BJU International (1999), **83**, Suppl. 1, 63–73

Involuntary circumcision: the legal issues

R.S. VAN HOWE, J.S. SVOBODA*, J.G. DWYER† and C.P. PRICE
*Medical College of Wisconsin, Department of Paediatrics, Marshfield Clinic — Lakeland Center, Minocqua, WI, *Attorneys for the Rights of the Child and †University of Wyoming, USA*

Introduction

Circumcision is the amputation of the prepuce from the rest of the penis, resulting in permanent alteration of the anatomy, histology and function of the penis [1,2]. Recently, legal scholars have challenged the legality of neonatal circumcision [3–7] and argued that it constitutes child abuse [8,9]. While this conjecture may seem outlandish to American physicians, who tend to a population in which 70–90% of the males are circumcised neonatally, such claims have a strong foundation in legal precedent and medico-ethical standards that aim to protect the bodily integrity of persons.

Bodily integrity and informed consent

Among a free society's most treasured principles are personal autonomy, respect for the individual and preservation of the body's physical integrity [10]. Patients are entitled to make decisions about their medical care through a process of 'informed consent'. Medical providers must refrain from unwarranted interventions and allow patients the individual self-determination to control their own lives [11,12].

Incompetent persons cannot, of course, exercise a right of self-determination; someone must make decisions for them. Ordinarily this surrogate decision-making is not regarded as anyone's right. Rather, some individual is accorded the privilege of acting as advocate for the incompetent patient's interests [13]. However, for children, the law in common-law jurisdictions has historically ignored this norm and has tolerated parents exercising power as if entitled to make medical decisions for their minor children, without having to demonstrate that their choices were in the children's best interests. This stance is particularly prevalent in the USA, although echoes of it are seen in other common-law jurisdictions, especially amongst lay people, who find ideas of children's rights uncomfortable. However, in recent years there has been a trend among legislatures, courts, legal scholars and child-welfare advocates toward insistence on respecting children, legally and morally, as distinct persons whose fundamental needs or 'welfare interests' warrant legal protection [14], rather than viewing children as appendages or property of their parents to be treated however parents (within minimal limitations) see fit [15]. Simply complying with parental wishes is increasingly less acceptable; the child's best interests now must also be considered [16,17]. Like surrogate decision-makers for incompetent adults, parents should be able to demonstrate that their judgement is the same as that which the child would rationally choose for himself, if able to do so. Such a demonstration should be necessary before medical professionals may accede to the preferences of parents regarding medical intervention for their children [12].

In an effort to protect the rights of children, the American Academy of Pediatrics Committee on Bioethics developed a policy about informed consent in cases involving children. Informed *parental permission* can substitute for consent from the child only for medical interventions in situations of clear and immediate medical necessity, such as an immediate threat to the child from disease, trauma or deformity. For non-essential treatments, which can be deferred without substantial risk, the physician and family should wait until the child's consent can be obtained [18]. Such a principle should apply even more strongly in the case of circumcision, which carries significant potential for causing serious harm. The committee emphasized the duty of the physician to protect the patient (the child) from parental desires that might be detrimental to the child.

United States case law

American case law clearly protects the bodily integrity of incompetent individuals. For example, doctors may not sterilize or administer contraceptives to a mentally retarded woman, regardless of parental wishes, without showing that it is the least restrictive means available for protecting the woman's interests [19]. Similarly, courts have limited the authority of parents to secure medical intervention for children. In *Wisconsin v Yoder*, the US Supreme Court held that parental authority may be limited 'if it appears that parental decisions will jeopardize the health or safety of the child' [20]. Lower courts have refused to allow parents to secure non-medically indicated procedures on children. For example, in *Little v Little,* the *guardian ad litem* of a 14-year-old mentally incompetent, but otherwise perfectly healthy,

girl applied at the behest of the girl's mother for an order authorizing the mother to consent to the removal of a kidney from the girl's body, for the purpose of transplanting the kidney into the girl's brother, who was suffering from end-stage renal disease. A Texas Court of Appeal rejected the request, holding that the 'power of parents ... to consent to surgical intrusions upon the person of the minor ... is limited to the power to consent to medical ''treatment''.' [21]. To date, all courts have held that surgical removal of a normal, healthy, uninjured part of the body is not 'treatment'. In a transplantation case similar to *Little v Little*, a Louisiana Court of Appeal ruled that surgery could not take place and accorded 'protection to a minor's right to be free in his person from bodily intrusion to the extent of the loss of an organ unless such loss be in the best interest of the minor'. [22].

United Kingdom

Under English law, assaults ranging from common assault to inflicting grievous bodily harm are offences under the *Offences against the Person Act 1861*. *The Children and Young Persons Act* 1933 makes wilfully assaulting a child an offence. *The Children Act 1989* requires that paramount consideration be given to the welfare of the child and the child's wishes [23]. Newborns can only be a subject of a research trial if the risk is no more than minimal and if the child stands to benefit directly [24]. The UK Department of Health guidelines similarly provide that 'those acting for the child can only legally give their consent provided that the intervention is for the benefit of the child. If they are responsible for allowing the child to be subjected to any risk (other than one so insignificant as to be negligible) which is not for the benefit of that child, it could be said that they were acting illegally' [25].

In Queensland, Australia, the Queensland Law Reform Commission concluded that 'on a strict interpretation of the assault provisions of the Queensland *Criminal Code*, routine circumcision could be regarded as a criminal act' [26].

International Law

International human rights law clearly protects the child from unnecessary bodily intrusion [27]. The *Convention on the Rights of the Child* [28] calls for states that are parties to the convention to take all measures to ensure that no violence, injury, or abuse occurs while the child is under the care of a parent or legal guardian (Article 19.1). It requires that children be protected from torture, from any cruel, inhuman, or degrading treatment or punishment (Article 37a), and from arbitrary and unlawful interference with their privacy (Article 16). Similarly, the *Declaration of the Rights of the Child* stipulates that children must be protected against all forms of cruelty, neglect and exploitation [29]. This respect for bodily integrity is also reflected in the *European Charter for Children in Hospitals,* which states that 'every child shall be protected from unnecessary medical treatment and investigation'. [30]

Can involuntary circumcision be lawful?

The test for the lawfulness of a surgical intervention on a child has three parts; the intervention must be medically necessary [21,26,31], must be in the best interests of the child [22,23,26,32,33], and must not expose the child to unnecessary suffering or injury [24,25,34]. When a child has an illness, a medical or surgical intervention selected to facilitate the child's recovery can be justified. On the other hand, when healthy flesh is amputated from a healthy organ in a healthy child, the intervention is presumptively unlawful and the onus lies upon those who conduct the amputation to demonstrate that it satisfies this three-part test. Justifications for neonatal circumcision have taken several forms, but as discussed below, under close scrutiny all of these purported justifications fail to satisfy these criteria.

'Neonatal circumcision is not child abuse because parental consent is given'

In the USA, parents sign a consent form that allows physicians to medically intervene on their children, and some physicians may believe that this absolves them of legal responsibility. However, if left unchecked, parents can thereby act to the detriment of their child, who is vulnerable and at the parents' mercy [35], so several safeguards exist.

First, parental consent is only effective for interventions that are in a child's medical interest. Routine circumcision entails the painful removal of healthy tissue from a child and thus entails significant physical harm. Without medical benefits that outweigh this harm, circumcision must be deemed contrary to a child's medical interests (see the following discussion of cost and benefits). When a conflict between parental preferences and the child's interests arises, the physician must protect the child, who is after all the physician's patient [18]. In such cases, a replacement for the surrogate should be sought [10]. Court authority should be obtained for any surgery that is invasive, irreversible, or major; if there is a significant risk of making the wrong decision; or if the consequences of the wrong decision are particularly grave [36]. As the circumcision of males (like circumcision of females) is clearly invasive and irreversible, and

arguably has substantial consequences for the person circumcised, court authority should be required for all circumcisions not required by exigent medical necessity. While on the face of it this may appear excessive, this rule is necessary to protect the individual's fundamental and legally protected rights, which, despite the clear law, have been ignored or over-ridden by dogmatic parents and/or complaisant doctors. Difficulty in accepting this conclusion may arise from a resistance to recognizing that infants have rights of their own.

The same point might be made by viewing parental consent as surrogate decision-making. Surrogates are expected to make decisions based on what the incompetent patient would want for himself if competent. Significantly, among males in the USA who were not circumcised as children, only 0.3% choose to undergo circumcision later in life [37]. This suggests that parents who elect to have their sons circumcised violate this principle of substitute consent.

Second, parental permission is reserved, even for medically indicated interventions, to those that cannot safely wait until the child can be involved in the decision-making process. Even if there were sufficient medical benefits derived from circumcision to outweigh the evident harms, would there be any harm in waiting to circumcise? Would most of the supposed medical benefits of circumcision still be realized if a male chose to be circumcised upon becoming competent to decide for himself? Are there significant benefits in postponing the operation for months or years rather than performing it on a newborn? Significantly, although circumcision is the most commonly performed urological procedure in children (indeed it is the most frequently performed surgery in the USA) a recent review article addressing the optimal timing for urological procedures in children did not even mention circumcision [38], suggesting either that there is no urgency to performing circumcision immediately after birth or, more probably, that this surgery has not been given the study it deserves. While a few urinary tract infections may be prevented with neonatal circumcision [39], the reported complication rates in the newborn period (2.0% [40] to 6.4% [41]) are higher than those reported in circumcisions performed later in life (1.7% [42,43]). The risk of meatal stenosis after circumcision may be reduced if the surgery is delayed until after toilet-training [44]. While general anaesthesia is considered too risky for neonates, the results of attempts to control pain with topical and local anaesthetics, although better than no anaesthetic, have been lacklustre [45–50]. Postponing circumcision until the risk of general anaesthetic is more acceptable would be in the child's best interest.

In Australia, the Queensland Law Reform Commission (QLRC) concluded that for neonatal circumcision 'consent by parents to the procedure being performed may be invalid in the light of the common law's restrictions on the ability of parents to consent to the nontherapeutic treatment of children'. [26] Likewise, in *Re Z* [32] a UK court ruled that it 'could refuse to permit a parent's exercise of parental responsibility even though it was *bona fide* and reasonable, if it was contrary to the child's best interests'. This invalidation of parental consent to an unjustified procedure has been suggested as applying to treatment performed with 'consent but without cause or excuse'. [31]. Thus, in these jurisdictions, parental privilege clearly does not extend to procedures not required by medical necessity, including purely cosmetic surgery. The over-riding criterion of the child's best interests limits parental power [36,51]. It is understood that what is in the parents' or family's best interest is not automatically in the child's best interest [26]. The child's best interests must be determined objectively, and parental preference is irrelevant.

Third, any parental consent to circumcision must be *informed* consent, and the actual process for obtaining parental consent to circumcision in the USA typically falls far below the standard for other surgery [52]. Physicians performing the operation often know little about the prepuce or the care of the normal, uncircumcised penis [53]. Not surprisingly, this low level of knowledge in physicians is paralleled by a similarly poor level of parental knowledge about the complete penis [52,54]. In addition, doctors typically do a poor job of communicating information to parents, such as the surgical risks inherent in circumcision [55].

Fourth, parental consent cannot be valid if any coercive elements affected or induced the granting of consent [56]. Nevertheless, it is routine in the USA to ask a woman during a prenatal visit or on admission to the obstetrics ward [57] whether she desires circumcision for her child if it is a boy [58]. Offering a medically unnecessary surgery that will benefit the physician and hospital but not benefit the patient is clearly unethical [59]. Such a practice is a subtle but no less insidious form of coercion. Offering circumcision to a mother is often interpreted as a recommendation [52,58,60]. Mothers are left with the impression that 'it must be the thing to do, or our doctor would not have told us about it'. [61]. Solicitation for circumcision places parents in the peculiar position of having to decline requests for unnecessary surgery. Given the perinatal emotional upheaval, parental consent in the neonatal context arguably is rarely, if ever, freely given [62]. The epitome of absurdity is Wiswell's suggestion of obtaining informed parental refusal [63].

To summarize, reliance on parental consent for neonatal circumcision is inadequate unless proof is provided that circumcision provides medical benefits outweighing

the harms it occasions, that the health of the child would be significantly prejudiced by postponing the procedure until he is capable of giving effective consent to it himself, and that parental decisions are fully informed and uncoerced.

'Neonatal circumcision is not child abuse because it has medical benefits'

Is the prophylactic value of neonatal circumcision enough to justify violating a newborn's bodily integrity against his will? (The use of restraints and the degree and character of crying [64,65] during the procedure clearly show that the child undergoes circumcision unwillingly.) Currently, surgical prophylaxis has been assessed in only one other instance [66]. Because the risk of breast cancer and ovarian cancer are significantly increased with *BRCA1* and *BRCA2* mutations, and their presence can be detected, women with these mutations may consider prophylactic mastectomy or oophorectomy. Even in the average 30-year-old woman without these genetic markers, prophylactically removing both breasts and ovaries would add an additional 8 months in life expectancy. In either case, such prophylactic surgery is considered a 'highly personal decision' made only after clear discussion of its effects on medical outcomes, and despite the increase in life-expectancy for the average woman, the authors of the study concluded that 'prophylactic surgery is obviously unreasonable for these women'. [66]. Yet, for every death from penile cancer in the USA, 264 women will die from either ovarian or breast cancer [67]. If prophylactic mastectomy and oophorectomy at age 30 are considered 'obviously unreasonable' [66], why should prophylactic circumcision be considered 'reasonable' when the benefits, the existence of which is dubious, are markedly more remote? One study found that circumcision decreased the number of quality–adjusted life years by a mean of 14 h [68], while another found a mean increase of just 10 days [69].

The assumption that neonatal circumcision has prophylactic value has never been conclusively proven [68–71]. Haberfield, who has written in defence of circumcision, relies heavily on its asserted benefits in asserting its legality [72]. By doing so, that author shows ignorance of the law, the medical evidence and the thrust of the QLRC report [26]. In contrast, that author argues that female circumcision is properly classified as illegal by many Western countries because it has no medical benefits acknowledged by Western medicine [72]. These arguments are fundamental flaws. First, female circumcision has in the past been proposed by some medical professionals as possessing many of the same medical benefits that supporters of male circumcision currently argue result from the latter procedure [73]. If studies of a quality comparable to that of the studies that have purported to show a medical benefit for male circumcision were performed for female circumcision, a medical benefit for female circumcision might be 'demonstrated' as well. Moreover, with both female and male genital alteration, the persons responsible for performing the procedures, as well as the respective cultures as a whole, validate the importance of childhood genital surgery, and for many of the same asserted reasons [74].

Second, Haberfield largely ignores the costs involved in circumcision. While amputating a foot to prevent ingrown toenails could be construed as a benefit, one clearly needs to incorporate into the decision-making process due consideration of the risks, complications and loss of function resulting from the proposed procedure. Neonatal circumcision has repeatedly been shown to be cost-ineffective and to have an overall detrimental impact on health [68–71]. These findings negate any argument that the procedure's asserted medical benefits override a child's rights to bodily integrity and health, both of which are protected by international human rights standards [5,7,28].

The *Convention on the Rights of the Child* [28] requires all nations to respect the child's right to enjoy the highest attainable standard of health (Article 24). The Convention calls for the abolition of traditional practices prejudicial to the health of children (Article 24.3). Unnecessarily exposing a child to health risks (including death), pain and genital alteration clearly contravenes these provisions. *The Convention of the Rights of the Child* has attained a rare level of international authority because it has been adopted by every nation in the world except the USA and Somalia.

'Neonatal circumcision is not child abuse because it constitutes only ''minor surgery'''

Haberfield's argument that circumcision is allowable because it is not 'major surgery' [72,75] conflicts with the conclusion of the QLRC [26]; Haberfield provides neither evidence or discussion. The analysis suggests that Haberfield is unfamiliar with the procedure, which clearly qualifies as serious, amputative surgery, and misstates the effect of the legal position. The all too common comment that 'minor surgery' is surgery that 'someone else undergoes' applies here. Circumcision performed on older children and adults often requires general anaesthesia with a mean recovery time of nearly 2 weeks [76]. Although newborns have a lower pain threshold than older infants, children and adults [77], the vast

majority of newborn circumcisions in the USA are performed with no anaesthesia [78].

During the circumcision, a baby's blood oxygen level decreases [79]; his heart rate, respiratory rate, blood pressure and stress measures such as cortisol level increase dramatically [80–84]. His cry takes on a surprisingly high-pitched character observed only when a baby experiences excruciating pain [64,65]. He may completely dissociate, a response that is similar to severe post-traumatic stress disorder. He may become oddly quiet in apparent despair at the lack of any available escape from his ordeal [85]. Nearly 20% of those circumcised without anaesthesia will have apnoea/choking episodes [49] consistent with an apparent life-threatening event [86,87].

A boy's sleep pattern is altered after circumcision, with light sleep increasing and deep sleep decreasing in the period after surgery [81,82,88,89]. Infants who are circumcised have been observed to suck harder, faster and more vigorously at their bottles, making them less available to their surroundings, and less able to interact with their mother [90,91]. Feeding also deteriorates after circumcision [45].

Even if the complications from the procedure are ignored, the penis is markedly altered. Circumcision amputates nearly all of the fine-touch neuro-receptors [1], thickens the epithelial layers of the exposed glans, reduces the mobility of penile shaft skin, and results in different sexual behavioural preferences [92,93].

The QLRC (Australia) stated that 'in the absence of ''real'' consent, circumcision would fall within the definition of assault under s.245 of the Queensland Criminal Code. It might also be an offence endangering life or health'. [26]. Some would even argue that the practice of neonatal circumcision constitutes torture, because of the intense and unwarranted pain the newborn suffers, and torture is clearly condemned by international instruments such as the *Convention Against Torture* [94] and the *Universal Declaration of Human Rights* [27].

'Neonatal circumcision is not child abuse where it is performed pursuant to a religious requirement'

While the USA Constitution prohibits government from interfering with religious beliefs, it does not protect practices performed in the name of religion that are harmful to society [95] or to another individual [96,97]. Rights of religious freedoms do not relieve an individual's obligation to comply with a valid, neutral law of equal application [98–104]. Likewise, the *Convention for the Rights of the Child* [25] (Article 14.3), the *International Covenant on Civil and Political Rights* [105] (Article 18.3), and the *American Convention of Human Rights* (Article 12.3) all provide that the free practice of religion is protected so long as it does not violate public safety, order, health, or morals, or the fundamental rights and freedoms of another human being.

The *European Convention on Human Rights* (1950) contains similar provisions and is in the process of being incorporated into the Human Rights Bill in the UK. Although the Bill currently before Parliament contains amendments by the House of Lords exempting mainstream religions, it is likely that the UK Government will remove or change those amendments so that the Bill follows the requirements of the Convention. Even without changes to the Bill as it now stands, there will be nothing to stop an aggrieved person, who complains that his protected rights have been damaged and that remedies have been made unavailable in domestic courts because of the defective incorporation of the Convention, from seeking remedies in the European Court of Human Rights.

Given the significant, lifelong harm caused by circumcision, the clear human rights violations entailed by the procedure, and the absence of genuine medical benefit, circumcision cannot be justified by appeal to the rights of religious freedom of parents or of religious communities. It is a mistake to understand anyone's right to religious freedom to include a right to make decisions regarding the medical care of another person. Rights in our culture protect individual self-determination, which includes control over one's body but which clearly does not include control over the body of another. Thus, regardless of how fervently a person may wish to decide what will happen to another's body, we simply do not understand that person's constitutional liberties to include that decision-making power. In fact, we deem that person's religious convictions to be entirely irrelevant in deciding what rules he or she must abide by in interacting with or making decisions on behalf of others [33].

The US Supreme Court endorsed this conclusion in *Prince v Massachusetts* [106]. In deciding a conflict between parents' religious beliefs and children's physical well-being, it ruled that 'parents may be free to become martyrs themselves. But it does not follow they are free ... to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves'. The religious beliefs of the parents, over which the child has no control, cannot be used to excuse harming the child's temporal interests [96] nor can they entitle the parent to control the child for the parents' benefit [33].

In English law, all factors must be taken into account in deciding what are the best interests of the child [33]. Thus, parents' religious beliefs are only one factor among many when looking at non-therapeutic circumcision, and should be relatively unimportant when making a decision about circumcising children.

Furthermore, it would be improper to impute any religious beliefs to children; doctors are no more in a position to assume what a person will believe when he grows up than are parents. Parents choosing circumcision for religious reasons may in fact be violating the child's own religious freedom, including the freedom to change religious beliefs [20,107–109]. Children should therefore not be compelled to undergo a painful, medically unjustified surgery that alters their genitals merely because the procedure is considered by some members of a religion to be essential to that faith. The procedure may well be inconsistent with the dictates of other religions that the person, who is presently an infant, might select when he becomes an adult. The common use of the phrase 'Jewish or Muslim boy' [72] reflects our inability to approach the decision about circumcision from the infant's perspective. These are boys of Jewish or Muslim parents; they have yet to determine their own religion. Cutting a child's genitalia takes away his right to choose whether to be marked with the scars of that particular religion. A boy, on reaching maturity, may resent a permanent change to his genitals made without his approval for a religion he did not accept.

Thus, Etchells *et al.* [110] are misguided when they suggest that physicians should base the content of the informed discussion on parental motives. They state that 'if the parents' decision is based on strong cultural beliefs and practices, a detailed, impersonal disclosure of all known risks and benefits would probably not be relevant or helpful. However, if the decision is based on personal experiences (e.g. the father was circumcised), a detailed discussion of the risks and benefits would be useful in helping the parents come to a decision'. This statement contradicts their positions on *therapeutic privilege* [111] and *substitute consent* [112], does not address the child's interests, and may be little more than misplaced 'political correctness' in an attempt to preserve tradition and placate Jews and Muslims. They fail to explain how parental motive alters the risks, benefits and treatment options, or the physician's duty to give full disclosure. Risks that these parents consider insignificant may well be significant for the infant. In short, all infants deserve the highest possible level of care, regardless of their parents' beliefs [113].

'Neonatal circumcision is not child abuse because it has cultural benefits'

Haberfield [72] argues that a child of Jewish or Muslim parents may feel psychologically and spiritually isolated from his religion and culture if not circumcised, that a practice integral to these religions has credible cultural value, and that ritual circumcision should be allowed on this basis. He argues that 'the autonomy of its citizens' is of enough value that a state's intervention is inappropriate. This prohibition 'seems further inappropriate in a multicultural society espousing tolerance for diverse cultural practices'. He recognizes that multiculturalism cannot be used as a blanket approval for all cultural practices and argues, for example, that female circumcision would not warrant approval, and that local legislators should be free to prohibit practices they perceive to be repugnant to their communities [114]. However, Haberfield provides little empirical support and no principled basis for treating male and female genital alteration differently.

More reasonably, Poulter [115] argues that a tentative argument for parents authorizing an intervention against a child's interests can be made if the harm caused by the intervention is compensated by sufficient advantage to others, and if the intervention is not seriously detrimental to the child. However, Poulter characterizes as 'unlikely' a justification based on 'the more remote and controversial benefit of satisfying a deeply felt community attachment to traditional customs'. A year later he wrote that any custom that involved 'cruel, inhumane or degrading treatment' such as female circumcision should not be tolerated [116]; he fails to discuss male circumcision.

While Haberfield chastises Richards for failing to 'consider the right of an individual's autonomy in a liberal society' [75], he inexplicably fails to recognize the autonomy of the individual whose genitalia are to be altered. A cultural or religious community may view the child, and more specifically the prepuce, as community property; however, a child must be regarded as possessing the same full rights as any adult to exclusive ownership of his body [33]. Supposed benefits to the rest of society are not accepted as sufficient justification for involuntary surgery on adults. Nor should they be so accepted with children. Such procedures cannot be justified by the possible existence of cultural blindness regarding a particular practice, a phenomenon that allows several clear human rights violations to persist in various cultures throughout the world. The QLRC states that the best interests of a child 'is a matter to be determined objectively'. [117]. Clearly, Haberfield's attempts to justify a harmful cultural practice fall short of the mark.

'Neonatal circumcision is not child abuse because it is not as damaging as female circumcision'

The notion that female circumcision is more damaging than male circumcision may be more the product of cultural blindness than any actual difference in severity. The justifications given for altering the genitalia of both sexes are strikingly similar [6,74], and several legal scholars find the practices equally problematic

[6–8]. The dramatic changes in anatomy, the horrific complications (including death) that can arise [118–124], and the prolonged psychological sequelae [85,125–128] leave little doubt as to the damaging effects of male circumcision. While the most drastic forms of female circumcision arguably entail greater harm than male circumcision, some forms of female circumcision involve less drastic procedures that are comparable in severity to male circumcision.

In any event, the human rights principles outlined above are absolute in their protection of certain basic rights that are violated by childhood genital alterations, regardless of severity. These human rights laws do not calibrate the illegality of various mutilations according to their relative levels of severity [3,5]. Any genital alteration that is not medically necessary infringes the basic human right to bodily integrity. Statutes that safeguard females against any alteration of their genitals while ignoring male genital alteration are illogical in their discrimination against males [5,7]. Such laws highlight the artificiality of our culturally based treatment of male circumcision.

The Fifth and Fourteenth Amendments of the US Constitution guarantee equal protection under the laws and prohibit discrimination on the basis of sex without 'an exceedingly persuasive justification' [129], i.e. proof by the state that affording lesser protection to one sex closely serves an important state interest [130]. It is therefore unlikely that American gender-specific laws against female genital alteration could survive constitutional scrutiny [131]. Circumcision serves no interest of the state, let alone an important one. Case law and constitutional law in the USA demonstrate that courts have the power and duty under equal protection principles to extend the protection of female circumcision statutes to boys [131–133].

Equal protection principles embedded in international law and binding all nations under treaty and/or customary law similarly prohibit invidious discrimination on the basis of gender, such as is inherent in the statutes that prohibit only female genital mutilation but permit the continuation of the male procedure. The *International Covenant of Civil and Political Rights* [105] provides that every child must have, without discrimination, the right to the same protections (Article 24.1). This is echoed in the *Universal Declaration of Human Rights,* which states that 'all are equal before the law and entitled without discrimination to equal protection of the law'. (Article 7). The *Charter of the United Nations* likewise calls for the 'observance of human rights and freedoms for all without distinction as to race, sex, language, or religion'. (Article 55c) [5].

Revealingly, lawmakers in the USA have at times implicitly acknowledged that male circumcision may constitute ritual abuse, at least in certain circumstances. No other apparent explanation exists for the specific exemptions for male circumcision in the ritual abuse laws of California (California Penal Code, para 662.83), Idaho (Idaho Criminal Code, para 18–15-06A,4b) and Illinois (Illinois Compiled Statutes para 5/12–32 and 5/12–33). These legislators must have considered male circumcision ritual abuse; otherwise there would have not been a need to include this statutory loophole.

'Neonatal circumcision is not child abuse because it has never been prosecuted as such'

The only judicial references to the lawfulness of male circumcision in the UK appear in two offhand comments by the court in *R v Brown* [134] and *R v Adesanya* [135]. In neither case is supportive evidence given for these declarations. With a similar lack of justification, Williams considered the illegality of ritual circumcision 'utterly absurd' [136]. Most commentary supporting circumcision's legality relies on the untenable notion that it is in no way medically harmful [115,137]. On the other hand, several scholars have credibly argued that neonatal circumcision could be prosecuted under current statutes [26,138]. Adequate consent is the usual source of privilege that may justify an otherwise medically unjustified and harmful surgery. In the absence of such consent, neonatal circumcision satisfies the definition of criminal assault and battery. All assaults that inflict bodily harm are illegal [139]. Brigman states that 'since circumcision is medically unwarranted mutilation and disfigurement, it would appear to be a clear case of child abuse' [8]. While there have been no reported cases of successful prosecution of a male circumcision that was performed to the standard of care and to which the parents consented, this may be largely an artefact of the cultural tolerance of a practice that other cultures consider reprehensible. Numerous activities once tolerated as lawful are now considered criminal, including violence against one's wife, children, servants, or animals [134]. Among the functions of criminal law are protecting citizens, especially the young and vulnerable, from what is injurious, and providing safeguards from exploitation [140]. Brigman recommends using existing state laws prohibiting assault and battery to prohibit circumcision, but acknowledges that it would be extremely difficult to obtain a conviction [8].

Discussion

American attitudes toward neonatal circumcision may be in the throes of a paradigm shift [141]. The medical

justifications suggested for neonatal circumcision are rapidly being exposed as myths, while the procedure's defenders are becoming more vocal in their attempts to prevent the truth about the procedure from being absorbed into mainstream American culture [142–144]. However, cultural blindness is likely to hinder progress in allaying the damage caused by male circumcision. Laws generally reflect societal attitudes and rarely herald dramatic social transformation. Likewise, judges are more likely to respond to well-established social trends than to be the vanguard of dramatic change. Courts naturally view issues through society's social and cultural prejudices [5].

There is little doubt that a physician who today performs an operation with no therapeutic benefit, and which results in significant risk and inevitable loss of function, risks a civil claim for damages as well as censure from his professional body. In the USA, circumcision commonly serves as a basis for malpractice claims [145]. The current practice of inadequate disclosure of information during the informed consent process may be responsible for some of these claims. Citing *Bolam* vs. *Friern Hospital Management Committee* [146], Haberfield [72] argues that while a physician is always obliged to fully disclose the risks and benefits of a proposed procedure, as long as the physician follows the practice accepted at the time by a responsible body of medical opinion, the doctor cannot be held negligent. However, that analysis does not take into account a recent Irish court ruling that a doctor who follows a practice approved by colleagues of similar specialities could nevertheless be challenged if it can be established that the practice has inherent defects that ought to be obvious to any person who gives the matter due consideration [147]. Likewise, under British law, physicians cannot defend themselves from charges of malpractice/assault/battery by stating that they were 'inspired by a belief in the efficacy of a pseudo-medical treatment' [134]. Haberfield's suggestion does not accord with the law in the UK or elsewhere; full disclosure is required regardless of contemporary medical opinion [148].

However, Haberfield also contends that circumcision's '*claimed* prophylactic medical benefits' would help a physician pass the Bolam test. In reality, the physician's liability is related to the body of medical opinion and, more importantly, to the validity of parental consent. In the context of circumcision, the current American practices of solicitation of a medically unnecessary operation with no prior parental inquiry and unrequested consultation represent glaring exceptions to ethically practised medicine [58]. In the absence of medical need, it is hard to see how solicitation for this surgery amounts to anything more than the exploitation of normal and healthy children for money.

Conclusion

The medical community is violating the law through a combination of faulty medical opinion, negligence and inadequate consent [7]. Circumcision amputates the prepuce from the penis, resulting in a permanent alteration in the anatomy, histology and functional integrity of the penis. The procedure is not without risk, and horrific complications have been widely recorded in the medical literature. For circumcision of a non-consenting minor to be legally valid there must be a clear and immediate medical necessity; unsolicited, uncoerced, fully informed parental consent; and a determination that it is in the child's best interest. It must be shown to a reasonable degree of certainty that the child would, upon attainment of the age of reason, desire circumcision for himself. For circumcision to be permitted as a religious ritual, it would need to be demonstrated that the child is virtually certain to choose to practise that religion upon attaining the age of reason and that the child will suffer in some way from having the decision reserved for him to make as an adult. Circumcision as currently practised on non-consenting minors fails to meet these criteria.

There is no reason, other than cultural bias, why the current child abuse laws and laws prohibiting female circumcision are not applied to those performing involuntary male circumcision. For those physicians currently performing involuntary circumcisions, the only protection may be full disclosure, but based on current legal precedent, this may not be enough.

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Authors

R.S. Van Howe, MD, FAAP, Clinical Instructor.
J.S. Svoboda, JD, Attorney, Director, Attorneys for the Rights of the Child.
J.G. Dwyer, JD, PhD, Professor of Law.
C.P. Price, MA, Solicitor.
Correspondence: Robert S. Van Howe, MD, 9601 Townline Road, PO Box 1390, Minocqua, Wisconsin 54548–1390, USA.
E-mail: vanhower@dgabby.mfldclin.edu