

Risks, Benefits, Complications and Harms: Neglected Factors in the Current Debate on Non- Therapeutic Circumcision

ABSTRACT. Much of the contemporary debate about the propriety of non-therapeutic circumcision of male infants and boys revolves around the question of risks vs. benefits. With its headline conclusion that the benefits outweigh the risks, the current circumcision policy of the American Academy of Pediatrics [AAP] (released 2012) is a typical instance of this line of thought. Since the AAP states that it cannot assess the true incidence of complications, however, critics have pointed out that this conclusion is unwarranted. In this paper it is argued that the AAP's conclusion is untenable not only for empirical reasons related to lack of data, but also for logical and conceptual reasons: the concept of risk employed—risk of surgical complications—is too narrow to be useful in the circumcision debate. Complications are not the only harms of circumcision: the AAP and other parties debating the pros and cons of circumcision should conceptualize their analysis more broadly as risk of harm vs. prospect of benefit, thereby factoring in the value of the foreskin to the individual and the physical and ethical harms of removing it from a non-consenting child.

INTRODUCTION

Much of the contemporary debate over the propriety of non-therapeutic circumcision of male infants and boys¹ revolves around a simple question: do the “benefits” outweigh the “risks”? Those who consider that the benefits do outweigh the risks fall into two main groups. (1) Strong advocates of circumcision argue that the benefits are so great and the risks so small that boys should be circumcised as a matter of routine, or even that the operation should be compulsory. (2) Weak advocates consider that while the benefits outweigh the risks they are not so great that doctors should recommend the operation, but great enough

to authorize parental discretion. The “strong” position is particularly associated with a grouping around Brian Morris, formerly a professor of biomedical sciences at the University of Sydney and a long-time advocate of universal circumcision (Morris 1999; Morris et al. 2006). The “weak” position is represented in the current circumcision policy statement of the American Academy of Pediatrics (2012), and by certain writers on the ethics of circumcision, such as Benatar and Benatar (2003). (They differ from the AAP, however, in arguing that it is the close balance between risks and benefits that justifies parental choice on the question.) Rejecting these positions are most child health authorities outside the United States, including all other medical bodies that have issued policy statements on circumcision, particularly those in Scandinavia (Finland CUCW 2003; Havskov 2014), Germany (Hartmann 2012), The Netherlands (KNMG 2010), Great Britain (BMA 2006), New Zealand and Australia (RACP 2010); as well as several independent analysts who have made their own survey of the medical literature (Hutcheson 2004; Malone and Steinbrecher 2007; Perera et al. 2010; McDonald 2011). These authorities argue that the benefits of circumcision to children are minimal, non-existent, or outweighed by the risks, and thus that circumcision is not warranted. Some authorities, such as the KNMG, argue that it is so harmful that doctors should actively discourage the practice.

It is the argument of this paper that the risk/benefit paradigm employed in this debate is fundamentally flawed and inadequate to the gravity and complexity of the question being decided: should a boy with normal genitals be allowed to retain his foreskin? The flaw is twofold: first, at the practical level, as critics of the AAP policy have pointed out, nobody has been able to produce a comprehensive risk/benefit calculation that has commanded widespread assent. Secondly, at the conceptual level, the paradigm is based on a false analogy between circumcision and therapeutic procedures to treat illness or injury that may entail nothing more than the administration of drugs. Even when the therapy involves surgery, it may be no more than an incision to repair something inside the body (as with a hernia operation), or at worst the removal of an insignificant or incurably diseased or injured body part (such as the appendix or a gangrened limb). Such operations are not analogous to surgery that amputates a healthy, functional, visible element from a sensitive organ of great significance to most males, particularly when done without their consent.

The risk/benefit paradigm is inadequate because it treats risk as nothing more than risk of surgical complications and—because it assigns little or

no value to the foreskin—ignores the harms resulting from its removal. To be adequate to a question as controversial and emotional as circumcision, the paradigm should rather be cast in terms of prospect of benefit vs. risk of harm, thus factoring in the value of the foreskin to the individual and the moral harms of denying him autonomy and choice in a highly personal decision. A boy’s risk of losing his foreskin during a circumcision procedure is 100 percent.

In this paper I shall consider various harms of circumcision, both physical and ethical, and focus on the moderate position, as exemplified by the AAP circumcision policy. Given the prominence of the AAP as a source of medical advice, the worldwide publicity given to its current policy, and the extent to which it is being cited in current debates, the issues canvassed here have more than local significance. The implications of the analysis, moreover, are not confined to the circumcision debate, but are relevant to the bioethics of surgeries on children and other incompetents more generally.²

THE AAP CIRCUMCISION POLICY STATEMENT

It is a sign of the increasingly controversial status of routine circumcision that the American Academy of Pediatrics policy released in August 2012 should have attracted strong dissent, not merely from long-standing critics of circumcision, but from previously uncommitted child health experts in Europe as well. The scale of the dissent is all the more striking given that the policy differs little from the quietly received 1989 statement (which found that circumcision had potential benefits, but not enough to justify it as a routine) or even the 1999 statement, which reached a neutral stance and left it up to the parents (Reis 2012).³ The only major difference in the new policy is that while it continues not to recommend circumcision, it states that the benefits outweigh the risks and are great enough to authorize parental decision-making and payments by health insurance providers. Although this is largely a continuation of the status quo, it is precisely on these points that objections have fallen most heavily.

According to the critics, the AAP policy is flawed because it does not establish that the benefits of circumcision outweigh the risk and does not justify its secondary (but unrelated) contention that the decision about whether a boy should be circumcised should be made by his parents (Frisch et al. 2013; Svoboda and Van Howe 2013). While the brief (widely quoted) statement asserts that “the health benefits of newborn male circumcision

outweigh the risks” (AAP Task Force on Circumcision 2012a) the lengthy (but less readily available) report acknowledges that

The true incidence of complications after newborn circumcision is unknown, in part due to differing definitions of “complication” and differing standards for determining the timing of when a complication has occurred (ie, early or late). Adding to the confusion is the comingling of “early” complications, such as bleeding or infection, with “late” complications such as adhesions and meatal stenosis. (AAP Task Force on Circumcision 2012b, e772)

In its reply to their critics, the AAP admitted that it had not surveyed the literature of complications case reports, but added that the benefits of circumcision “were felt to outweigh the risks of the procedure” (AAP Task Force on Circumcision 2013). As Svoboda and Van Howe (2013, 436) remark, if an accurate estimate of the incidence of complications cannot be achieved, it is logically impossible to reach the conclusion that they are outweighed by the benefits. On the question of “who decides?” there is a now considerable literature arguing that parents do not have the authority to procure non-therapeutic bodily alterations in their children and that it would be contrary to generally accepted principles of bioethics and human rights for doctors to perform such surgeries on their behalf (Dwyer 1994; Povenmire 1998; Lang 2012; Van Howe 2013b; Adler 2013; Testa and Block 2014).

If these criticisms are valid they raise serious doubts about the usefulness of the AAP document as a source of medical advice, but I wish to argue that the statement is flawed in other ways—not just empirically, but at a conceptual level as well. The deeper problem is that the Task Force is operating with an inadequate concept of risk.

RISK OF WHAT?

Although *risk* is one of the most frequently used words in the circumcision report (usually in the phrase “risks and benefits” or risk of disease), and the thrust of the document is to establish that the benefits outweigh the risks, there is no explanation of what is meant by risk. Nonetheless, it is clear from the context that the AAP means risk of surgical or other complications (i.e. adverse outcomes additional to foreskin loss, such as bleeding, infection, meatal stenosis, etc.) arising from the circumcision procedure. The risk/benefit calculation is thus misconstrued at the most basic level because it is taken to mean risk of surgical complications vs. prospect of benefit. This is an interpretation out of line with the prevailing

bioethical standard: as I shall show, the usual and more helpful formulation of the principle is risk of *harm* vs. prospect of benefit. Since the foreskin is an integral part of an organ with profound sexual, psychological, and social significance, the harm of losing it should be factored into the equation. Failure to do so loads the dice to an unacceptable degree: it is akin to arguing that the risks of amputating a leg or arm are nothing more than complications arising from the surgery (bleeding, infection, etc.) and ignoring the usefulness and value of the limb to the individual. (See section below on anatomy and functions of the foreskin.)

The report does speak of harms, such as when it observes that “Reasonable people may disagree as to . . . how the potential medical benefits and potential medical harms of circumcision should be weighed against each other” (AAP Task Force On Circumcision 2012b, e759). But it is clear from a subsequent passage that by harms the Task Force means no more than surgical mishaps, such as those caused by inadequately trained operators or failure to guard against infection:

there is a moral obligation to take reasonable steps to reduce the risk of harm associated with the performance of any surgical intervention. These include ensuring that the providers who perform circumcision have adequate training and demonstrate competence in performing the procedure; the provision of adequate procedural analgesia and postprocedural pain control; and that the risks of infection are minimized. (2012b, e760)

There is no suggestion here that the loss of the foreskin itself could be a harm—despite the admission that it is reasonable to consider “non-medical harms” (social, cultural, religious, and familial) when making a decision about circumcision (2012b). What the AAP means here is that the traditions of circumcising cultures should be respected; but recognition that the harms of circumcision could be social or cultural as well as purely medical leaves open the possibility that a child from a non-circumcising or neutral culture would be harmed by the mere fact of being circumcised.

HARM/BENEFIT

A widely accepted formulation of the risk/benefit principle can be found in a standard text on bioethics, such as the Beauchamp and Childress *Principles*, which states that “physicians routinely base judgments about the most suitable medical treatments on the balance of probable benefits and *harms* to patients” (Beauchamp and Childress 2009, 221). They define risk as a “possible future harm” and harm as “a setback to interests,

particularly in life, health and welfare”—a broad understanding consistent with the World Health Organization’s definition of health as more than the mere absence of disease or injury, but “a state of complete physical, mental and social well-being” (WHO 2006). Beauchamp and Childress go on to define benefit as

something of positive value, such as life or health. . . . Probable benefit is the proper contrast to risk, and benefits are comparable to harms rather than the risk of harms. Thus, we can best conceive risk-benefit relations in terms of a ratio between the probability and magnitude of an anticipated benefit and the probability and magnitude of an anticipated harm. (2009, 222)

This seems to be the standard understanding of the concept. The World Medical Association (2009, 108) defines risk as “the potential for an adverse outcome (harm) to occur.”

When the *British Medical Journal* devoted a special issue to the question, it was called “Balancing benefits and harms in health care” (not benefits and risks, and certainly not benefits and risk of complications). Aronson writes:

Benefits are properly balanced by harms. However, the two are incommensurate and cannot be combined into a ratio. One should therefore talk about the benefit to harm balance, which is a complex function of the seriousness of the problem to be treated, the efficacy and safety of the drug to be used, and the efficacy and safety of other available drugs. (2004, 30)

He is referring to drugs, but there is no reason why the same principles should not apply to surgery. Several papers published in the same issue referred to the harm/benefit ratio as a complex question that could not always be resolved without resort to subjective factors, such as patient values. As Greenhalgh, Kostopoulou, and Harries (2004, 47–50) write, “Even when good scientific data are available, people’s interpretation of risks and benefits will differ,” and they go on to point out that “The balance between benefit and harm in medicine is neither simple nor static. Conclusions derived from clinical trials . . . may not apply to individual patients for a host of genetic, physiological, psychological, and sociocultural reasons.” In his editorial for that issue, Smith (2004) warned that “We need to think about harm all the time” because “every intervention by a doctor . . . carries the potential for harm.”

These comments echo Beauchamp and Childress’s insistence that “obligations of non-maleficence are more stringent than obligations of beneficence: medical interventions are justified only when the harm/benefit

ratio is strongly in favor of the latter” (2009, 150). I suggest that the AAP Task Force paid insufficient attention to the question of harm, and thus remained blind to the possibility that non-therapeutic circumcision of an infant or boy might be harmful even without surgical complications. In the case of a useful but incurably diseased body part, removal would be justified on the basis that the harm of leaving it there would outweigh the harm of its loss, and probably also because the disease had already reduced its value to the individual. But this consideration does not apply to a useful and healthy body part. Here the only medical justification for removal is that it would significantly increase the risk of certain serious diseases to which the individual is at high risk in the foreseeable future; and that the body part is so trivial and unappreciated that the individual would be unlikely to care. Although these calculations are difficult to quantify, we can be confident that the average individual would be far more relaxed about losing his tonsils or appendix than an erotogenic feature of his genitals.

But the flaw in the AAP’s position runs even deeper than this, because even if it were established that the prospect of benefit outweighed the risk of harm, it does not necessarily follow that the decision about whether a boy is allowed to retain his foreskin should be taken out of his hands and made by a third party. Since he is the one who must live with the consequences, it is not clear why he should not be the appropriate person to judge whether the risks of retaining his foreskin are outweighed by its corporeal benefits and the risks of operative complications and side effects. Circumcision is not an ordinary medical procedure, and the penis is not an ordinary body part; since valuations of the foreskin are subjective and vary from one individual to another, a boy might well decide that the risks of retaining the foreskin are outweighed by the benefits of having one. As Beauchamp and Childress point out, risk assessment is highly subjective:

An individual’s perception of risks may differ from an expert’s assessment. Variations may reflect not only different goals and “risk budgets,” but also different qualitative assessments of particular risks, including whether the risks in question are voluntary, controllable, highly salient, novel or dreaded. (2009, 227–28)

The AAP’s position on parental authorization is both ethically suspect and illogical: as Ungar-Sargon (2013) has argued, if there is so much divergence of opinion among the various authorities, how can parents, lacking appropriate knowledge for making judgments about such a

contested medical issue, be expected to make the right decision? Parental choice might be appropriate in the case of cultural or religiously motivated circumcision, but it is hard to see how it could play a decisive part in decisions based on medical benefit. As Dritsas (2001) observed with respect to the AAP's 1999 statement, it appears that the AAP, faced with inconclusive evidence and powerful passions among its members and the public, wished to evade responsibility for the possible results of its advice.

The AAP does not give a figure on how far the benefits of circumcision outweigh the risks, but since it does not consider the benefits great enough to recommend circumcision, it follows that the balance must be fairly fine. This could mean either that both the benefits *and the risks* are substantial (like the old heroic surgery); or equally that both the risks *and the benefits* are minor. Two of the benefits of circumcision listed in the policy statement and report (and constituting all the "new evidence" that is supposed to justify the change of stance) appear to impose risk and harm on a child but little or no prospect of benefit. In the case of Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STIs), children are not sexually active and thus not at risk of these diseases.⁴ When they become sexually active as young adults they are competent to make their own decision about how best to avoid such diseases, and elect circumcision if that is what they desire (Lyons 2013).

A further instance of risk and harm but zero benefit is the suggestion that boys ought to be circumcised to reduce the risk of cervical cancer in future female sexual partners. Since this argument first emerged in the Edwardian period, when observations suggested that Jewish women had a lower incidence of cervical cancer (Glick 2005, 193–96), it can hardly be regarded as "new evidence," though it has been powerfully revived in recent times (Castellsagué et al. 2002); some advocates have gone so far as to suggest that even if circumcision was of no benefit to the boy, it should still be done routinely to protect his future wife (Sandeman 1971, 1985). Such an argument is ethically untenable, for even if it were true that having an uncircumcised partner increased a woman's risk of human papilloma virus (HPV) infection and thus cervical cancer, it is not permissible to remove the offending body part from a non-consenting child on the basis that, as a sexually active adult, he might later become infected with HPV and might then go on to infect hypothetical sexual partners some time in the future. As Beauchamp and Childress comment, medical interventions are permissible only when they are intended to benefit the person being treated: "Best interests judgments are meant to focus attention entirely

on the value of the life for the person who must live it, not on the value the person's life has for others" (2009, 140). The best interests standard should not be interpreted in such a way as to privilege "values irrelevant to the individual's benefits or burdens." Indeed, as Waldeck (2003, 485–89) points out, to circumcise a boy for this reason might also be unlawful, as the person bearing the risks and harms of the surgery is not the person reaping the benefit. Research suggesting that uncircumcised men were more likely to harbour HPV has been disputed (Van Buskirk et al. 2011; Vardas et al. 2011), while the development of safe, effective vaccines is rapidly making the question of circumcision in this context irrelevant (Clothier et al. 2013; The Kirby Institute 2013).

DOES THE FORESKIN HAVE ANY VALUE?

The foreskin is an anatomical structure common to the genitals of all mammals, male and female, particularly well developed in human and non-human primates. In females it is known as the clitoral hood. In males it is the double-sleeve of soft, sensitive, highly elastic tissue that forms the covering of the penis and usually extends beyond the glans to end in a tapering spout or nipple (the acroposthion, as the ancient Greeks named it). Far from being mere skin, the foreskin is a complex web of specialized skin, mucous membrane, muscle fibers, blood vessels, and nerves; recent research has established that it contains one of the densest concentrations of nerves in the body, perhaps exceeded only by the fingertips, and has thus been described as the principal sensory platform of the penis (Taylor, Lockwood, and Taylor 1996; Cold and Taylor 1999). Foreskin length and thickness vary considerably from one individual to another, but it has been estimated that if the average adult foreskin were unfolded and laid flat, it would cover a three by five inch index card. In infancy the foreskin is very tight and normally fused to the glans, thus operating as a valve and guarding the urethra against the entry of dirt and protecting the glans from irritation and abrasion. As the boy matures the foreskin becomes mobile and retractable, an organic process that takes time and does not normally need to be hastened.

As Fleiss and Hodges (2002) show, the foreskin is an ingenious piece of biological engineering, the functions of which are primarily erotic. Its dense web of specialized nerve endings convey fine touch sexual sensations, while its mechanical action in sliding back and forth stimulates and lubricates the glans, thus facilitating sexual activity of all kinds, whether alone or with partners. These facts were well understood by doctors and the general

public (e.g. Marten 1709, 12) until the late nineteenth century, when the anti-sensualism of the period led to belief in imaginary diseases such as spermatorrhoea, the rise of circumcision as a preventive and therapy, and a serious loss of knowledge about the male genitals. These mistakes have been corrected by recent research (Kim and Pang 2007; Sorrells et al. 2007; Dias et al. 2014). In addition to its erotic significance, the foreskin has several other major functions. (1) It contributes to the hygiene and cleanliness of the penis: its long, tapering, spout-like shape works like a valve, letting urine out and keeping it away from the body while blocking the entry of dirt. (2) It covers and lubricates the glans, an internal organ easily irritated, but eventually desensitized, if it is exposed to the abrasion of clothes, etc. (3) It provides the slack tissue necessary to accommodate the enlargement of the penis during erection. This is particularly important after puberty, when the difference between the flaccid and the erect organ may be several hundred percent. There are recorded cases in which a severe circumcision has made erections painful or impossible (Peterson 2001).

Apart from these practical benefits, the foreskin has deep psychological significance for many men and boys and contributes to masculine self-esteem and body image. In the eighteenth century the foreskin was popularly referred to as “the best of your property” and regarded as a feature essential to sexual activity (Darby 2005). As Gairdner found in discussions of circumcision “those still in possession of their foreskin have been forward in their insistence that any differences which may exist in such matters [aesthetic and erotic] operate emphatically to their own advantage” (1949, 1436). So deeply did they value their foreskins that many men circumcised unwillingly have expressed great distress at its loss: as one British soldier captured and forcibly circumcised by Sultan Tipu lamented, “I lost with the foreskin of my yard all those benefits of a Christian and Englishman which were and ever shall be my greatest glory” (Colley 2002, 288). In more recent times men circumcised as infants or children have felt resentment and shame at their condition and envied their foreskin-equipped peers; the classical scholar Kenneth Dover regarded himself as a “victim” of circumcision, and reported that he had “never been reconciled to my mutilation” (1994, 20). Similar comments have been recorded from many others (Watson 2014).⁵

HIGH STAKES IN THE HARM QUESTION

There are high stakes in the question of harm, for if it were proved that one value of the foreskin was to enhance genital sensation and function

it would undoubtedly be counted as a harm, and it would become more difficult to defend, irrespective of the benefits. This is recognized by contemporary circumcision advocates, who insist that circumcision makes no difference to or even improves sexual function (Morris 1999, 52–54, 88). In striking contrast, the consensus of the Victorian–Edwardian doctors who introduced circumcision was that the operation did inhibit sexual function, and they strongly recommended it for precisely that reason. For Freeland, the fact that circumcision “tends to dull the sensibility of . . . [the penis] and thereby diminishes sexual appetite and the pleasurable effects of coitus” was a positive advantage of the operation (1900, 1869–71). Throughout its history, medicalized circumcision has meant circumcision as performed on infants or boys, not as offered to adult men who are capable of both informed consent and refusal. This situation cannot be understood unless it is appreciated that the principal reason for the introduction of widespread circumcision in late nineteenth century Britain and America was the desire to curb juvenile sexual expression, especially masturbation (Gollaher 2000; Darby 2005; Hodges 2005); it was a punishment for “playing with yourself” as much as a medical intervention. But if circumcision is not a surgery that adult men normally elect for themselves, it is ethically problematic to impose it on children merely because they lack the capacity for effective resistance. Although contemporary advocates tend not to stress this point, some have cited the suppression of sexual interest as an advantage of circumcision (Immerman and Mackey 1997; Immerman and Mackey 1998), and there is a growing body of scientific evidence that the foreskin contributes substantially to the sexual experience (Taylor, Lockwood, and Taylor 1996; Kim and Pang 2007; Sorrells et al. 2007; Dias et al. 2014).

Other advocates have left a hostage to fortune by conceding that if circumcision were shown to be harmful it would not be permissible. In a vigorous defense of Jewish circumcision traditions, the German Jewish doctor Abraham Glassberg also urged the gentile world to adopt circumcision of infants as a health measure, but added that if it were proved to be harmful, the state would be entitled to step in to protect children (Glick 2005, 135–36). An American doctor circumcised as an adult reported significantly reduced sexual sensation, and concluded his account by stating: “If it [the foreskin] does have a function, its routine removal in newborns cannot be justified. Perhaps the foreskin does have a rationale that has been ignored or not recognized” (Valentine 1974, 32–33). More recently, the Canadian bioethicist Margaret Somerville has

commented: “If we view a child’s foreskin as having a valid function, we are no more justified in amputating it than any other part of the child’s body unless the operation is medically required treatment and the least harmful way to provide that treatment” (2000, 204–05).

Proving harm to those who want to perform the act in question is as difficult as proving benefit to those who are skeptical of the operation. Nobody advocating circumcision has been able to set firm benchmarks for an acceptable level of harm or to define the criteria by which harm could be measured, much less to admit the possibility that it is the loss of the foreskin itself and the denial of choice—quite apart from any “complications”—that in themselves constitute the principal harms. As Darby and Svoboda observe, even many of those who are critical of circumcision on ethical and human rights grounds “often overlook the most obvious and universally experienced harm of all: the harm of being deprived of an integral, visually prominent, and erotically significant feature of the penis” (2008, 257).

This is not the place to establish the needed benchmarks, but we need to consider where the burden of proof should lie. When circumcision was introduced in the nineteenth century, principles of medical ethics were in their infancy, there was as little discussion of the morality of the procedure as there was proof of the health benefits, and the operation became established in the medical culture of Anglophone countries long before concepts such as autonomy and informed consent existed. Because there was no genuine debate about the propriety of pre-emptive amputation as a disease control strategy when it was introduced, those who wanted to remove a normal body part from children were able to throw the burden of proof onto their opponents. Instead of the advocates having to demonstrate that the gain outweighed the loss, it was up to the doubters to prove that the loss outweighed the gain—or as Abraham Wolbarst put in it his call for universal infant circumcision in 1914: “If there is any objection to circumcision it should be based on valid, scientific grounds” (95). The upshot is that what should have been a debate about the introduction of circumcision in the 1890s has turned into a debate about its abolition a century later. Since the foreskin is normal mammalian anatomy (Cold and McGrath 1999), most men throughout the world have neither been circumcised as children nor elected the operation for themselves as adults, and many circumcised men resent their condition (Hammond 1999; Watson 2014), it would appear that the burden of proof lies on advocates

to prove that circumcision is both necessary and harmless, not on critics to prove that it is harmful.

It is indicative of the difficulties faced by circumcision critics that in other contexts involving invasive procedures on the genitals, such as female genital mutilation or rape, the harm is simply assumed and the actions categorized as sexual assault. Rape is regarded as a serious wrong even without physical injury simply because it is sex without consent; Archard (2007) argues that rape is both properly defined as non-consensual sex and properly evaluated as a serious wrong, and further suggests that society has an interest in protecting sexual integrity. But if the temporary unwanted invasion of the genitals is regarded as evil, immoral, and criminal, how much worse is an assault on a child that permanently excises genital tissue? There are resentful men who regard themselves as having been sexually violated and have compared circumcision to rape (Watson 2014, 26). In the case of female genital mutilation (FGM) Western societies see no need to prove physical harm and regard the action as ethically and legally unacceptable even where the cutting is less extensive than in the average male circumcision. As Rahman and Toubia write:

The cutting of healthy genital organs for non-medical reasons is at its essence a violation of girls' and women's rights to physical integrity. This is true, regardless of the degree of cutting or the extent of the complications that may or may not ensue. (2000, 3)

They go on to point out that because the surgery is usually performed on children “who have no say in matter,” female circumcision “violates a number of recognized human right, including those protected by the Convention on the Rights of the Child.” [CRC]⁶ All these objections apply just as strongly to medically unnecessary circumcision of male minors.

The double standard here is evident in the policy statement on female genital mutilation issued by the Royal Australasian College of Physicians (RACP). This points out that FGM is an injury to the external genitals; it is usually performed on girls between infancy and 15 years of age; it causes harm; it violates the human rights of the victims; it is wrong because it is performed on minors without consent; it is illegal in all Australian states; and, although it is a practice authorized and recommended by some cultural and religious minorities, it is unacceptable in Australia. Accordingly, doctors should vigorously oppose any form of FGM and become advocates for girls who are threatened with it, even against their parents and culture of origin (RACP 2012). These sentiments are notably

absent from the RACP policy on circumcision of boys, yet most of the above objections to FGM apply just as strongly to male genital cutting: circumcision is also an injury to the external genitals, usually more severe than mild forms of FGM, such as the “ritual nick” briefly approved by the AAP in 2010 (AAP 2010; Van Howe 2011); it is usually performed on boys between infancy and 15 years of age; it causes harm; it violates the human rights of the victims; and it is performed on minors without consent. The only difference is that female genital cutting is prohibited while circumcision of males is allowed, and in some places encouraged by health insurance coverage.

An assumption behind our differing attitudes to male and female circumcision is that the former offers “medical benefits” while the latter does not. In truth, we do not know whether some forms of female genital cutting might reduce the risk of certain diseases, such as HIV, because Western abhorrence of the practice precludes research into this interesting question.⁷ Clitoridectomy was practiced for a short time in mid-nineteenth century Britain as a therapy for certain female ailments (Darby 2005), and various forms of female genital cutting were advocated as a health precaution by respectable American doctors until well into the twentieth century (Rodriguez 2008). The real reason Western societies reject female while accepting male circumcision is that the latter is comfortably familiar while the latter seems outlandishly strange.

Another assumption behind the rejection of female and acceptance of male genital cutting is that circumcision deprives the woman of all sexual feeling but makes no difference to males, or even (according to the strong advocates) improves their sex life (Morris and Kruger 2013). How much contribution the foreskin makes to sexual sensation and performance is a matter of controversy (Frisch 2012), but it is contrary to what we know about biology to suppose that such a modification of structure could have no impact on function, and it certainly makes a noticeable difference to bodily aesthetics. The effects of genital cutting (both male and female) on sexual pleasure are variable, subjective, and difficult to measure, meaning that circumcision will affect men (and women) to differing degrees and in different ways (Johnsdotter 2013); since sexual experience and bodily aesthetics are highly subjective, the ethical implication is that each *individual* should be allowed to make his (or her) own decision.

Assuming circumcision does make a difference, how is such harm to be measured and assessed? In several judgments, courts in Europe have determined that medically unnecessary circumcision of a child constitutes

both bodily harm and a violation of the child’s right to bodily integrity (Merkel and Putzke 2013); a law reform report from Australia has concluded that non-therapeutic circumcision of minors is sufficiently harmful to require strict regulation and partial prohibition (Tasmania Law Reform Institute 2012); and many men have stated that they have been harmed by circumcision (Warren et al. 1996; Goldman 1997; Hammond 1999; Peterson 2001; Darby and Cox 2008). In his introduction to a collection of personal accounts from fifty men who consider themselves seriously harmed by a “successful” circumcision, with no complications or abnormal outcomes, Watson (2014) reports that feelings of violation, grief, anger, resentment, shame, and humiliation, among others, are prominent. It is often said that boys are afraid to be “different” down there, but the fact that most of these men are American and grew up among predominantly circumcised peers suggests that they were far more worried about the loss of their foreskin than the prospect of teasing in the proverbial locker room. There would hardly be a vigorous, community-based anti-circumcision movement in places where the practice remains common unless many people were convinced that circumcision was harmful and thus wrong.⁸ The fact that many circumcised men are attempting to restore their foreskins is proof that they believe they have suffered sufficient harm to warrant a complex and laborious project (Wilson 2013). The issue cannot be resolved here, but it is to the AAP’s discredit that their report did not consider it worthy of detailed attention.

CIRCUMCISION AS A MEDICAL ANOMALY

The central fact ignored by the AAP statement is that circumcision is a unique intervention because it involves (1) prophylactic (2) amputation of (3) a component of a highly significant body part (4) without the consent of the subject. It is not, therefore, an ordinary medical intervention that can be covered by the risk/benefit calculation, but one that requires special rules. I shall deal with each of these points in turn.

1. Risk/Benefit Rule Not Applicable to Non-Therapeutic Surgery

The history of the origin and evolution of the risk/benefit rule is obscure, but it appears to have been devised on the assumption that it would be applied to therapeutic procedures or treatments—i.e., where there was a pathological condition that required treatment. Supporters have tried to liken circumcision to vaccination—as in the slogan “surgical vaccine” (Cooper, Wodak, and Morris 2010)—but the comparison is invalid

because the nature, extent, risks and costs of the protection gained or claimed are quite different (Forbes 2009; Darby and Van Howe 2011; Lyons 2013). More importantly, vaccination does not entail surgical alteration of a significant body part; the only similarity is that they are both prophylactic procedures. In the case of vaccination, the only possible harms are those arising from unintended adverse events (side-effects, complications, etc.); in the case of circumcision, the harms are not only unintended adverse events, but the intended outcome: removal of the foreskin. This is reasonably regarded as a harm because the foreskin has sexual functions and many people value it for sexual, aesthetic, functional, and other personal reasons,⁹ as evidenced by both positive comments (such as those on Internet dating sites) and the distress that many men express when deprived of it against their will.

But when is a prophylactic intervention on a minor acceptable? Hodges, Svoboda, and Van Howe (2002) sought to answer this question by laying down a set of standards on how conflicts between the demands of public health and human rights might be resolved. Noting that such interventions were traditionally justified on the grounds of “best interests of the child” and/or “public health,” they proposed two sets of criteria that had to be met before an intervention could be accepted as ethical. The criteria for the “best interests of the child” argument were (1) presence of clinically verifiable disease, deformity, or injury; (2) least invasive and most conservative treatment option; (3) net benefit to the patient and minimal negative impact on patient’s health; (4) competence to consent to the procedure; (5) standard practice; (6) individual at high risk of developing the disease. The criteria for the “public health benefit” argument were: (1) substantial danger to public health; (2) condition must have serious consequences if transmitted; (3) effectiveness of the intervention; (4) degree of invasiveness of the intervention; (5) whether individual receives an appreciable benefit not dependent on speculation about future behavior; (6) the health benefit to society must outweigh the human rights cost to the individual. The authors evaluated several interventions against one or other of these sets of criteria, and routine neonatal circumcision against both of them. They concluded that while immunization generally satisfied the “best interests” and “public health” justifications, circumcision failed to satisfy either of them. Such an intervention was thus impermissible because it was performed on a minor without consent; the human rights cost to the individual exceeded the proven public health benefit; and the diseases from which circumcision might provide protection could be

avoided through appropriate behavioral choices or otherwise managed without surgery.

2. *Circumcision Is Not Ordinary Medical Treatment*

Circumcision is not ordinary medical treatment, and not even ordinary surgery, since it involves not merely cutting tissue, but permanently removing a genital feature that many men—and women—value (O’Hara and O’Hara 1999; Bensley and Boyle 2003; Frisch et al. 2011). Comparisons have been made with routine tonsillectomy, which are valid up to a point, insofar as the tonsils were regarded as functionless and prone to infection, leading to the acceptance of a “let’s cut them out” attitude. But since the tonsils were invisible and held no sexual or cultural significance for anybody, few people cared whether they were taken out or left in; it was thus an easy matter for the medical profession to drop the operation as a routine, and confine it to therapeutic situations when it was really needed (Glover 1948; Bolande 1969). In contrast with the foreskin, there was no great struggle over the fate of the tonsils. Despite more than a century of medical application, it is further evidence of the anomalous status of circumcision that no entirely satisfactory and universally adopted surgical technique has yet been devised (Young 2013); even in modern hospitals and surgeries we find an unacceptable incidence of complications (Demaria et al. 2013). The AAP Task Force implies that the major cause of surgical complications is lack of skill on the part of operators, but the deeper problem lies in the complex and variable anatomy of the penis (Cold and Taylor 1999).

3. *The Foreskin Is Not an Ordinary Body Part*

Unlike the tonsils, the foreskin is a special body part that is the focus of strong passions, both positive and negative, and is freighted with an immense weight of sexual, cultural, and psychological significance (Richters 2006). It is part of the penis, the organ most central to masculine identity and self-esteem, and must therefore be treated with far greater care than would be applied to an inessential organ that nobody much cared about. Although some may find it provocative, an enlightening comparison might be with the breast in women, and the same caution that is now shown with respect to prophylactic mastectomy should be observed when we consider prophylactic foreskin removal.

An analogy: Prophylactic mastectomy

From a strictly medical perspective there would be a far stronger argument for routine mastectomy in girls with the BRCA1 mutation than for routine circumcision of normal boys. Women with this mutation have a 66% risk of breast cancer by age 70, compared with a lifetime risk of 1 in 10–12 among those not so predisposed (Eisinger 2007). By contrast, the risk of cancer of the penis in men—although less accurately measured—has been estimated as 1 in 100,000 patient years in the United States, 1 in 250,000 in Australia, and 0.82 per 100,000 in Denmark (American Cancer Society 2013; RACP 2010; Frisch et al. 1995). But we balk at the idea of prophylactic mastectomy even in consenting adult women (let alone girls) because breasts are highly valued symbols of femininity, and we are horrified at the prospect of disposing of them in this hardheaded way (Somerville 2000, 204). As the Cochrane Review puts it, although the data “support a large benefit . . . prophylactic mastectomy is such an extreme intervention that [it] . . . is not appropriate” (Eisinger 2007, 5). In a wide-ranging critique of this proposition, Eisinger (2007) makes several points that seem applicable to prophylactic circumcision.

(1) A risky condition is not a disease: prevention does not improve a person’s well-being, but merely reduces the risk of succumbing to the disease; nor is risk reduction equivalent to prevention. There is no way of knowing whether an individual has derived any benefit from such an operation because we cannot know how she would have fared had it not been performed; the benefits appear only in broad statistics. Similar considerations apply to circumcision: just because a circumcised boy does not contract UTIs, HIV or penile cancer does not prove that it was the operation that made the difference, and that he would have contracted them had he retained his foreskin. Most men with foreskins never experience any of these problems. While it is possible to identify and name many boys who have been killed or maimed by circumcision (CIRP 2013; Ncayiyana 2003; Bollinger 2010), it is impossible to identify a single one who died because he had not been circumcised.

(2) The breast is not an ordinary organ, but a special, highly visible organ with a significance that far transcends its biological function (lactation). As Eisinger puts it, since “there is no organ as connected with femininity, sensuality, sexuality, adulthood and motherhood,” such a mutilation should not be undertaken lightly. Similar considerations apply to the penis, as the organ most central to masculinity, sexuality, adulthood, fatherhood, and masculine self-esteem. It is true that the foreskin is not the

whole penis, but it is still an integral component of the penis, the removal of which requires a surgical operation that affects the appearance and function of the organ. Whether one regards circumcision as a mutilation or a beautification, the penis is unquestionably modified thereby and, as a matter of anatomical fact, diminished in both bulk and complexity (Richters, Gerofi, and Donovan 1995).

(3) Ethics are needed to assist with the resolution of controversial medical questions. A doctor's decision about whether to recommend or even suggest prophylactic mastectomy to an at-risk woman is not primarily a medical question, but an ethical one. A woman's decision about whether to undergo such surgery hinges on more than an assessment of the risks and benefits; it will be determined more by her personal values—how much she values her breasts. In this situation the doctor should provide all relevant information but respect the decision of the patient.

In this analogy, we are dealing with a category of women who are at proven high risk of breast cancer, and who are mature women capable of making an informed decision for themselves and giving valid consent. The cautions proposed here must be applied far more strongly to circumcision performed on infants who cannot give informed consent and are at low or zero risk of the diseases of which circumcision is said to be preventive (Malone and Steinbrecher 2007; Perera et al. 2010; McDonald 2011), and all this without any selectivity on the basis of increased genetic or other risk factor. Medically targeted circumcision might make sense; random circumcision on the basis of parental preference makes no *medical* sense at all.

The harm in prophylactic mastectomy is not merely the risk of complications, but the loss of one or more breasts, or part thereof, and the same principle applies to circumcision. Since the penis is also a special body part, it follows that an operation to remove part of it should be classified as a "special medical procedure." In the Australian High Court decision in "Marion's case," in which parents sought permission to have their handicapped daughter sterilized, the judges held that if parents wanted to perform what it termed a "special medical procedure" on a child, they required permission from the Family Court (High Court Australia 1992). Some authorities have argued that non-therapeutic circumcision of a minor is also a special medical procedure and should be subject to the same requirement (Richards 1996; Boyle et al. 2000).

4. *Autonomy and Informed Consent*

Non-therapeutic circumcision of a minor is performed without the consent of the subject. This in itself must raise the level of necessary scrutiny far above what is required for a therapeutic (or even a non-therapeutic) procedure on a consenting adult, and it raises many bioethical, human rights and legal issues, all of which have received considerable exposure in recent years (Earp 2013). The general rule for any invasive medical treatment, especially if it involves surgery, and *a fortiori* if it involves amputation of a functional body part, is that surrogate consent is valid only in two situations: (1) life-threatening emergencies; (2) when the operation is unequivocally in the best interests of the subject, it cannot be delayed, it is what he would be likely to choose for himself if he were competent, and other options have failed or are not available (Dwyer 1994; Svoboda, Van Howe, and Dwyer 2000; Adler 2013). The sort of scrutiny that should be applied to circumcision of minors is not that of an ordinary medical procedure, but of a cosmetic procedure that makes irreversible alterations to the appearance or functions of the body. In many jurisdictions, cosmetic surgeries on minors, even nothing more than a tattoo or a piercing, even when sought or agreed to by the person him/herself, are now legally prohibited (Earp 2012), as are all forms of female genital cutting, even when less extensive than circumcision (Davis 2001b; Van Howe 2011). There is no medical reason why circumcision should be treated differently.

AUTONOMY AND PERSONAL VALUES

The AAP argues—or rather asserts—that the existence of a favorable benefit/risk ratio legitimizes parental choice as to whether a boy is circumcised for health/prophylactic reasons. This is not, however, a conclusion that follows logically from their evidence, which could just as well support the view that it is the owner of the penis who should be the one to decide. By the AAP's own account, the balance is a fine one, so fine in fact that it is unable to make any firm recommendation on the matter, but leaves the decision to others: why those others should be the parents and not the boy himself when old enough is not established. It is apparent, however, from a reading of the report that what the AAP is really trying to do is legitimize religiously or culturally motivated circumcision, and in particular to protect such practices from popular movements aiming to eradicate all forms of non-therapeutic circumcision (Stern 2013). In

this context it is notable that other exponents of the parental authority argument (Benatar and Benatar 2003) cite a combination of cultural and medical arguments, suggesting that they recognize that neither is adequate on its own.

As I have acknowledged, there may be a case for parental choice in culturally or religiously motivated circumcision, since this is based on emotional attachments, not medical evidence. But it makes no sense to privilege parental discretion in a decision about whether circumcision is in the best *health* interests of the child. If the experts are unable to agree, how can the average uninformed parent be expected to know what is best? Recommending parental choice is presented as a moderate compromise, but it looks moderate only if contrasted with coercive situations where the doctor makes the decision or the operation is made compulsory. Parental choice has always been the rule; it is simply the status quo. But from the child's point of view, each of these options is equally bad because each denies him autonomy and choice in a matter affecting an intimate part of his own body. If the risk/benefit equation is only slightly tilted (AAP) or equally balanced (Benatar and Benatar 2003), it does not logically follow that parents are the appropriate party to make the proverbial circumcision decision. It would make just as much sense, and be more satisfactory from a bioethical and human rights perspective, to conclude that in this situation of uncertainty the right person to make the decision is the one who must wear the life-long consequences.

Pace the AAP, therefore, a favorable risk of harm/prospect of benefit balance does not legitimize parental choice as to whether a minor is circumcised for health/prophylactic reasons; the decision should still be left to the owner of the foreskin because individuals have different attitudes to both risk and their bodies, none of which can be predicted in advance. Some men grow up indifferent as to whether they were circumcised; some say they are glad; some resent it sufficiently to attempt foreskin restoration; and some suffer serious psychological dysfunction (Peterson 2001; Boyle et al. 2002; Watson 2014). People value body parts in different ways and may place quality of life—in which the properties, function and appearance of the foreskin-equipped penis may play an important role—over mere longevity. Criticizing Savulescu's (1995) concept of "rational non-interventional paternalism" and emphasizing the importance of autonomous patient choice, Madder (1997) gives the example of a woman who presented with a lump in her thigh that proved to be a malignant tumor invading the bone. Her surgeon recommended

full amputation of the limb, but because the woman believed her limbs to be integral to her body and personal identity she would not agree, even if it was the only means to prolong her life. Her surgeon referred her to a second and then a third surgeon, both of whom advised amputation, but the third suggested alternatives: local resection to remove as much tumor as possible followed by radiotherapy, or radiotherapy alone. The woman chose local resection, understanding that while this might alleviate symptoms, it would not reduce the risk of metastatic spread. At operation the tumor was found to be fixed to the thighbone as expected, but as the cancerous bone was scraped away, normal bone was revealed, and complete removal of the tumor was achieved. As Madder comments, the point is not that the woman was lucky that the first doctor was wrong, but that she was willing to accept the risk of death rather than lose her leg.

The lesson of this episode is that when it comes to their own bodies individuals should be free to choose the course of action that best suits their needs, desires and values. There is little disagreement that this principle is applicable to adults, but reluctance to extend it to children and infants. The objection is that they lack the power to make rational choices and must therefore be guided by adults. This is perfectly true, but circumcision is not something that has to be done before a person is capable of rational thought; the major benefits claimed (reduced risk of STIs, HIV, and various cancers) can be obtained by circumcision in adulthood, if that is what the individual wishes. Children may not be able to make rational choices; but this is not a justification for doing things to them that they would not elect for themselves if they were old enough to make an informed decision. The open future principle holds that adults should not take steps that preempt or foreclose the future options of their children, but leave them the greatest possible scope for making choices for themselves in adulthood (Feinberg 1992; Davis 1997). This principle has been widely accepted in relation to genetic counseling, provision of educational opportunities, and proper health care (Davis 2001a), and it has been argued that it is just as applicable to permanent bodily alterations such as circumcision (Darby 2013). The essential point is that if you deny choice to an infant or child you are also denying it to an adult: the foreskin does not grow back when he turns eighteen.

CONCLUSION

Despite their differing conclusions and recommendations, all parties in the current circumcision debate share a certain amount of common

ground, in particular the idea that non-therapeutic circumcision of non-consenting minors would be acceptable if it were shown that the “benefits” outweighed the “risks.” What I have sought to argue is that this paradigm is based on a false analogy between a cosmetic (and usually culture-driven) non-therapeutic procedure such as circumcision and therapeutic procedures where there is a pathological condition that needs treatment. This confines the understanding of risk to nothing more than surgical complications. The problem is that this paradigm assigns zero value both to the foreskin and to such moral issues as the possible future wishes of the boy and basic principles of bioethics and human rights that are accepted in other contexts (such as FGM). “Strong” circumcision advocates are on fairly safe ground to argue that the risk of complications in clinical settings these days is comparatively slight, making it difficult to oppose them effectively if their impoverished concept of risk is accepted.

It is noteworthy that the AAP report includes no discussion of the anatomy or functions of the foreskin, and completely ignores the considerable medical, scientific, and cultural literature on this point. At the Pitts Lectureship in Medical Ethics, Charleston, October 2013, AAP Task Force on Circumcision member Dr. Michael Brady is reported to have asserted that nobody knew what the functions of the foreskin were (Svoboda 2013). This is a surprising admission from somebody whose first task, when compiling a policy document on a subject as contentious as circumcision, should have been to undertake a comprehensive survey of the anatomy, physiology, and functions of the body part that is to be excised. The failure of the Task Force to perform such an exercise, and thus to recognize that there were benefits in retaining the foreskin, has resulted in the publication of a deeply flawed document with limited usefulness as a source of medical advice.

Circumcision advocates tend to exaggerate the benefits of circumcision and downplay the risk of complications while critics of the procedure do the reverse. Because the AAP decided at the outset that it would ignore circumcision complications case reports, it almost guaranteed that it would end up with an unrealistic assessment. Critics, on the other hand, insist that complications are far more common than reported, and that severity is as significant as frequency. Since it is not likely that there will ever be comprehensive data in this area (given the difficulty of defining a complication and assessing its severity), nor that agreed benchmarks for an acceptable incidence will ever be established, it is clear that mere numbers will never settle the circumcision debate. The source of the impasse is

that both sides of this argument tend to assume that the old risk/benefit calculation applies to prophylactic amputations. I have argued that this is a fallacy and that the traditional risk/benefit analysis was meant cover only therapeutic procedures and non-therapeutic procedures on adults; it does not apply to non-therapeutic amputations from non-consenting minors, especially when the organ affected is something as sensitive (in all respects) as the penis. Quite apart from the question of medical benefits and harms, individuals have a right of ownership in their bodies, and own their foreskins as much as their toes, fingers, liver, and belly button (Testa and Block 2014). Because routine circumcision involves surgical modification of a significant body part without the consent of the subject it is an anomalous operation that should be regarded as a special medical procedure, like sterilization, as defined by the Australian High Court in Marion's case, and should be subject to special rules. The vital questions are not whether circumcision might have some long-term health benefit, but who owns the foreskin and whether it is too valuable to lose unless absolutely necessary. Both the latest AAP policy statement and many circumcision advocates base their risk/benefit calculation on the assumption that the foreskin is worthless and that the only risk of circumcision is of surgical complications; once the value (both objective and subjective) of the foreskin is taken into account, it is unlikely that many men would regard the balance as favoring circumcision. Those that do can elect the operation for themselves when competent.

NOTES

1. In this paper circumcision means medically-rationalised, non-therapeutic circumcision of male infants and other minors, that is, circumcision performed on normal children in the belief that it will improve their future health prospects. It is not concerned with non-therapeutic circumcision performed for religious or other cultural reasons, nor with voluntary circumcision of adult males in regions of high HIV seroprevalence (sub-Saharan Africa), as recommended by the World Health Organization. I follow the definition of non-therapeutic given by the Tasmania Law Reform Institute (2009, 7): "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."

2. The publications of Professor Morris and colleagues on this subject are too numerous to list, but most of them can be found in Morris, Bailis, and Wiswell (2014). Despite his impressive productivity, Morris's papers tend to repetition and differ little in essence from his short book (1999). For a brief critique of his position, see Earp and Darby (2014).
3. Previous AAP statements are collected at <http://www.cirp.org/library/statements/>
4. While there is plausible evidence that circumcision provides some degree of protection against HIV in certain risk situations and epidemiological environments, there is no proof that it provides any overall protection against other STIs (Van Howe 2013a), most of which are readily curable with antibiotics.
5. For non-pornographic images of the foreskin, see <http://acroposthion.com/> or any site featuring ancient Greek sculpture or Renaissance paintings.
6. In fact, the CRC makes no mention of female genital cutting, but in Article 24 (3) refers cryptically to “traditional practices prejudicial to the health of children”—a gender neutral term that encompasses boys as well.
7. There is evidence that some forms of female genital cutting may reduce the risk of HIV infection: see Kanki et al. (1992), Stallings and Karugendo (2005).
8. See www.intactamerica.org, www.circumcisionharm.org, and mendocomplain.com (Accessed December 23, 2013).
9. Positive assessments, including video evidence, may be found in popular publications and on many websites too sexually explicit to be mentioned here, but see <http://acroposthion.com/>.

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