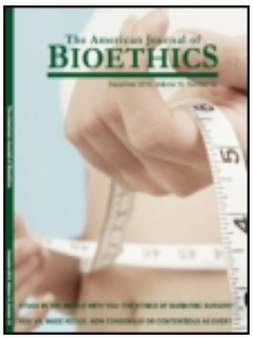

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Can Anyone Authorize the Nontherapeutic Permanent Alteration of a Child's Body?

George Hill, Doctors Opposing Circumcision

Michael Benatar and David Benatar's (2003) "cost-benefit" analysis of male circumcision rests on the premise that the major "cost" is pain during the procedure and that this can be alleviated with local anesthesia. They say nothing about pain afterward, nor do they discuss the literature on after-effects: interference with breast feeding (Howard, Howard, and Weitzman 1994), disturbed sleep (Anders and Chalemian 1974), elevated cortisol levels (Emde et al. 1971), increased sensitivity to pain (Taddio et al. 1997), and so on. They say much more about "benefits." They recite the familiar case for "prophylaxis" against a variety of diseases. Despite the objective tone, however, their article is yet another defense of a procedure that has been in search of justification for more than a century—a matter well documented by Gollaher (2000), who the Benatars cite in another context.

The Benatars' statement that "circumcision has received negligible attention" in the bioethics literature is inaccurate. In fact, there have been extensive discussions in both the bioethics literature (Denniston 1996; Price 1997; Hodges 2002) and the general medical literature (Kluge 1993; Warren 1996; Canning 2002). In all papers, the authors found male neonatal non-therapeutic circumcision to be highly unethical. More importantly, perhaps, are the very extensive discussions that have appeared in the *legal* literature (Brigman 1985; Richards 1996; Povenmire 1998–99; Boyle 1999; Edge 2000; Svoboda 2000). The authors all question the lawfulness of the non-therapeutic circumcision of children. Certainly, if circumcision is an unlawful medical practice, then it is also an unethical medical practice.

The Benatars argue that the circumcision of children is a suitable matter for parental discretion. They fail to show, however, that the circumcision of children is an ethical procedure for doctors to carry out. In all cases involving children, it is essential to remember that the child is a separate person from the parents. The interests of the two may diverge and that is certainly true in the matter of male circumcision. A child has a separate set of rights and privileges, and it is to the child that the doctor's responsibilities are directed (Committee on Bioethics 1995). The doctor must keep the child-patient's interests paramount (Council 2001). The doctor must provide medical care based on the patient's needs, not what someone else desires (Committee on Bioethics 1995). Since no infant needs a circumcision, the doctor has an obligation to not perform the circumcision. Nonessential procedures should be deferred until the patient is sufficiently mature to decide for himself (Committee on Bioethics 1995). The doctor has a duty to listen to the child (Shield and Baum 1994) and, since circumcisions clearly are not essential for child health (Task Force 1999), the doctor has a duty to defer a non-therapeutic circumcision until the child can decide for himself.

The Benatars are silent on developments in Europe. Article 20(1) of the *European Convention on Human Rights and Bioethics* (1997), now in force in 15 nations, prohibits organ or tissue removal on a person who does not have the capacity to consent. This obviously applies to non-therapeutic circumcision of children. The Norwegian Council for Medical Ethics has determined that the circumcision of male children is an unethical procedure because of human rights concerns and lack of consent by the patient (Gulbrandsen 2001).

The foremost "cost" of male infant circumcision—never mentioned by the Benatars—is the loss of the most heavily innervated tissue in the male genitals (Taylor, Lockwood, and Taylor 1996) and the resulting loss of substantial sexual sensation in adult life (Falliers 1970). The Benatars know this. Gollaher's book includes a chapter describing research on the anatomy and functions of the foreskin. But, rather than facing this very real issue, the authors drift into a pointless academic discussion of the meaning of *mutilation*—a gigantic red herring—which leads them to the comfortable conclusion that talk of that sort is just "dogma," not the kind of "reasoned conclusion" required in a legitimate discussion of bioethics.

The question is not whether circumcision is "mutilation." The question is whether anyone, parents included, has the right to decide to remove the extremely sensitive genital tissue from an infant for any reason other than unquestionably urgent medical necessity (Richards 1996; Price 1997; Povenmire 1998; Svoboda, Van Howe, and Dwyer 2000; Edge 2000).

Women also pay a high price for male circumcision (O'Hara and O'Hara 1999). The O'Haras surveyed 138 women who had sexual experience with both circumcised and intact males. The women preferred the intact male over the circumcised male by a ratio of 8.6 to one. O'Hara reported that the women surveyed were much more likely to experience orgasm when the partner was intact (O'Hara 1999).

The foreskin plays an essential role in the dynamics of sexual intercourse, enabling nontraumatic intromission (Taves 2002) and facilitating gliding action (Warren and Bigelow 1994). Older women in particular may experience friction and irritation during intercourse with circumcised men, but the problem affects all ages. Note that sale of sexual lubricants in this country far exceeds that in countries where routine, nontherapeutic circumcision is unknown—that is, most of the world.

Which brings me to a final point, again one that the Benatars gloss over. In Britain, Canada, and elsewhere in the English-speaking world, physicians have already decided that there is no justification for routine circumcision (British Association of Paediatric Surgeons et al. 2001; Fetus and Newborn Committee, Canadian Paediatric Society 1996; Beasley et al. 2002), and rates have dropped sharply. Continental Europeans have never accepted the practice, nor have nearly all the countries of Latin America and Asia (the single exception being South Korea, owing to the influence of the U.S. military). Are French, German, Belgian, Dutch, Swedish, Norwegian, and Danish men suffering from high rates of penile carcinoma, AIDS, or any of the other diseases discussed in such careful detail by the Benatars? If not (and they are not), what happens to the authors' carefully constructed argument on "benefits"?

A genuinely balanced article on the ethical question posed by circumcision would have acknowledged that the arguments for "prophylaxis" are equivocal at best, while the argument for what they misleadingly label "child abuse" is in fact quite solid once we recognize that loss of the foreskin is a genuine loss and that removal of a nonconsenting person's vital genital tissue is a clear violation of that person's right to bodily integrity and freedom from arbitrary physical harm.

The commonly accepted ethical tests are beneficence, non-maleficence, justice, and autonomy. The Benatars have avoided applying these basic tests to child circumcision. Circumcision fails all four tests:

1. Non-therapeutic circumcision of male children fails the test of beneficence because it lacks a proven documented benefit. (Gulbrandsen 2001; Hodges 2002)
2. Non-therapeutic circumcision of male children fails the test of non-maleficence because it inflicts bodily injury and pain to the patient by surgically excising healthy functional tissue. (Price 1997)
3. Non-therapeutic circumcision of male children fails the test of justice because it violates the patient's legal right to bodily integrity. (Price 1997)
4. Non-therapeutic circumcision of male children fails the test of autonomy because consent must be given by proxy. (Price 1997; Gulbrandsen 2001)

The Benatars have left many issues unexplored. Their failure to adequately address these issues is disturbing. ■

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