Targeting Patients Who Cannot Object? Re-Examining the Case for Non-Therapeutic Infant Circumcision

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Abstract
Recent restatements of the case for routine circumcision of normal male infants and boys typically base their arguments on a range of medical evidence showing circumcision to have a protective effect against certain pathological conditions. It is then assumed that this evidence leads automatically to a clinical recommendation that circumcision should either be "considered" or strongly urged. Closer analysis reveals that the recommendation of infant or child circumcision has less to do with the medical benefits than with the historic origins of the procedure, the convenience to the operator and the status of the patient. It is further suggested that it is not clear that the medical benefits of infant or child circumcision outweigh the risks and harms, and that this style of advocacy fails to pay due regard to basic principles of bioethics and human rights that are accepted in other areas of medical practice.

Keywords
circumcision, minors, consent, bioethics, human rights, sexually transmitted infections, child health

The ultimate popularity of circumcision depended not on convincing normal men to undergo the ordeal of surgery, but on targeting a group of patients who could not object.

—David Gollaher

The controvertists, answered my father, assign two and twenty different reasons for it: others indeed, who have drawn their pens on the opposite side of the question, have shewn the world the futility of the greatest part of them.

—Laurence Sterne, Tristram Shandy

Recent restatements of the case for non-therapeutic circumcision (NTC) of normal male infants and boys rest their case on the proposition that the benefits are so great and the risks so small that the operation should be widely (perhaps even universally) performed. They also assume that circumcision will be performed in infancy or early childhood, and propose (usually without detailed argument) that removal of the foreskin from non-consenting children is permissible within accepted principles of bioethics and human rights. When challenged on these points, advocates argue that infancy is the best time for the operation because it is simpler and cheaper at that age, provides the greatest benefits, and permits parental choice. In this article, it is argued that these propositions are medically and logically questionable, that it is far from certain that circumcision provides significant net benefit to males in developed countries, and that the preference for circumcising infants (rather than recommending the operation as a health precaution to competent adults) has more to do with history, habit, and power than with the interests of the child.

NTC of normal male infants and boys has been such a familiar feature of Anglophone medical practice that it is difficult to appreciate what an anomaly it is. Surgical removal of body parts normally requires proof of pathology, efforts at non-surgical (medical) cure, and valid informed consent. In the case of circumcision of healthy male minors, none of these conditions is met. In this article, it is argued that the reasons for this peculiarity are not to be found in the familiar litany of benefits and risks advanced by circumcision advocates and financially interested providers; they must rather be sought in the history of medical knowledge, the structure of the profession, and the advance of technology. As historian David Gollaher points out, had circumcision not become established in Anglophone societies in the Victorian era, and in view of the development of evidence-based medicine, the advance of bioethics and the recognition of children’s rights since that time, “no physician would dream of proposing such a thing today.” Furthermore, considering the parallel

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case of female genital cutting/mutilation, he suggests that if "circumcision [of boys] were confined to developing nations, it would by now have emerged as an international cause celebre, stirring passionate opposition from ... the global human rights community” (Gollaher, 2000, p. xiv). Although there are community-based anti-circumcision movements in many countries, particularly the United States, it remains true that the response from mainstream human rights and bioethical institutions has been surprisingly muted (Carpenter, 2014).

**A Brief History of Routine Medical Circumcision**

Circumcision of boys was introduced in mid-19th-century United Kingdom and United States as a means of controlling manifestations of juvenile sexuality (principally “masturbation,” by which was meant any fondling of the genitals) and as a treatment for what became known as “congenital phimosis” (Darby, 2005; Glick, 2005; Hodges, 2005). Under the influence of nerve force theory, phimosis (i.e., a tight and/or non-retractable foreskin) was blamed for a host of pathological conditions, from epilepsy to bed-wetting. It was also seen as an incitement to penis fondling, and thus to masturbation, then regarded as both a moral crime and the cause of many diseases, both real and imaginary, and behavioral problems. At first, circumcision was performed ad hoc on boys caught playing with their penis or found to have an adherent or otherwise non-retractable foreskin. But as doctors discovered the scale of these problems—hardly surprising, as nearly all boys masturbated, and a tight, non-retractable foreskin is the normal condition of the juvenile penis (Agarwal, Mohta, & Anand, 2005; Cold & Taylor, 1999)—they wondered whether it was their duty as far-sighted health providers to take action before these problems produced their damaging consequences. The transition of circumcision from a case-by-case therapy to a general prophylactic was registered in Dr. Norman Chapman’s observation that the incidence of adhesive foreskins was probably far higher than people realized. Because “a long and contracted foreskin” was so often a source of “secondary complications,” he proposed in 1882 that it was “always good surgery to correct this deformity . . . as a precautionary measure, even though no symptoms have as yet presented themselves” (Gollaher, 2000, p. 84). He might well have been following the advice of Erichsen’s (1877) *Surgery*:

> So great are the evils resulting not only from congenital phimosis, but from an abnormally long, though not phimotic, prepuce, that it is only humane and right from a moral point of view, to practise early circumcision in all such cases. (Vol. II, p. 932)

If it was scientifically valid, it had to be morally right. Another U.S. doctor who had become a circumcision convert after discovering that it could cure brass poisoning went further:

> Whether it be curative or not it [circumcision] is conservative, and removes one source of irritation from an exquisitely sensitive organ. I would favour circumcision, however, independent of existing disease, as a sanitary precaution . . . (1) The exposure of the glans to friction etc. hardens it, and renders it less liable to abrasion in sexual intercourse, and consequently venereal ulcer. (2) It is acknowledged to be useful as a preventive of masturbation. (3) It certainly renders the accident of phymosis and paraphymosis impossible. (4) It prevents the retention of sebaceous secretion and consequent balanitis. (5) It probably promotes continence by diminishing the prurience of the sexual appetite. (Gollaher, 2000, p. 85)

As Gollaher (2000) remarks, these declarations and many like them represent an important transition in thought: Circumcision becomes not just a treatment for existing problems, but an anticipatory intervention designed to prevent possible problems in the future.

By the turn of the century, it was accepted that circumcision was generally desirable as a means of preventing masturbation, phimosis, venereal disease, certain forms of cancer, and various minor penis problems loosely grouped under the catch-all heading of “balanitis,” as well as reducing the male sex drive (Darby, 2005). Most of the real medical problems in this list occurred in adults rather than children, but because adult men were not exhibiting much eagerness to get themselves circumcised, the doctors concentrated on the younger generation. As Gollaher (2000) sums up, “The ultimate popularity of circumcision depended not on convincing normal men to undergo the ordeal of surgery, but on targeting a group of patients who could not object” (p. 100). Take-up of the procedure was inhibited, however, by the difficulty of the operation (often quite messy and bloody, especially in infants and young boys), the lack of suitable instruments, and the high incidence of complications, including deaths from infection and bleeding. These obstacles were gradually overcome by the progress of aseptic surgery and, in the 1930s, with the development of effective antibiotics and a purpose-built device—the Gomco clamp. This was the brainchild of U.S. gynecologist Hiram Yellen and businessman Aaron Goldstein, owner of the Goldstein Manufacturing Company (Yellen, 1935). They claimed to have invented an instrument so elegant in design and so simple to use that even an untrained intern, accoucheur or general practitioner (GP) could easily perform circumcision procedures with a negligible incidence of complications and a neat result. Whatever the truth of those claims, the device took off, and it remains the instrument of choice among U.S. circumcision providers to this day, rivaled only by the Plastibell (Glick, 2005; Wan, 2002). In 1941, Alan Guttmacher, professor of obstetrics at Johns Hopkins, recommended the “gadget,” and discussed “phimosis” (foreskin tightness) and prevention of masturbation among the reasons the baby should be circumcised (Guttmacher, 1941).
child health, but of a power play within the medical profession and the temptations of technology. The Gomco clamp allowed the obstetricians to become the dominant players in the circumcision market, replacing the midwives who had previously been responsible, and cutting out the pediatricians and urologists (who were left with the task of repairing the botches) because they could perform the operation as a routine part of the childbirth process at a significantly lower cost to the parents: Unlike operations performed by surgeons, Gomco circumcisions were done without anesthetic. Contrary to Yellen’s claim, the Gomco did not ensure “bloodless” surgery, but its design characteristics did produce a standardized, radically denuded organ, which has come to be widely regarded as the “normal” condition of the U.S. penis. Specialists in women’s health and midwifery thus became the branch of the medical profession with prime responsibility for delicate operations on intimate parts of the male body of which they had no expert knowledge, and it was the incorporation of circumcision as a routine phase of childbirth that has been the most important factor in the persistence of NTC in the United States (Cohen, 2011; Darby, 2013b; Hodges, 1997). The non-development of this division of professional responsibilities in other countries that adopted circumcision (the United Kingdom, New Zealand, Australia, Canada) helps to explain why routine circumcision has largely died out in these regions. The fact that it was the pediatricians who saw the complications helps to explain why they were the ones who took the initiative in discouraging the practice (Leitch, 1970).

The importance of the obstetricians in promoting routine circumcision of infants is further highlighted by a key paper from 1953 that consolidated the principle that the earlier circumcision was performed, the better. According to the authors, Richard Miller and Donald Snyder, the principal “indications” for circumcision were to promote “hygiene” and to prevent phimosis, venereal disease, and cancer of the penis. Additional (disputed) advantages were to discourage masturbation, increase the male libido, and promote longevity. Despite the fact that the only real benefits in this list accrue to adults rather than children, the authors went on to list nine additional reasons as to why circumcision should ideally be performed immediately after birth, and certainly before mother and child are discharged from the hospital. These include (a) greater safety, (b) lower incidence of complications, (c) faster healing, (d) convenience, (e) opportunity for close observation, (f) simpler to ensure sterile environment, (g) operation wakes sleepy babies up,” (h) faster healing and lower incidence of infection, and (i) less pain than if done later.

The authors had little evidence for any of these assertions, but it is clear that the most important factors in their mind were not the health and well-being of the child, but expediency and cost. As they explain under the “Convenience” heading,

Prior to this new plan . . . a line-up on Sunday morning was routine. It meant an extra hospital trip, a good deal of unavoidable delay between cases, and the resulting traffic problem in the birth rooms was prodigious. Under the present regime the obstetrician finishes his episiotomy, walks across the hall and circumcises the infant, and is finished with the whole business. The time saved for both the physician and nursing staff is considerable. (Miller & Snyder, 1953, p. 4)

So impressed were Miller and Snyder with the efficiency of their production line that they returned to its advantages in their conclusion, there making the additional points that “there is no conflict in the scheduling of cases, and no babies are forgotten and left uncircumcised” (p. 10). For all those reasons, “as well as those of economy, convenience, safety, rapidity of healing and close observation,” they continued, “we feel that immediate circumcision of the newborn male infant might well be more universally adopted” (p. 10). As indeed it was, though only in North America. Although the practice became rare in the United Kingdom and began to decline in Australia and New Zealand during the 1950s, routine circumcision did not reach its peak incidence in the United States until the 1970s (Darby, 2013b; Hodges, 1997; Wallerstein, 1980).

The New (African) Evidence

Routine circumcision declined in the 1970s after critical statements from pediatric health bodies in Australia, Canada, and the United States, the aim of which was to try to halt a practice that their 19th-century forebears had initiated. Whereas these efforts had a substantial impact in Australia and a moderate impact in Canada, they made only a small difference to the incidence of circumcision in the United States, where large sections of the medical profession remained committed to the belief in the value of the operation. The effect of this intransigence has been to spawn two contradictory trends: a vigorous, community-based anti-circumcision movement; and in response to this, a reassertion of Victorian arguments for the medical benefits of circumcision, fortified with “new evidence” whenever available.

Like their predecessors, the new generation of advocates rely most heavily on evidence that circumcision has a protective effect against sexually transmitted infections (STIs), especially HIV. The problem is that children are not sexually active; that most of this “new evidence” is from studies of circumcision of adult males, not infants; and that it derives from African countries with very different social and epidemiological environments from those in the developed West (Green et al., 2010). Whether or not the evidence from the clinical trials is sufficient to justify the massive scale of the African circumcision programs, advocates of widespread circumcision in developed countries stretch it far beyond its logical and geographical limits, asserting that it constitutes a “compelling” argument (a) for circumcising infants and (b) applying the programs universally, regardless of the local conditions, no matter how different they may be from the
regions where the evidence was generated (Bossio, Pukall, & Steele, 2014). The rhetorical maneuver by which they achieve these leaps should be examined because it involves a cluster of logical errors and failures of ethical awareness that inhibit clear thinking about the ethics, benefits, risks, and harms of NTC as a medically rationalized procedure in developed nations.

The fundamental flaw in this argument is that it rests on a logical fallacy that may be called the health benefits logical slide. It comes in two forms. The original form conflates children and adults as subjects of medical concern and of ethical consideration:

1. A range of evidence suggests that the surgical removal of the adult foreskin may reduce a male’s risk of contracting certain infectious diseases to which he may later be exposed and may also alleviate some other potential problems.
2. It follows that doctors should remove the foreskin of all infant males as a routine precaution.

The second form of this fallacy is a more recent development, modeled on the first, which fails to distinguish not only between adults and children but also between sub-Saharan Africa and developed (Western) nations with radically different social and epidemiological environments:

1. Three clinical trials and some other evidence suggest that in the sub-Saharan African environment, surgical removal of the foreskin may significantly reduce a male’s risk of contracting HIV through unprotected heterosexual intercourse.
2. It follows that doctors should remove the foreskin of all infant males as a precaution against HIV/AIDS, not only in sub-Saharan Africa but also in the United States and in other developed nations.

Expressed as baldly as this, the non-sequiturs involved in the above arguments should be evident. Yet, in various forms, the logical leap from (1) to (2) in the original form of the fallacy has been marketed relentlessly by circumcision advocates over the past decade. So ingrained in Anglophone countries is the idea that circumcision means circumcision of infants that we even hear the term “elective circumcision” used to mean, not a free choice by an adult for himself, but rather parents making the decision on behalf of a child (“Should Elective Circumcision,” 2012). The second form is a recent refinement but suffers from the same flaws. Both arguments appear regularly in both the popular media and in professional journals, both prestigious and obscure (Cooper, Wodak, & Morris, 2010; Morris, Wodak, et al., 2012; Tobian & Gray, 2011). For those committed to evidence-based and ethically aware medical practice, the uncritical acceptance of this sort of rhetoric by the media and health authorities should be a cause for concern.

The first objection to these arguments is that the original premise of both—that the surgical removal of the foreskin confers lifelong health benefits that exceed the risks of surgery and the harms of losing a visually prominent and sexually functional body part—has not been established. Reviews of this question by competent authorities (such as Australian Safety and Efficacy Register of New Interventions Procedures [ASERNIP], 2008; Hutcheson, 2004; Perera, Bridgewater, Thavaneswaran, & Maddern, 2010) have failed to confirm the claims of significant benefit, and after a detailed review of the evidence, Malone and Steinbrecher (2007) conclude that the only indications for circumcision in childhood were intractable cases of phimosis caused by balanitis xerotica obliterans and recurrent balanoposthitis. Surveys by the Organisation for Economic Co-Operation and Development (2009) and Dewey and Fisher (2013) show that children in the United States (where circumcision is common) fare less well on several health indicators than in comparably developed European countries where circumcision is rare. There are certainly many confounding socio-economic factors in play here, but health statistics do not support the proposition that circumcision improves child health outcomes. Studies in Australia (Australian Institute of Health and Welfare [AIHW], 2010) similarly bear out the converse: that a substantial decline in circumcision incidence did not lead to worse child health outcomes.

The Opinion of Child Health Authorities

It is also significant that, with one semi-exception, all the medical organizations that have issued policy statements on infant or child circumcision have found that there is no justification for it as a routine health precaution. The exception is the American Academy of Pediatrics (AAP), whose 2012 policy statement has been widely (though inaccurately) interpreted as a recommendation for circumcision. In fact, the AAP does not recommend the operation or regard it as medically necessary, but concludes merely that the benefits exceed the risks. Even this moderate position has been criticized on empirical grounds by child health experts (Frisch et al., 2013) and on logical and philosophical grounds by others (Darby, 2015; Svoboda & Van Howe, 2013). What is interesting about the AAP policy is not its central contention, but a couple of subsidiary conclusions that are not backed up by any real evidence at all: first, that it is legitimate for parents and doctors to circumcise for cultural and religious reasons; and second, that it is appropriate for medical insurance systems (both government and private) to pay for circumcision procedures. To take the second point first, the AAP offers no argument as to why it is acceptable for systems intended to improve health to pay for cultural or religious rituals. As Adler (2011) argues, if a medical procedure is neither clinically necessary nor recommended, it may be unlawful for Medicare to fund it.

As to the first point, I do not wish to make an argument about the ethics of religious and culturally motivated
circumcision, but point out that the timing of the operation in these instances is not dictated by health considerations or the best interests of the child, but by the traditions of the culture. Most circumcision cultures perform the operation around puberty, signifying the boy’s (and in most cases also the girl’s) transition from childhood to adult responsibility. Exceptions to this pattern are found in Islam, which sets no specific age and imposes no obligation on parents to circumcise their children (Aldeeb Abu-Sahlieh, 1994); and in Judaism, which (uniquely) prescribes circumcision in early infancy (the eighth day). There was never any “health logic” to these rules, which were purely a matter of tribal custom or religious tradition (Glick, 2005).

As indicated above, the AAP is quite isolated in its support for circumcision, moderate and equivocal though it is. More typical of world opinion are the policies of the Royal Australasian College of Physicians (RACP) and the Canadian Paediatric Society (CPS). After a comprehensive analysis of the relevant literature, the RACP concluded that “the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia or New Zealand” (RACP, 2010, p. 5). The CPS, Fetus and Newborn Committee (2015) concurs, “While there may be a benefit for some boys in high-risk populations . . . the Canadian Paediatric Society does not recommend the routine circumcision of every newborn male” (p. 311). What makes the position of both these bodies all the more significant is that they reached this conclusion on the basis of a narrow calculus of risks and benefits and paid little attention to the value of the foreskin to the individual and his possible wishes in later life. There has never been a comprehensive assessment of the complications of circumcision, some of which (such as excessive tissue removal, leading to uncomfortable erections) may not become evident until after puberty (Peterson, 2001). The value of the foreskin itself as a functional body part that the individual might want to keep and enjoy has rarely been factored into such harm–benefit calculations as have been attempted. Both the reviews mentioned above and the policy statements of medical authorities acknowledge evidence from Africa that circumcision of adult males can reduce their risk of acquiring HIV through unprotected intercourse with an infected female partner in regions of high heterosexual HIV prevalence. But they point out that these conditions are not present in developed countries and that children, not being sexually active, are not at risk of sexually transmitted HIV (Bossio et al., 2014; Lyons, 2013). It is, therefore, far from clear that circumcision does confer the benefits claimed by its promoters, undermining the premise of both versions of the argument outlined above.

Questions of Logic and Evidence

These considerations bring us to the next stage of the argument: that even if premise 1—that circumcision did confer lifelong health benefits—were granted, it would not follow that the operation may ethically be performed on minors. The argument of those who advocate routine neonatal circumcision is now so familiar that it hardly needs detailed exposition: The health benefits of circumcision accrue to the circumcised infant, on a probabilistic basis, at future points in his life, some in infancy or childhood, but the bulk (and most significant) in adulthood. They include such advantages as a reduced risk of urinary tract infections (UTIs), phimosis and minor penile problems in childhood, and of STIs and rare forms of cancer in maturity. This list corresponds closely to the Victorian trilogy that circumcision prevented masturbation in childhood, syphilis in maturity, and cancer in old age (Darby, 2005). The principal pillar of the case for circumcision is not, therefore, the claim that it meets the health needs of the infant or child, but that it improves the health prospects of the adult he will later become. These future benefits, it is claimed, not only outweigh the risks and harms (physical, psychological, and emotional) of the procedure but also justify (or even require) the widespread adoption of circumcision as a preventive measure of public health.

None of these claims follows logically from the evidence. Because the major benefits claimed—reduction in the risk of STIs (including HIV)—can be enjoyed only by mature and sexually active males, the logical prescription arising from the premise is to provide the information to young adults and allow them to elect to have their own foreskins removed if they judge it to be prudent and are willing to face the risks and losses. This would correspond to voluntary medical male circumcision (VMMC), as recommended by the World Health Organisation in regions with epidemic levels of heterosexually transmitted HIV and low circumcision prevalence. The fact that few adult males in developed nations choose to have themselves circumcised, and that forcing men to submit to circumcision would be a criminal assault under any legal code (or, if legally sanctioned, a gross violation of personal autonomy and individual human rights), is in itself a powerful argument that it would be unethical to perform the same operation on infants or children, who cannot resist.

Health Benefits of Circumcision

The health benefits claimed for circumcision fall into three categories: (a) benefits to the person as a child, (b) benefits to him as an adult, and (c) benefits to hypothetical third parties.

Children

If pathological phimosis and UTIs (the principal benefits claimed for early circumcision) were as common and as infectious as, say, chicken pox and frequently fatal (or as crippling as polio); if there were no effective treatments; and if all boys were at equally high risk of these problems, it might indeed be ethical to circumcise them in infancy as a
precaution. These conditions do not, however, apply. Pathological (as opposed to physiological) phimosis\textsuperscript{11} is an uncommon condition, affecting approximately 0.6% of boys by age 15 (or 0.04 cases per 100 person years), and it is usually curable by application of steroid ointment (Ashfield, Nickel, Siemens, MacNeily, & Nickel, 2003; Shanker & Rickwood, 1999). Minor penis problems grouped under the heading “balanitis,” if they arise, can usually be treated without the need for surgery (Edwards, Bunker, Ziller, & van der Meijden, 2014). Although severe persistent phimosis plus poor hygiene may increase the risk of cancer of the penis in later life, it is not in itself a pathological condition, and in most cases causes little more harm than intermittent discomfort. Any adult so inconvenienced can easily take the necessary medical or surgical steps. UTIs are also a rare condition, affecting about 8% of girls and 2% of boys by age 7, and usually associated with congenital abnormalities of the urinary tract or bladder, or a preterm birth; most cases are readily cured with antibiotics (Sureshkumar, Jones, Cumming, & Craig, 2009). Persistent recurrent infections may be an indication for circumcision, but that is no justification for performing the operation in advance of proven pathology (Na, Tanny, & Hutson, 2015; Williams, Hodson, Isaacs, & Craig, 2012).\textsuperscript{12} Breast-feeding is highly protective against UTIs (Marild, Hansson, Jodal, Odén, & Svedberg, 2004).

**Adults**

The benefits of circumcision to adult males are said to be reduced risk of STIs (including HIV) and cancer of the penis. The first point to make is that there is no consistent evidence that circumcision does reduce the risk of STIs: Some studies show uncircumcised men to be at greater risk of some STIs; others that there is no difference; and yet others that circumcised men are at greater risk of some infections.\textsuperscript{13} There is certainly no evidence that a high incidence of circumcision is doing anything to restrain the spread of STIs in the United States, which exhibits a far higher STI incidence than Europe, where circumcision is rare (Centers for Disease Control, 2015; Paul, 2005). Whereas the prevalence of chlamydia, gonorrhea, and syphilis has declined steadily in Europe since 1980, in the United States the incidence of all three has steadily increased, and the incidence of gonorrhea is 20 times higher: more than 100 cases per 100,000 persons, compared with about five in Europe. Even more alarming is the far higher incidence of HIV in the United States, particularly in some cities: Washington, D.C., reports an incidence of 179.56 per 100,000—very similar to the epidemic levels found in sub-Saharan Africa (“Americans Are More Likely to Have an STD Than Europeans,” 2015; Online Doctor, 2015).

These comparisons might be rejected on the basis that they suffer from the “ecological fallacy”—that broad population groups cannot validly be compared for statistical purposes because this does not allow specific variables, such as circumcision status, to be distinguished. It could be claimed, for example, that in Europe, all the STI cases occur in uncircumcised men and none in the circumcised. Against this gambit, there is an increasing body of specifically U.S. research comparing circumcised with uncircumcised men showing that circumcision does not reduce the risk of STI transmission or may even increase it. A study of men attending sexually transmitted disease clinics in the United States (Crosby & Charnigo, 2013) found that circumcised men had double the incidence of STIs and were significantly less likely to use condoms. This is the first U.S. study of condom use that compared circumcised with normal men, and reached a conclusion strongly at variance with the popular perception that circumcised men are less susceptible to STIs and find it easier to use condoms. On the contrary, as Crosby and Charnigo (2013) point out,

> These findings suggest quite the opposite in that intact men were less likely to report UVs [unprotected vaginal sex] and less likely to report infrequent condom use compared with their circumcised counterparts. These two observations are quite consistent with the descriptive finding that showed a greater than two-fold past history of STIs for circumcised men compared with intact men. (p. 177)

A further study (Crosby et al., 2015), this time of men who have sex with men (MSM) in a southern U.S. city with an “extremely high” HIV prevalence, found that there was no difference in the incidence of HIV and other STIs between circumcised and uncircumcised partners. The study also found that circumcised men were twice as likely not to wear a condom when taking the active role in intercourse. The key point is that because condoms (even if worn inconsistently) are the most effective means of HIV prevention, anything that discourages condom use raises the risk of infection with HIV and other STIs.

The second point is that the greatest risk factor for all these diseases is a multiplicity of sexual partners, meaning that they can be avoided by appropriate behavioral choices: care in selection of partners and commitment to safe sex, including consistent condom use in penetrative sex. The third point is that most STIs are readily cured with antibiotics. An adult male is entitled to choose circumcision in preference to a course of penicillin, but it is far from an obviously rational decision, and it is certainly not one that an adult is entitled to make on behalf of a child. HIV remains incurable (though no longer fatal and now manageable by anti-retroviral therapy), but adult males are at high risk of STIs only if they engage in high-risk sexual behavior. In the developed world, moreover, unlike in Africa, HIV is not a heterosexual epidemic, but a relatively rare disease largely confined to the sub-cultures where it originated: homosexual men and injecting drug users, neither of which groups derives any risk reduction through circumcision (Darby & Van Howe, 2011).\textsuperscript{14} Because the only means by which children could contract HIV is through surgical procedures and blood transfusions, it is not necessary to circumcise them as a precaution.
In the case of genital cancers and human papilloma virus (HPV), similar points apply. Since the days of Jonathan Hutchinson (Darby, 2005), circumcision advocates have made much of the value of circumcision in preventing cancer of the penis (Morris et al., 2011). Whether or not it does so is less significant than the fact that penile cancer is a rare disease of older men—so rare that accurate statistics on incidence are difficult to find, and so rare that it is even less common than male breast cancer. The American Cancer Society (2016) estimates that 2,600 cases of male breast cancer will be diagnosed in 2016 and that 440 men will die of it. The figures for cancer of the penis are 2,030 cases and 340 deaths. If prophylactic removal of infant male breasts is not recommended as a breast cancer preventive, there is certainly no need for prophylactic removal of the foreskin as a penile cancer preventive. Replying to recent media claims, the Australian Cancer Council (2012) warns that the evidence of circumcision having a protective effect was not sufficient to justify the operation on children. Because cancer of the penis is usually associated with severe, persistent phimosis, an adult male can reduce the danger by seeking either medical or surgical treatment for the condition. Because HPV—certain strains of which are now thought to be a causative or predisposing agent—is spread by sexual contact, it is an infection that only sexually active adults can contract, and there is no conclusive evidence from developed countries that uncircumcised men are at any greater risk than the circumcised (Albero et al., 2014; VanBuskirk et al., 2011; Weaver et al., 2004). The introduction of an effective vaccine for both girls and boys, moreover, offers far greater protection than anything conferred by surgical alteration of the genital anatomy. An adult male may prefer to get himself circumcised instead, but that does not oblige him to impose this option on his children.

Third Parties

The third category is benefits to hypothetical others, namely, the suggestion that boys ought to be circumcised to reduce the risk of cervical cancer in future female sexual partners. As Darby (2015) argues, however, the idea is morally untenable, for even if it were true that having an uncircumcised partner increased a woman’s risk of HPV infection and thus cervical cancer, it is not ethically permissible to remove the offending body part from a non-consenting child on the basis that he might later become infected with HPV and might then go on to infect hypothetical sexual partners sometime in the future. Nobody would regard it as ethically acceptable to take a child’s blood, bone marrow, or any internal organ, even if the transaction were sure to benefit another person who might die without them; it cannot, therefore, be ethical to remove a child’s foreskin in the hope of providing a less substantial benefit (risk reduction) to somebody whose identity is unknown. As Beauchamp and Childress (2009) comment, obligations of non-maleficence are more stringent than obligations of beneficence, and in some cases non-maleficence overrides beneficence, even if the best utilitarian outcome could be obtained by acting beneficently. If a surgeon, for example, could save two innocent lives by killing a prisoner on death row to retrieve his heart and liver for transplantation, this outcome would have the highest net utility . . . but the surgeon’s actions would be morally indefensible. (p. 150)

With rare exceptions, medical interventions are permissible only when they are intended to benefit the person being treated. While it is legitimate for a donor to supply bone marrow or a kidney, even though the operation benefits only the recipient, this is on the basis that the donor volunteers and understands what is at stake. It would be a gross violation of medical ethics for any body part to be taken by force or without informed consent, no matter how great the advantage to the recipient.

Bioethical and Human Rights Principles

Because most circumcision advocacy places little emphasis on bioethical and human rights issues, it is well to be reminded of the basic principles of bioethics as set out by Beauchamp and Childress (2009): autonomy (requiring respect for informed choice), non-maleficence (not doing harm), beneficence (doing good), proportionality (ensuring that the outcome of the intervention provides a significant net benefit to the patient in relation to the risks run and the losses sustained), and justice (treating the person fairly). To establish the legitimacy of circumcision of non-consenting children, it is necessary to show that the operation is consistent with these principles, but it is difficult to find any circumcision advocacy that discusses them in detail. Some circumcision advocates seek to reverse the onus of proof by suggesting that not circumcising a boy is a violation of his human rights because it denies him both protection against the health risks attributable to the foreskin and the advantages accruing from its removal (Bates et al., 2013). But this is to assume that the benefits of circumcision are as great as claimed (the very point in dispute), that the foreskin is worthless and its removal not a deprivation or even a harm, and that the boy’s own possible future preferences are of no account.

To take the question of harm, despite arguments to the contrary by some moderate (parental choice) supporters of NTC, it cannot plausibly be maintained that excision of the foreskin is not a harm. Removal of normal tissue is not necessarily a harm, for few people would be likely to mind if a healthy appendix was extracted as a precaution, as it is imperceptible and has no psychological significance. The genitals are a different matter: A visually prominent component of a body part as sexually significant as the penis will never be regarded with the same indifference, neither by admirers nor detractors. Some advocates have likened circumcision to minor surgical procedures such as cleft palate or hare lip repair or even orthodontic treatment; but the comparison fails because these are...
therapeutic procedures aimed at restoring anatomical normality and full physiological functionality. Moreover, as Brian Earp (2015b) points out, there is no evidence that the beneficiaries of these interventions object to what was done to them. While we can observe a voluble anti-circumcision movement in the United States and elsewhere, and cohorts of men who deeply resent their circumcision and seek to restore their foreskins (Watson, 2015), it is not possible to detect any anti-cleft lip repair movements or a surge of online communities dedicated to recovering their crooked teeth. Leading exponents of the view that parents have the right to circumcise their boys acknowledge that circumcision is a harm, but argue that it is not sufficiently harmful to warrant prohibition (Benatar & Benatar, 2003; Cannold, 2006). That may be so, but the argument here is not whether NTC of minors should be illegal, but whether it is of “compelling” net medical benefit and ethically permissible.

Open Future, Best Interests, and Substituted Judgment

Fundamental as they are, the Beauchamp and Childress principles are not the only guidelines to be considered when we perform surgical procedures on children. There is also the question of the child’s right to an open future, the best interests and substituted judgment tests, and the increasingly prominent matter of human rights. These include a person’s right to physical integrity, as embodied in much Western law and custom, and in certain international human rights treaties and declarations. These rights are now generally accepted as applying to girls, but if they are human rights they must, logically, apply to boys as well (DeLaet, 2009; Hellsten, 2004; James, 1994; Johnson, 2010; Svoboda & Darby, 2008). In the Victorian era that gave birth to circumcision, children were to be seen but not heard and medical ethics were rudimentary; but during the 20th century, the slow human rights revolution (Pinker, 2011) that began with John Locke reached children, who are now seen as possessing the same sort of rights to bodily integrity and protection from harm that adults enjoy (Orend, 2002). This does not mean that children have equal rights as adults, but, as Brennan and Noggle (1997) argue, that they are entitled to the same moral consideration as adults because they are persons. At the same time, children may be treated differently from adults by virtue of their immaturity and dependent status, and parents have real but limited authority to direct their upbringing. As Tobin (2013) recently argues, because children have interests, they also have rights, even though they (temporarily) lack the capacity to articulate, much less enforce, them. The concept of the child’s right to an open future can provide a bridge between the child’s temporary lack of capacity and the preservation of his long-term interests.

The child’s right to an open future is an accepted principle in legal philosophy, applied to bioethical issues by Dena Davis (1997, 2001) and in recent times specifically to circumcision (Darby, 2013a; Hainz, 2015; Sarajlic, 2014) and surgical treatment of hypospadias (Carmack, Notini, & Earp, 2015). The principle holds that children are adults-to-be, and that it is the duty of parents to make efforts to preserve and protect their options so that they can make choices about matters of personal preference for themselves in adulthood. This applies not only to the provision of affection, food, shelter and education but also to freedom from irreversible and potentially harmful decisions about their body that they might later resent. If this extension is valid, the open future principle would allow parents to compel children to brush their teeth and prevent them from getting obtrusive marks such as a tattoo, a nose-ring, or permanent genital modifications, and at the same time would constrain them from imposing such modifications. It would preclude deaf parents who believe that deafness is a valid culture from deliberately causing their children to be deaf. Forcing children to clean their teeth, preventing them from smoking, and preserving their foreskin all have the same rationale and objective: to maintain the body for future use and to ensure that the future adult will be able to make his own decisions about such matters when he becomes responsible for his own self-management.

“Best interests” and “substituted judgment” are two tests that may be applied when decisions have to be made on behalf of those incompetent to make them for themselves, whether minors or disabled adults. “Best interests” are the long-term interests of the person as a person, taking account of the society in which he or she lives, interests, skills, hopes, wishes, values, self-image (among others), and if a minor the person’s interests in the future, as an adult. In the case of Re J—Child’s Religious Upbringing and Circumcision (2000), for example, an English court determined that it would not be in his best interests for a 6-year-old boy to be circumcised merely because his Muslim father wanted him to be. A similar conclusion was reached by the Family Court of Australia (2003) in the case of K and H. It would, however, be in the child’s best interests to be given necessary therapeutic medical treatment, such as a life-saving blood transfusion, even if his parents were Jehovah’s Witnesses, whose religion prohibited such procedures. It would also be in his best interests to be vaccinated against serious diseases, such as hepatitis B, if he was at risk of infection (say from a parent with the disease), even if the parents were philosophically opposed to vaccination (Isaacs, 2009). In both cases, the child’s welfare trumps the parents’ wishes. When medical treatment is either necessary to save a person’s life, or provides proven and substantial benefits (such as immunity to serious diseases) without harm, loss of body parts or function, and without a significant risk of complications, it is acceptable to provide it without the informed consent of the recipient.

The other test is the substituted judgment test—the option that an incompetent person would be most likely to choose for himself if he were competent to form and express an opinion (Beauchamp & Childress, 2009). Analyzing this concept, the legal scholar James Dwyer (1994) suggests that
children should not have fewer rights than or be treated with less consideration than incompetent adults. Dwyer acknowledges that infants and young children would not have shown much evidence of preferences on any aspect of their lives, but does not regard this as invalidating the substituted judgment principle so long as there are reasonable grounds for determining what the incompetent person would choose if he or she were competent. One way of establishing the answer in relation to medical issues is to ask what competent adults choose when faced with the same question. Most adults would agree to a blood transfusion if it meant the difference between life and death, and most would agree to get vaccinated against a serious disease if they were likely to be exposed to it and at risk of infection. The case of circumcision is even more clear-cut: Because a negligible number of adult men in Western societies elect circumcision for themselves, we may reasonably infer that if the average minor were asked whether he wanted to get circumcised he would refuse.

**The Case for Infant Circumcision?**

If the health benefits are not as great as claimed and the important ones can be secured by voluntary circumcision in adulthood, and if the ethical objections to NTC of minors are greater than circumcision advocates allow, it follows that the case for infant circumcision has not been made. The reasons given for insisting on it in commentaries by Tobian, Gray, Morris, and, with less enthusiasm, the AAP place too much emphasis on the wishes of adults and not enough on the interests and autonomy of the child. Instead, they scarcely go beyond the narrow utilitarianism of Miller and Snyder: that it is simpler, more convenient, cheaper, less painful, and attended with fewer complications than if done later. The first three points show insufficient regard for the interests of the child, his autonomy, or even his personhood, but focus entirely on the needs of adults and impersonal health systems. They are questionable because they ignore the fundamental point that medical interventions are not normally permissible unless their intent, rationale, and result are to benefit the person being treated. Procedures intended to benefit other parties, as is the case if they are performed for reasons of economy, convenience, or simplicity (here meaning that a baby is more easily persuaded than an adult), fail both the non-maleficence and beneficence tests and are plainly unacceptable. By analogy, it is probably cheaper and more convenient to have sex with an unwilling 5-year-old than with an unwilling adult, but that does not make the practice desirable.

If it is cheaper to circumcise children rather than adults this is only because infants are usually circumcised as part of larger process (the childbirth sequence), with inadequate anesthesia, or none at all (Bellieni, Alagna, & Buoncore, 2013; Paix & Peterson, 2012). Given the dense innervation of the foreskin (Cold & Taylor, 1999), any cutting in that area is intensely painful, no matter what the age, but circumcision is probably less painful for an adult because he can be given both effective anesthesia and post-operative pain control, and he can articulate his needs. To circumcise without effective anesthesia would be a gross violation of the non-maleficence principle and extremely cruel: even supporters of a parental right to circumcise regard such an omission as ethically unacceptable (Benatar & Benatar, 2003). Research into the effects and complications of circumcision is too inadequate for anybody to know whether it is safer and less harmful in infancy, childhood, or maturity. If mere cheapness is the aim of health care, the best policy is to avoid unnecessary surgeries (Van Howe, 2004). The “increased cost” argument is based on the false assumption that circumcision will be necessary at a later stage: In the vast majority of cases, circumcision will not be necessary, meaning that there will be no costs at all.

A disturbing feature of much current circumcision advocacy is the underlying assumption that the biomedical evidence “speaks for itself”; once the evidence is available, public policy should follow automatically as a logical consequence. As de Camargo, Mendonca, Perrey, and Giami (2015) comment, however, this is a technocratic and authoritarian approach that over-simplifies the complexities of medical decision making, ignores social and other contextual factors, dismisses bioethical and human rights principles as nebulous, and considers “subjective” issues such as the value of the foreskin and the preferences of the individual to be irrelevant. Savulescu (2015) similarly warns against the tendency to “scientify” everything: “Evidence will tell us what to do, people believe. But what constitutes sufficient evidence is an ethical decision,” as is weighing risk and benefit (p. 30). “Ethics is not peripheral to medicine and research—it is central. What you study will determine what you find” (p. 30). We typically hear arguments that circumcision is justified or not justified on the basis that the benefits exceed the risks of the surgery or that the risks of surgery exceed the benefits. But the risk–benefit rule was devised for therapeutic procedures, where there is a pathological condition that requires treatment. In the case of normal male infants and boys, there is no pathology to treat, meaning that circumcision is a non-therapeutic procedure, and hence should be governed by far stricter rules. In the case of minors, who by definition cannot give consent, the rules should be stricter still. Furthermore, as Buchanan (1983) points out, risk–benefit equations are not merely clinical (objective) calculations, but moral judgments about a person’s values and how he wishes to manage his life. The principal quasi-ethical argument commonly advanced by circumcision advocates is that parents are entitled to make medical decisions for their children; because it is widely agreed that parents can provide surrogate consent for a child to be vaccinated, they can equally provide consent for a child to be circumcised. This proposition is highly dubious. Although circumcision advocates have sought to liken circumcision to vaccination, there...
are fundamental differences in mode of operation, effectiveness, and personal outcomes, both bodily and psychological (Forbes, 2009; Lyons, 2013). A logically invalid analogy does nothing to support the case for circumcision.

**Parental Rights or Parental Duties?**

As for the parental rights argument, it is not parents who need rights over their children, because they already have full power over them. Parents have authority, but because children are vulnerable, and infants a powerless and even voiceless group, in need of special protection, they are the ones who require and possess rights, and society places limits, both moral and legal, on how parents may treat them. Parents may not sell their children into slavery, subject them to unreasonable corporal punishment, or have sex with them; on the positive side, they must nurture and care for their children, provide them with an adequate education, and socialize them into the ways of society. It follows that parents do not have an unfettered right to choose medical treatments for their children, and it has been argued that parents have no legal right to authorize controversial or non-recommended medical treatments for their children, and certainly not if it involves unnecessary removal of healthy body parts (Povenmire, 1998-99). Forty years ago, William Bartholome was concerned about the wide discretion conferred by proxy consent and disputed the assumption that parents had “the right to make all medical care decisions involving a minor child.” Because children, in his view, belonged primarily to themselves, he proposed the following principles for pediatric care:

1. Any proposed medical intervention that could be delayed, without significant adverse consequences, until the child could provide his own consent would be *prima facie* wrong.

2. Any medical intervention for which there is no demonstrable need would be *prima facie* wrong—e.g., circumcision.

3. Any medical intervention that holds out the prospect of demonstrable benefit to the child whose life or well-being were in jeopardy would be *prima facie* obligatory—e.g., immunizations. (Bartholome, 1981, pp. 271-272, 275)

In other words, what parents have is an obligation to protect their children’s rights and provide appropriate, beneficial, and needed treatment that is manifestly in the child’s best interests, has regard to the open future principle, and satisfies their children’s rights and provide appropriate, beneficial, and needed treatment that is manifestly in the child’s best interests, has regard to the open future principle, and satisfies the substituted judgment test—that it was a decision a reasonable adult would be expected to reach for himself. A parent is not entitled to provide a sick child with harmful, inappropriate, or spurious treatments (such as faith healing or bogus “alternative” cures), or to deny a healthy child vaccination against serious diseases of which he is at risk (Isaacs, 2009). Rejecting the argument that observance of a “harm threshold” is an adequate yardstick for parental decisions about medical treatment of children, Birchley (2016a, 2016b) argues that parents are not automatically entitled to deny them beneficial and necessary treatments; and, it follows that they are not entitled to impose harmful or unnecessary treatments. In these situations, medical personnel may be entitled (even morally obliged) to override parental wishes, either by insisting on a beneficial intervention to which parents object, or by refusing an intervention that parents have sought. It is reasonable for parents to have their children vaccinated against the risk of future diseases because such prophylaxis protects them and the community from diseases that affect them as children and does not deprive them of a normal body part. Vaccination may thus be assessed as being in the child’s best interests and also—as shown by the fact that adult men regularly get themselves vaccinated—as passing the substituted judgment test. As Beauchamp and Childress (2009) point out,

> Best interest judgments are meant to focus attention entirely on the value of the life for the person who must live it, not on the value of the person’s life for others. “Quality-of-life” judgments also concern only the individual’s best interests, not his or her worth to enhance another’s quality of life. (p. 140)

It follows that, barring a genuine pathological condition for which circumcision is the only cure, the only person entitled to make a health-based decision about such surgery is the person who must live with the consequences.

**Routine Peripubertal Circumcision?**

Recognizing that if circumcision does offer significant health benefits they do not apply until adulthood, some commentators have suggested that infant circumcision be abolished and replaced with “elective” circumcision in late childhood or early adolescence (around 11 years of age). As MacDonald (2011) points out,

> There is no new evidence that infant circumcision provides any added benefit to the neonate, infant or young child with respect to HIV and HPV protection. The potential benefit from circumcision only begins to accrue when the male becomes sexually active. (p. 872)

Accordingly, “the important question for . . . pediatric societies is not about a change in infant circumcision recommendations, but rather the need to address whether there would be merit in routine peripubertal male circumcision.” This is an interesting idea, but there is clearly a difference between offering circumcision to an 11-year-old boy and performing it routinely at that age, as in South Korea or the Philippines (Glick, 2009; Kim & Pang, 2002), and MacDonald goes on to make the dubious suggestion that an 11-year-old can give informed consent. Although a boy at that age would indeed be more competent to give informed consent than he was at 6 weeks or 6 months, it is still difficult to accept that he would have sufficient competence to consent to an
irreversible alteration to a central part of his genital anatomy. Few boys of that age would have adequate maturity of judgment or knowledge of both what the operation entailed and its short- and long-term consequences, and many would be subject to such strong parental, peer, and social pressures that they would not be capable of making a free choice. The earliest age at which a person is held to be competent to consent to sexual relations is 16 or 18; it is hard to see why the rules for irreversible genital alterations should be less strict than those governing sexual relations.

MacDonald’s suggestion was picked up by the Canadian media, and attracted comments that demonstrated, yet again, the depth of the Anglophone assumption that circumcision means circumcision of infants. One medical practitioner was reported as stating that the idea was unacceptable because “If you explain to any 11-year-old what you were proposing, likely an 11-year-old would never consent to have that done.” Quite—for as a reader of the National Post (“Simon of Toronto”) commented, it would be hard to find a more convincing ethical argument as to why circumcision of children should not be done at all:

“That’s about as solid an argument against circumcision as anybody should need. Basically, he’s saying that the best reason to cut babies is because they can’t tell you to stop. It neatly—and brutally—clarifies the moral injustice of the practice. (Kirkey & Fraiman, 2011)

The AAP (2012) concedes that

Newborn males who are not circumcised at birth are much less likely to elect circumcision in adolescence or early adulthood. Parents who are considering deferring circumcision should be explicitly informed that circumcision performed later in life has increased risks and costs. (p. e760)

So although the AAP does not recommend circumcision, it still puts strong pressure on parents to have it done. Brian Morris (1999) similarly admits that if the circumcision choice were left to them, many boys would make the “wrong” decision. “Parental responsibility must override arguments based on the rights of the child,” he writes, “parents have the legal right to authorise surgical procedures in the best interests of their children” (pp. 61-62). When they are old enough to give legal consent, males “are reluctant to confront such issues” and are neither “mature nor well-informed enough” to make the right decision for themselves. In other words, Morris concedes that if doctors waited until boys were old enough to make up their own mind, most would not consent to the operation. It would be hard to think of a stronger argument as to why circumcision should not be done before the person is able to provide informed consent.

**Conclusion**

I have sought to show that recent restatements of the medical case for NTC of normal infants fail on three major points, one ethical, one medical, and one logical. They do not demonstrate that circumcision of non-consenting minors is permissible within accepted principles of bioethics and human rights; they fail to establish that the benefits are sufficiently great to outweigh the harms and risks; and, they do not show that circumcision must be performed in infancy to secure the major benefits claimed for it. Even if it were true that circumcision did confer all the health benefits claimed, and ignoring such unsettled questions as complications and the harms arising from loss of the foreskin, the ethical principles governing surrogate consent for surgical procedures on incompetent persons would not allow the operation to be performed on normal infants or other minors. Even if circumcision did confer a significant reduction in the risk of contracting certain diseases in adulthood, such as STIs, it does not follow that circumcision must be performed in infancy. If that were the case, the expensive African programs for mass circumcision of adults as a tactic against heterosexually acquired HIV would be pointless. Despite mounting concern that these programs are less effective and more risky than commonly believed, advocates still consider circumcision as a means of reducing the risk of HIV and other STIs to be no less effective in adulthood as in childhood.

That being so, why do their arguments for circumcision in developed countries such as the United States and Australia focus on circumcision of infants? I have argued that the answer to this question leads us into an ethical and logical void: The preference for circumcising infants has little to do with the greater efficacy of the intervention in early life, and almost everything to do with its mechanics. Adult men are usually reluctant to be circumcised and are not readily coerced; infants and children have less power to resist and can easily be compelled to submit. Because they are incapable of saying no, children are a softer target. The notion of infancy as the “best time to circumcise” is based on the assumption that prophylactic circumcision is desirable for all and that it will be necessary at some point: If later, the argument goes, why not do it now and get it over with (Wallerstein, 1980)? But if prophylactic circumcision is neither desirable nor necessary, and if unnecessary surgery is “bad” surgery (Begg, 1953, p. 604), the only appropriate times to circumcise are when it is clinically necessary to address a problem that has not responded to medical treatment; or, when a competent male elects the operation for himself and gives his informed consent.

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**Notes**

1. I refer particularly to Morris (1999); Morris, Bailis, Castellsague, Wiswell, and Halperin (2006); Morris (2007); Tobian and Gray (2011); Morris, Wodak, et al. (2012); Morris, Waskett, et al.
(2012); and American Academy of Pediatrics (AAP; 2012). Unless otherwise indicated, in this article, circumcision means medically rationalized, NTC of male infants and other minors, that is, circumcision performed on normal children in the belief that it will improve their future health prospects. I am not concerned with NTC performed for religious or other cultural reasons. I follow the definition of non-therapeutic circumcision given by the Tasmania Law Reform Institute (2009):

A circumcision is non-therapeutic if it is performed for any reason other than remedying or treating an existing disease, illness or deformity of the body . . . A circumcision performed for the purpose of preventing or reducing the likelihood of possible future disease, illness or deformity of the body (a prophylactic circumcision) is a non-therapeutic circumcision. (p. 7)

As the Australasian College of Surgeons points out, “male NTC is not clinically necessary as it does not treat an underlying pathological process” (Australian Safety and Efficacy Register of New Intervventional Procedures [ASERNIP], 2008, p. 3).

2. Such as spermatorrhoea: see Rosenman (2003, Chapter 1) and Darby (2005, Chapter 8).
3. As well it might, especially as no anesthetic was provided.
4. Statements from pediatric bodies are collected at http://www.cirp.org/library/statements/ and http://www.circinfo.org/doctors.html
5. See references in Note 1.
6. The somewhat equivocal position of the American Academy of Pediatrics (AAP) is discussed below.
7. These include Canadian Paediatric Society (CPS), Fetus and Newborn Committee (2015); British Medical Association (2007); Royal Dutch Medical Association (2010); and Royal Australasian College of Physicians (RACP, 2010).
8. I do not discuss the “guidelines” on circumcision issued by the Centers for Disease Control in December 2014 because the document is merely an exposure draft for public comment and has no official status. Although cited by defenders of routine circumcision, the document is vulnerable to many of the same criticisms that have been leveled at the AAP policy statement. For a thorough critique, see Earp (2015a).
9. For an analysis of the weakness of the risk/benefit paradigm, see Darby (2015).
10. As indicated in Australia by claims for reimbursement from Medicare, the national health insurance scheme.
11. Pathological phimosis is usually associated with some sort of infection, such as lichen sclerosus; physiological phimosis is a normal developmental stage that most boys grow out of naturally. The difference is explained in Dewan (2003) and McGregor, Pike, and Leonard (2007).
12. Curiously, and suggestive of a certain schizophrenia within the organization, the AAP’s (2011) policy statement on management of urinary tract infections (UTIs) does not recommend circumcision as a preventive, but discusses it only as a treatment in intractable cases.
13. The list of studies is as vast as it is inconclusive, but see Laumann, Masi, and Zuckerman (1997); Dickson, van Roode, Herbsion, and Paul (2008); Ferris et al. (2010); and Van Howe (2013).
14. There is a disturbing increase in HIV incidence among heterosexual African Americans, whose lifetime risk is considerably greater than other ethnic groups (Sansom et al., 2010). The reasons for this are obscure, but not related to the foreskin, because African Americans exhibit higher circumcision prevalence than either Hispanics or Whites.
15. For a detailed argument, see Darby (2015). There are United States legal decisions stating explicitly that unnecessary surgery is ipso facto harmful: see Adler (2013).
16. Too voluble, according to hostile critics such as Mark Stern (2013).
17. See Note 1.
18. There are no studies comparing complications rates in infant versus adult circumcision, and very few have looked at the complication rates of neonatal and later circumcision based on the same population and using the same definitions. Machmouchi and Alkhotani (2007) find higher complication rates in neonates, whereas Yegane et al. (2006) find no difference. A recent study of child circumcision in Melbourne (Gold, Young, O’Brien, & Babl, 2015) found a higher incidence of complications in boys aged below 4 months. The question is not whether neonatal is safer than circumcision at, say, 2 or 3 years of age, but whether circumcision in childhood (below 16 years) is safer than in adulthood.
19. For example, Tobian and Gray (2011) and Morris, Waskett, et al. (2012).
20. As argued by Boyle and Hill (2011) and Ncayiyana (2011).

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