Male circumcision – see the harm to get a balanced picture

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Introduction

Female circumcision is subject to a worldwide campaign for its eradication. Male circumcision has been practised for non-therapeutic reasons for 6000 years. Male circumcision predates the Hippocratic oath and no doubt claims 'grandfather rights' from its antiquity. Medical intervention today should, however, be evidence-based and justified in terms of the moral, ethical and legal standards of our time.

The minute that the surgeon cuts the skin, harm is done. The benefits of treatment have to exceed the harm before the doctor is doing any good [1]. I write on behalf of a charity established to represent the rights of patients to avoid therapeutically unnecessary circumcision. As such, I will approach the subject from the point of view that the highest standards of male health can only be achieved when the normal male sex organs are kept intact unless there is some unavoidable justification to remove a part of them.

I will set the medical situation in its historical context and then examine the main ethical issues in relation to male circumcision. This discussion is purely confined to male circumcision in a medical context and in no way seeks to address circumcision performed for religious reasons.

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Historical background

For over a century, countless claims have been made for the effectiveness of male circumcision in preventing or treating disease. A selection, which is by no means exhaustive, includes the following:

- Mental illness [2]
- Tuberculosis [3]
- Masturbation [4]
- Penile cancer [5,6]
- Syphilis [7]
- Urinary tract infections [8]
- Accelerated hypertension [9]
- Schistosomiasis [10]
- Human immunodeficiency virus (HIV) [11–14]

None of these claims meets the gold-standard of proof of clinical efficacy: the randomised *double blinded* controlled trial. While randomised controlled trials (RCTs) of circumcision to prevent HIV have been published, they were not subject to blinding and are, therefore, subject to observer bias. The trials were stopped early on criteria set by the authors. Trials stopped early tend to overestimate the efficacy of the intervention [15]. A RCT of circumcision for the prevention of urinary tract infections (UTIs) in boys with vesico-urethral reflux concluded that circumcision was *not* effective in reducing recurrences of UTIs [16].

Having said that, I do not intend to challenge the validity of any of these claims. Rather, I wish to set them in the context of that which is invariably overlooked: that circumcision is harmful. Only by understating or ignoring the harmful aspects of circumcision can it be concluded that the procedure is acceptable in the absence of unavoidable therapeutic need or the consent of an informed adult patient.

Harmful effects of circumcision

Male circumcision permanently removes normal, functional, specialised tissue. It removes

specialised sensory tissue [17], half the penile skin [17] and removes the normal gliding function that facilitates intromission [18]. Circumcision removes the most sensitive part of the penis [19].

The penis has its appearance permanently altered by circumcision. These changes are not welcomed by all [20]. While some consider circumcision to be a beautification others consider it a disfigurement.

Reported complication rates for circumcision have been as high as 55% [21]. In one British series, more than 20% of day-case circumcisions required later intervention by their General Practitioner (GP) [22]. Complications of circumcision include tetanus, loss of the glans, loss of the entire penis and death [23]. Bailey et al reported a 1.5% complication rate including anaesthetic morbidity, pubic abscess and impotence [13]. Gray et al reported complications in 3.6% [14]. These complications are potentially devastating for the individual and may present a burden on future health services. Recent studies have reported a reduction in sexual satisfaction following circumcision in 17% [24], 27% [25] and 38% [26] of patients.

As a charity, we have received and responded to many letters from men who object to having been circumcised as children and who have suffered decades of anguish over a procedure that was imposed on them without personal consent and, in most cases, without adequate therapeutic need.

Health is not just about prevention of disease. It is also about wholeness, wellbeing and avoidance of harm. Any consideration of circumcision for the treatment – let alone prevention – of disease must take account of the lifelong burden imposed on the individual being circumcised as a result of what is an irreversible and harmful intervention. I suggest that anyone who can empathise with the patient would not subject them to such a treatment unless it was necessary as a treatment of last resort.

Ethical background

Many medical treatments, including male circumcision, are invasive. Doctors have a duty to favour the use of less invasive techniques for treatment [27]. Invasive treatments are only acceptable where they form part of a hierarchy in which treatment is only given where there is a valid clinical indication for treatment and non-invasive techniques have been exhausted.

Invasive medical treatments are legally and morally acceptable only because they have the informed consent of the patient. Informed consent requires disclosure by the doctor of the effects of the procedure, the complications giving rise to significant risk, the prospects of success and the possible alternative treatments.

Consent is required to safeguard an individual's autonomy – that anyone has a right to determine what happens to his own body. The golden rule is that nobody should have to suffer something they would not be happy to have done to them [28].

What of someone incompetent to consent? Children need special protection since they are unable to safeguard their own interests and – if very young – they cannot achieve the understanding necessary to give or withhold consent. It is, however, important that they receive medical treatment when it is in their best interests to have it. Likewise, it is important that they be protected from unecessary medical treatment or unnecessarily invasive medical treatment [29].

In the common law jurisdictions parents have a power of proxy consent. However this is not without its problems. Doctors have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses [30]. A parent's power of proxy decision-making in respect of their child stems from their duty to protect and nurture the child. As such it is right for parents to give consent to medical procedures that are in their child's best interests; but it is also their duty to withhold consent on behalf of the child where the procedure would not be in the child's interests.

Parents are expected to exercise substituted judgement in respect of whether a child should have an intervention or not. A parent will not be able to exercise that judgement correctly if they do not have the proper unbiased information from the doctor. Moreover, the parents may lack capacity for the appropriate substituted judgement if the father himself lacks a foreskin and, therefore, they do not understand what the child will

lose. Thus it is imperative for the doctor to give full, unbiased, information and to be held to account if he does not.

Acceptability of circumcision

Circumcision is unusual in that the same procedure may be used either as a therapeutic procedure, for the treatment of disease, or as a non-therapeutic procedure. It is important to distinguish the two in order to clarify the issues.

Non-therapeutic surgery is normally only acceptable when it is requested by an informed consenting adult. It is difficult to find any persuasive reason why non-therapeutic circumcision should be treated any differently to non-therapeutic removal of any other body part.

In keeping with the hierarchy of medical intervention favouring less invasive treatment, therapeutic surgery is normally justified if the following considerations are met:

1. That disease is present in the patient.
2. That non-invasive treatment for the patient's disease is not possible, i.e. that it has been tried and has failed.
3. The proposed surgery is of proven efficacy for treating the disease.
4. Valid informed consent has been obtained.

In the specific context of male circumcision, the British Medical Association has given advice that is broadly consistent with the above:

> *Unnecessarily invasive procedures should not be used where alternative, less invasive techniques, are equally efficient and available. It is important that doctors keep up to date and ensure that any decisions to undertake an invasive procedure are based on the best available evidence. Therefore, to circumcise for therapeutic reasons where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate* [27].

It remains the case, however, that far more circumcisions are being prescribed than are actually justified by the presence of disease [31–36]. Since surgical interventions should only be performed when clinically necessary, especially in children [37], it seems appropriate for those of us who set ourselves up as medical educators to propose a clinical protocol for prescribing circumcision. A suggested protocol is given in Box 1.

Circumcision of children requires special consideration in view of the fact that the patient may not be old enough to give consent in their own right. Since most circumcisions of children are being performed to treat a normal self-correcting condition of childhood, delaying the surgery can have the dual benefit of allowing more time for resolution of the condition and allowing the decision for the surgery – if any – to be made by the person who will be under the knife.

It would seem ethically inappropriate to perform surgery on children to prevent diseases of adult life. The decision as to whether or not it is worthwhile to have a circumcision to prevent penile cancer or HIV could be made by the individual himself when of sufficient age and maturity to give or withhold consent in his own right.

The world does now face demands to introduce mass infant circumcision on the basis that it is necessary to fight the pandemic of HIV in poor countries. To do so would be unethical in the extreme. Not only would it ride roughshod over the rights of the child to self-determination, but it could also prove counterproductive. While the proponents of circumcision to prevent HIV claim to have proved their case by carrying out randomised trials, uncertainties remain. The reality is that circumcision would facilitate iatrogenic transmission of HIV [38], encourage male-to-female transmission [39] and bring about risk compensation. Another factor is that male circumcision may facilitate HIV transmission by reducing production of langerin – a natural barrier to HIV transmission [40]. These factors could more than offset the 0.66 cases of HIV per 100 man years saved by the introduction of male circumcision. And of course the complications of circumcision could outweigh the number of HIV cases prevented.

The elephant in the room is that some cultures do practice non-therapeutic infant circumcision as a traditional practice. Perhaps this is a 'grandfather right'. But it is not consistent with modern standards of law, ethics or human rights to remove a normal foreskin from a normal unconsenting child. The levels

Box 1 Suggested treatment protocol for foreskin complaints

1. Confirm the presence of disease.
   a. The normal foreskin may not become retractable until late adolescence [41–45].
   b. The normal non-retractable foreskin of childhood is not a disease and requires no treatment [46–48].
   c. 'Ballooning' of the foreskin is not diagnostic of disease [49].
   d. 'Pinhole Meatus' is not diagnostic of disease [46].
   e. Length of the foreskin is not diagnostic of disease.
   f. Balanitis xerotica obliterans (BXO) is more properly referred to as lichen sclerosus [50–55].
2. Consider availability of less-invasive treatment.
   a. A tight foreskin (phimosis) where no disease is present at a cellular level can be treated by gentle stretching [56,57], potent steroids [58–60] or conservative surgery [61–74].
   b. Recurrences of balanitis can be minimised by the restriction of washing with soap [75,76].
   c. Lichen sclerosus of the foreskin can be treated with potent topical steroids; the success rate for treatment being dependent on the potency of the steroid [77–79].
3. Consider the clinical effectiveness of circumcision:
   a. There is no reliable evidence to show that circumcision is effective in preventing recurrences of balanitis.
   b. There is no evidence that circumcision is effective in treating lichen sclerosus other than where it solely affects the foreskin [80–87].
   c. Circumcision has been shown to be ineffective in preventing recurrences of urinary tract infection in boys with vesico-urethral reflux (VUR) [16].
4. If, then, circumcision is recommended, the following must be disclosed for informed consent:
   a. Circumcision permanently alters the appearance of the penis.
   b. Circumcision removes the normal gliding function of the penile skin [18].
   c. Circumcision removes specialised sensory tissue that has a possible role in the control of ejaculation [17].
   d. Studies show that up to 38% of men report diminished sexual pleasure following circumcision [24–26].
   e. A realistic assessment must be given of the prospects of circumcision achieving the goal of treatment.
   f. Circumcision has a high incidence of complications and, while most of these are minor, they can include loss of sexual satisfaction, impotence, loss of glans, loss of the penis and death [23].
   g. Treatment alternatives.

of complications from circumcision are consistent with the practice being prejudicial to the health of children. Those countries that have ratified the 1988 Declaration of the Rights of the Child are obliged to take effective steps with a view to abolishing such practices.

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