation of the state to provide protection and care for the well-being of the child.

Article 4

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 4 establishes the obligation of the state-party to take action to implement the provisions of the CRC.

Article 6

- 1. States Parties recognize that every child has the inherent right to life.**
- 2. States Parties shall ensure to the maximum extent possible the survival and development of the child.**

Article 6 acknowledges that children have the same right to life as adults. Article 6 is particularly relevant to such countries as South Africa, where children regularly lose their lives in “initiation schools” where they are circumcised. It is also relevant to circumcision in the advanced Western nations, where children sometimes die of bleeding or infection after circumcision.

Article 19

- 1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.**
- 2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.**

Article 19 recognizes the right of children to special protection from all forms of mental or physical violence or abuse.

Article 24

Article 24 recognizes the right of the child to health. Article 24.3 is relevant to the traditional and injurious practice of male circumcision.

- 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.**

Article 24.3 makes clear that children have a right to protection from the traditional practice of child circumcision.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse.

The penis is a sexual organ, so circumcision is a violation of this article.

Article 36

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Doctors exploit the presence of the foreskin on male children as an excuse to do a circumcision and collect a fee for the surgery. Children have a right under this article to protection from such exploitation.

Article 37(a)

a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

This article provides the child with a right to freedom from cruel, inhuman, and degrading treatment. Circumcision excises functional tissue from the human body and degrades the sexual and protective functions of the prepuce. This is cruel, inhuman, and degrading treatment.

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

By this article, children have a right to whatever treatment will help in the recovery from the effects of circumcision.

Smith, writing for the Netherlands Institute of Human Rights (Studie- en Informatiecentrum Mensenrechten), reported that male circumcision is an obvious violation of the human rights of the child, equivalent to female circumcision.¹⁸ All members of society, including parents and professionals, have a duty to protect the rights of children.²⁰ We shall see in a later chapter how this impacts the medical ethics of the circumcision of male children.

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Chapter Ten: American Law and the Circumcision of Children

In the absence of definitive legislation or court rulings regarding the lawfulness of non-therapeutic circumcision of male children within United States law, there is some latitude for different opinions regarding its lawfulness.

Introduction

Anglo-American law historically has been slow to recognize the natural legal rights of children. Partly this is due to an ancient but lingering religious notion that children were born tainted by sin and thus to ‘spare the rod’ is to spoil the child, physically and morally. Partly this is due to deference to the rights of parents who, for centuries, were deemed sole proprietors of their children, rather than trustees responsible for the care of a soon-to-be fellow citizen. Only slowly has Anglo-American law developed any recognition that the child, a member of the larger community and not a mere chattel of anyone, has rights independent from his or her parents, and, being vulnerable, deserves special protection.

It is not surprising, therefore, that with a long history of few identifiable legal rights, children have been subject to inhumane practices having more to do with social whims than with the actual day-to-day needs of the child.

It is true that we have evolved, haltingly, away from tolerating child labor, child soldiers, child sex objects, child prisoners, and child death-row inmates. But physical chastisement—withholding food, medicine, education, social interaction, and other basic human needs—is still tolerated, especially where religious beliefs of the parents are invoked.

Nowhere is the tension between ancient parental rights and the nascent rise of the child's legal rights as a citizen more striking than in the instance of non-therapeutic, merely cultural, non-consensual modifications of a child's genitalia. Subject to strict analysis under modern international law, and seen through the scrim of the developing rights of children, circumcision—a non-therapeutic procedure amputating a highly nerve-supplied portion of the child's natural and healthy genitalia, often without the slightest anesthesia or analgesia—would seem difficult, if not impossible, to defend.

Traditional View

The medical community has assumed that parents may grant surrogate consent to non-therapeutic circumcision of children based on the fiction that non-therapeutic circumcision is a medical procedure and that parents have a “right to a circumcision.” *Circumcision of a child is considered to be lawful, provided that one parent signs a consent form after being fully informed of the alleged benefits and known risks.* This is the view expressed by the American Academy of Pediatrics for the past three decades,¹⁻³ and it is the view that best fits the needs of the members of the AAP. The AAP is an association of medical doctors that has no power to make law or establish social policy. The medical community, thus far, has been unwilling to accept changes in law and ethics as applied to circumcision.⁴

There are many reasons to believe that this view is incorrect. The AAP's view treats the child as the property of the parents. In the view of the AAP, parents may do whatever they wish to the male child in regard to circumcision. The AAP does not recognize the child as a separate person, with legal and human rights of his own. The AAP position, first enunciated in 1975, is not in accord with contemporary international human rights law and international bioethics documents, nor is it in accord with other policies of the AAP.⁵

Contemporary View

Lack of valid consent. Parents do not own their children. Society merely entrusts parents with the care of their children until their children reach the age of majority. Although competent adults have very broad powers to consent, the power of a surrogate to grant consent is limited.⁶ Parents must act only in a child's best interests.⁵ There is no reason to believe that parents have any right or power to authorize the excision of healthy functional tissue from a child. A child is a separate person from his parent and has his own set of rights. Parents have a duty to protect the child's rights and person, which conflicts with any alleged power to circumcise.

Newborn boys are not born with diseased foreskins and, consequently, no medical indication for circumcision exists in the newborn period. The prerequisites for surrogate consent to treatment or surgery are:

1. a physical complaint, followed by
2. a diagnosis by a medical doctor, followed by
3. a medical recommendation for treatment,
4. presentation of all relevant material information,^{6,7}
5. followed by granting of consent by the surrogate.

In the case of circumcision of a male child, the first three prerequisites are absent, so any consent for non-therapeutic circumcision would appear to be invalid.

Parents have duties to a child, which have been traditionally described as "their maintenance, their protection, and their education."⁸ Parental "rights" are simply empowerment to carry out the duties owed to the child. According to Lord Scarman of the House of Lords:

"The principle of the law ... is that parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child."⁹

If a child does not need a circumcision, then the parental power to seek a circumcision does not exist. A consent for an unnecessary circumcision would be vitiated and invalid, so any circumcision performed with such a consent would be medical battery or criminal assault.^{6,10}

Moreover, consent for circumcision, which entails the excision of healthy, functional tissue,¹⁰ does not accord with the parental duty of protection of the child's person from harm.

Offense against general criminal law. Every jurisdiction makes battery a criminal offense. Genital cutting without valid consent would violate laws against battery.⁶

Offense against laws for the protection of children. Circumcision also fulfills the definition of child abuse¹² and would be a crime of child abuse.

Offense against the child's right to bodily integrity. The common law right to bodily integrity was affirmed by the U. S. Supreme Court in 1891¹³ and in numerous later cases. Circumcision necessarily violates the child's right to bodily integrity. There is no reason to believe that parents are empowered to violate a child's right to bodily integrity in the absence of a clear and present compelling medical indication.

Denial of equal protection of the law. All citizens of the United States have a right to the equal protection of the law.¹⁴ Female children are granted the protection of their genital integrity by criminal law that prevents excision of healthy tissue from female genitals.¹⁵ Gender-based discrimination is subject to scrutiny. Parties who seek to defend gender-based distinctions must demonstrate an "exceedingly persuasive justification" for that action.¹⁶ Courts must provide "heightened scrutiny" of gender-based discrimination.¹⁷ Equal protection of the law is available to males just as much as it is to women.¹⁸

According to Povenmire:

"For female infants, the right to the integrity of the genital organs is protected against surgical "mutilation" by federal law and United Nations resolutions. Under the law, the right of bodily integrity is deemed so fundamental that it displaces any consideration of the parents' cultural or religious beliefs. Unfortunately, no similar recognition has been extended to male infants in the United States. The failure of the law to provide equal protection to males can find no "exceedingly persuasive" justification, and is unconstitutional."¹⁹

The genital integrity of males should receive the same protection accorded to the genital integrity of females.

Protection from religion-based abuse. Some would argue that religious beliefs give a parent the right to violate a child's right to bodily integrity, however, that is not the case. The law makes a very clear distinction between the right to believe, which is absolute, and the right to practice religion, which may be limited by laws of general application. According to the 1878 United States Supreme Court:

"Laws," we said, "are made for the government of actions, and while they cannot interfere with mere religious belief and opinions, they may with practices. . . . Can a man excuse his practices to the contrary because of his religious belief? To permit this would be to make the professed doctrines of religious belief superior to the law of the land, and in effect to permit every citizen to become a law unto himself."²⁰

Children are entitled to protection from religiously inspired abuse. This matter was settled by the United States Supreme Court in the case of *Prince v. Massachusetts*. The court said:

"The right to practice religion freely does not include liberty to expose the community or the child [p167] to communicable disease or the latter to ill health or death. *People v. Pierson*, 176 N.Y. 201, 68 N.E. 243. [n13] The catalogue need not be lengthened. It is sufficient to show ... that the state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare, and that this includes, to some extent, matters of conscience and religious conviction."²¹

and famously:

Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.²¹

Parents may believe that religion requires child circumcision' but the right to practice religion is limited. Religious practice generally is subject to and limited by laws of general application.²¹ The *International Covenant on Civil and Political Rights*, which has been part of the supreme law of the United States since 1992, limits parental religious rights over their children to "religious and moral education of their children in conformity with their own convictions".²³

Circumcision of children is a human rights offense. Male circumcision under international human rights law is discussed in Chapter Nine. The Congress of the United States ratified the United Nations *International Covenant on Civil and Political Rights* (1966) (ICCPR)²³ on June 22, 1992. The ICCPR is part of the supreme law of the United States in accordance with Article VI of the United States Constitution. The United States has undertaken to guarantee the human rights recognized by the ICCPR to all persons in its territory (Article 2.1). Children have the same general human rights as adults, but have a greater right of protection due to their vulnerable status as minors (Article 24.1).²⁵

State and federal courts are required and empowered to enforce the rights provided by the ICCPR (Article 2.3).²⁷ Rights pertinent to the circumcision of male children include the *right to equal enjoyment of all rights* (Article 3), the *right to freedom from cruel, inhuman or degrading treatment* (Article 7), *right to security of the person*, (Article 9.1), the *right to protection during minority* (Article 24.1). The circumcision of minor male children, who are legally incompetent, violates these rights. The ICCPR requires the United States and the several individual states to take action to protect the human rights of boys as well as girls.

Conclusion

The law of circumcision is in a transitional state.⁶ There is no clear reason to believe that non-therapeutic male circumcision of children is lawful⁶ and many reasons to believe that male circumcision is unlawful.

Non-therapeutic circumcision of male children already is a criminal act in Washington.²⁷ Its continued practice depends upon the failure of public prosecutors to enforce criminal law. A law that more clearly expresses the unlawfulness of circumcision is needed for the protection of children.

A Chicago court concluded in 2006 that one boy is entitled to protection against circumcision and issued protective injunctions to the parents of the boy to protect him from circumcision until he reaches his majority and can decide for himself.²⁸

Consent for non-therapeutic circumcision appears to exceed the powers granted to parents. A circumcision carried out without consent or with ineffective vitiated consent is an act of medical battery and may expose the perpetrator to possible civil and/or criminal penalties.

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Chapter Eleven: Medical Ethics and the Circumcision of Children

*All infants, children and adolescents – regardless of physical or mental disability – have dignity, intrinsic value, and a claim to respect, protection, and medical treatment that serves their best interests.*²⁶

The surgical operation of male circumcision permanently and irreversibly excises and destroys a functional body part, as reported in Chapter Two.^{1,2}

For this reason, the medical ethics associated with the operation must be scrutinized carefully and doctors who contemplate performing a circumcision must carefully consider and adhere to proper ethical conduct.

Doctors, especially in the U.S., frequently are asked to perform medically unnecessary, non-therapeutic circumcision on minors. Since minors cannot consent, special ethical rules, applicable to pediatrics, must be applied. One must always remember that the child is the patient. The doctor must consider first the well-being of the patient³ and keep the interests of the child-patient paramount.^{4,5}

Some older authorities, e.g., American Academy of Pediatrics, simplistically maintain that non-therapeutic circumcision of a child is ethical if parents request and consent to the circumcision.⁶⁻⁹ As Fox & Thomson (2005) note:

Only limited consideration is given to the seemingly obvious fact that circumcision is the excision of healthy tissue from a child unable to give his consent for no demonstrable medical benefit.¹⁰

The view espoused by these older authorities is outmoded and inadequate because it fails to consider the doctor's duties to the child, the child's legal rights, the child's human rights, and limitations on the power of surrogate consent. Moreover, these statements favor parent privilege over the child's legal rights and best interests. According to Fox and Thomson:

Particular attention is devoted to the privileging of parental choice, notwithstanding documented medical risks and the absence of conclusive evidence of medical benefit.¹⁰

This chapter considers the medical ethics of non-therapeutic circumcision of children by several ethical tests.

1. Lawfulness

Doctors must respect the law¹¹ because they are subject to the general laws.¹² If a proposed circumcision operation is unlawful in a particular locale or under the existing circumstances, then it also is unethical and must not be performed. The law of the United States has been discussed in a previous chapter.

2. Human Rights

Doctors have a general duty to respect the human rights of the patient.^{5, 10-15} According to the World Medical Association:

“Ethics and human rights are no longer the 'two solitudes' that did not have much to do with each other. Increasingly, human rights organizations are recognizing the ethical dimension of their work, and organizations whose primary concern is ethics are discovering that human rights is a foundational element of ethics. ...”¹⁴

Human rights are now an integral part of medical ethics. As reported in the Chapter Nine, children have both general and special human rights that must be protected. As previously stated, non-therapeutic circumcision of children violates the child-patient’s human rights. Both parents and professionals have a duty to respect human rights.

The United Nations Educational, Cultural, and Scientific Organization (UNESCO), being well aware that many current medical practices are unethical because they do not comply with international human rights law, has compiled and published the *Universal Declaration on Bioethics and Human Rights* (2005) to guide organizations and institutions toward compliance with human rights. The *Declaration* provides in part:

Article 8 – Respect for human vulnerability and personal integrity

In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.¹⁵

Children are among the most vulnerable persons. This provision would require respect for their genital integrity and prohibit the non-therapeutic excision of healthy functional human tissue, such as the foreskin, from their genital organs.

3. The Cardinal Principles of Medical Ethics

The four cardinal principles of medical ethics are beneficence, non-maleficence, justice, and autonomy.^{16,17}

Beneficence. This concerns “doing good.” We have previously demonstrated that the alleged prophylactic benefits cannot be shown to actually exist. Therefore, there is no provable beneficence to the non-therapeutic circumcision of male children, so non-therapeutic circumcision violates the principle of *beneficence*.

Non-maleficence. This concerns “not doing harm.” We have previously demonstrated that male circumcision is harmful, so non-therapeutic circumcision violates the principle of *non-maleficence*.

Justice. This concerns “treating patients fairly.” We have previously demonstrated that non-therapeutic circumcision inflicts needless injury on a patient and violates his legal right to bodily integrity and human rights. This is not fair treatment, so non-therapeutic circumcision violates the principle of *justice*.

Autonomy. This concerns letting the patient control his/her own treatment. Consent for the circumcision of children must be given by surrogates. In this case, the patient does not control his own treatment, so non-therapeutic circumcision violates the principle of *autonomy*.

Some ethicists add a fifth principle:

Proportionality.^{17,18} This concerns having benefits that are proportionate to the risks and losses. The nebulous and mythical benefits of male circumcision are completely disproportionate to the known risks, disadvantages, and permanent injury of circumcision. Male non-therapeutic circumcision violates the principle of *proportionality*.¹⁷

Non-therapeutic circumcision of children violates all five principles of medical ethics.

4. Provision of Futile or Ineffective Treatment

Non-therapeutic circumcision is performed on healthy persons. Under this circumstance, there can be no effect, so the treatment is both ineffective and futile. Physicians have *no* duty to provide futile or ineffective treatment.¹⁹⁻²¹

5. Misuse of Medical Resources

Physicians have an ethical duty to conserve medical resources and use them wisely.^{17,22-24} The provision of non-therapeutic circumcision wastes medical resources, such as physician time, hospital space, insurance money, and medical staff. Provision of medically unnecessary, non-therapeutic circumcision may consume resources needed for the medically necessary treatment of other patients.

6. Surrogate Consent

The necessity for consent by surrogates poses many ethical problems. Competent adult patients have full powers to consent to treatment, but surrogates have limited powers. The American Academy of Pediatrics states that the surrogate is limited to providing “informed permission for diagnosis and treatment of children.”²⁵ Non-therapeutic child circumcision is neither diagnosis nor treatment and falls outside parental power to consent.

Both parents and physicians must act in the *best interests* of the child.^{15, 25-30} Doctors must, in considering the best interests of the child, remember that parents have a primary duty to the child to protect his bodily integrity. The best interests of the child must include the protection of his legal right to bodily integrity, except when the presence of clear and present clinically identifiable disease makes invasion of the child’s bodily integrity necessary. Therefore, there should be an assumption that protection of the child’s bodily integrity is in his best interests, unless proven otherwise by clear and convincing evidence.

In surrogate consent for therapeutic circumcision, the necessary prerequisites are:

1. a physical complaint, followed by
2. a diagnosis by a medical doctor, followed by
3. a medical recommendation for treatment, followed by
4. a trial of conservative treatment,⁵ followed by

5. a recommendation for circumcision, only after conservative treatment fails, and where circumcision is proven to be effective, followed by
6. presentation of all relevant material information,^{5,25,26,28,30,31} followed by
7. granting of consent by his representative.³²

These would be present in the case of therapeutic circumcision, but the first five would be glaringly absent in the case of non-therapeutic circumcision at parental request. A consent obtained without these prerequisites would lack validity. Performance of a circumcision without valid consent would be unethical.

7. Patient Exploitation

Some doctors may exploit the presence of the foreskin by performing a circumcision simply to collect a fee for the procedure. According to the *Boston Globe*, quoting Thomas E. Wiswell, M.D. (the advocate of male circumcision to prevent UTI):

"I have some good friends who are obstetricians outside the military, and they look at a foreskin and almost see a \$125 price tag on it," says Wiswell. "Each one is that much money. Heck, if you do 10 a week, that's over \$1,000 a week, and they don't take that much time."³³

Patient exploitation is a violation of human rights and is unethical.^{33,34}

8. Duties to Child-Patients

Doctors have "legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses."²⁵ "The principal obligation of the physician is to the individual patient rather than to society or the healthcare system."²⁶ Doctors have a duty to act in the best interests of their child-patient.^{5 25-30} Genital integrity provides the highest state of health and well-being,^{17 36} therefore, doctors have an ethical duty to their child-patients to protect and preserve the genital integrity of their child-patients by abstaining from performing circumcision at parental request.

9. Preservation of the Child's Right to an Open Future.

Although infant boys are not competent at birth, they will, in the vast majority of instances, be competent later. The principle of *autonomy* requires that parents, to whom the care of the child is *entrusted*, preserve as many of the child's future options as possible. Joel Feinburg writes:

"... if the violation of a child's autonomy right-in-trust cannot always be established by checking the child's present interests, *a fortiori* it cannot be established by checking the child's present desires or preferences. It is the adult he is to become who must exercise the choice, more exactly, the adult he will become if his basic options are kept open and his growth 'natural' or unforced, In any case, that adult does not exist yet, and perhaps he never will. But the child is *potentially* that adult, and it is that adult who is the person whose autonomy must be protected, now (and in advance)."³⁷

Parents and doctors, therefore, have a duty to the child to preserve the child's options in adult life. A circumcision in childhood forecloses the child's right to opt for genital integrity in adult life, so a non-therapeutic circumcision unethically violates the child's right to an open future.

Summation

Child circumcision was introduced into medical practice in the nineteenth century.³⁸ Medical ethics has changed over the years, especially since the advent of the human rights era. In this chapter, non-therapeutic circumcision of children has been subjected to nine tests by contemporary standards of medical ethics. It has failed all nine. Although non-therapeutic circumcision of children remains a common practice, under contemporary standards of medical ethics, it has become unethical and needs to cease. Medical societies have a duty to revise their guidance regarding non-therapeutic male circumcision to reflect 21st century medical ethics. Similarly, medical doctors, hospitals, and other institutions have a duty to change their practices regarding non-therapeutic circumcision of children to protect their genital integrity.

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Chapter Twelve: Conclusion

We have set forth in this statement the reasons why non-therapeutic circumcision of male children should not be performed.

Summary

We have discussed in Chapter One the impediments that preclude medical societies from producing an accurate and useful statement, and why it is necessary for Doctors Opposing Circumcision to produce this statement.

We have shown in Chapter Two that the prepuce has various physiological functions throughout life, including:

- protective,
- immunological,
- mechanical,
- sensory, and
- sexual.

The excision of the prepuce exposes the newborn to meatal disease and leaves the patient permanently diminished, with impaired and degraded functions.

We have shown in Chapter Three that there is no medical indication for circumcision of the newborn and that the alleged benefits relate to the possible but unproved prevention of future disease. We now know that these alleged benefits are fear-based, confer potential protection at best, and are often overstated and advanced in part by circumcised doctors who are compelled to justify and reenact their own circumcision.^{1,2}

We have shown in Chapter Four that the immediate complications of non-therapeutic male circumcision primarily include:

- bleeding, that may result in hypovolemic shock and exsanguination;
- infection, including life-threatening CA-MRSA;
- surgical accident resulting in mutilation, and
- death.

We have shown in Chapter Five that the post-operative complications of circumcision include:

- urinary retention that may result in ruptured bladder, renal failure, interruption of circulation in the lower extremities, and death;
- adhesions and skin bridges that may require surgical separation;
- meatitis, meatal ulceration, and meatal stenosis that may require additional surgery;
- urinary tract infection;
- post-circumcision phimosis, requiring additional surgery;
- buried, trapped, or concealed penis, requiring additional surgery;
- keloid formation, requiring additional surgery;
- circulation problems;
- chordee;

- inclusion cysts;
- lymphedema;
- neuromas, and
- cancer.

We have shown in Chapter Six that long-term complications of circumcision include:

- adverse emotional effects,
- adverse sexual effects,
- adverse effects on female sexuality, and
- adverse effects on medical literature
- adverse effects on society.

We have shown in Chapter Seven that conservative non-invasive or minimally invasive treatment usually is superior to therapeutic circumcision for the treatment of foreskin conditions.

We have shown in Chapter Eight that the United States has a low incidence of genital integrity as compared with other English-speaking nations.

We have shown in Chapter Nine that the non-therapeutic circumcision of male children violates numerous general human rights and children's rights.

We have shown in Chapter Ten that non-therapeutic circumcision of children is more likely to be unlawful than lawful.

We have shown in Chapter Eleven that non-therapeutic circumcision of male children fails nine ethical tests and is an unethical surgical intervention.

Discussion

We have shown that the genital cutting of male children is unnecessary, harmful, injurious, a threat to good health, and a violation of the child's human rights. The child's best interests include the protection of his legal right to bodily integrity. Boys whose genital integrity is protected suffer none of the harms and insults described above. They enter life with body, mind, and spirit intact. Genital integrity, therefore, is most likely to provide the highest state of health and well-being.

The United States infant morbidity and mortality rates are much higher than they should be in a developed nation. The high incidence of child circumcision has not purchased good infant health. The United States needs a dramatic overhaul of U.S. medical policy and a change in the medical culture with regard to non-therapeutic circumcision of male children and the protection of their genital integrity.

The male is the weaker and more fragile of the two genders,³ with higher rates of disease, infection,^{3,4} and death.³ The male, therefore, has greater need of protection. America has it backward, protecting females from circumcision, but not males. This needs to be rectified. Children of both genders deserve our protection.

Ending circumcision is safe and cost-free. Prior to 1971, Australia had an incidence of neonatal circumcision of more than 65 percent.⁵ In that year, the Australian Paediatric Association recommended that neonatal circumcision should not be performed.⁶ The incidence of neonatal circumcision in Australia

then declined precipitously⁷ and settled at about 13 percent. Concurrently, with the decline in circumcision, infant mortality showed a marked improvement and the gap in male and female death rates was narrowed.⁸ It is clear, therefore, that non-therapeutic male circumcision can be discontinued safely and is likely to result in an improvement in child health.

Twisselmann (2008) writes:

The foreskin has a role in male sexual health, and circumcision is more than merely another disagreeable experience like vaccination that infants are subjected to. Were circumcision a new procedure, ethics approval, scientific support, cooperation from colleagues, trial participants, and government or charity funding would not be forthcoming.⁹

America needs and is ready for a new policy of genital integrity for its children.

Recommendations

We recommend that the genital integrity of boys be preserved. Parental request for non-therapeutic circumcision of a son appears to exceed the powers granted to parents by law. We further recommend that doctors refuse to perform non-therapeutic circumcision at parental request.

We call on medical schools to stop requiring medical students to perform non-therapeutic circumcisions.

We call on medical societies to repudiate the practice of non-therapeutic child circumcision and to adopt genital integrity policies.

We call on hospitals to prohibit the practice of non-therapeutic circumcision of children in their facilities.

We call on the American Hospital Association to adopt a uniform genital integrity policy for its members.

We call on the United States Conference of Catholic Bishops to apply paragraph 2297 of the *Catechism of the Catholic Church* and Directives 1, 6, 9, 23, 29, and 33 of the *Ethical and Religious Directives for Catholic Health Care Services*, Fourth Edition,¹⁰ to non-therapeutic circumcision of male children.

We call on public and private health insurance providers to support efficient use of health-care resources by ending subsidies for non-therapeutic male circumcision and by promoting genital integrity.

We call on medical doctors everywhere to refuse to perform non-therapeutic circumcision of children.

We call on healthcare professionals everywhere to make clear to the public that non-therapeutic circumcision of children is unhealthy and injurious to children and should not be performed.

We call on state medical boards to establish legal and ethical guidelines for the regulation of male circumcision.

We call on courts to recognize and apply human rights law in cases involving children.

We call on all segments of the medical community and of society to work together to create an environment in which newborn and immature human beings receive the respect for human dignity and the special protection they so richly deserve.¹¹⁻¹³

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