

SYMPOSIUM ON CIRCUMCISION

The development of professional guidelines on the law and ethics of male circumcision

R Mussell

See end of article for authors' affiliations

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Correspondence to:
R Mussell, Ethics
Department, BMA,
Tavistock Square, London,
WC1H 9JR; rmussell@
bma.org.uk

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This paper does not attempt to lay out the arguments relating to male circumcision for non-medical reasons. Rather, the aim is to focus more on the process and the problems of a professional body (in this case the British Medical Association (BMA)) attempting to produce any consensus guidelines for its members on an issue which clearly polarises doctors as much as it divides society as a whole. The legal and ethical considerations of male circumcision are inevitably touched upon here but are not the central issue. In 2003, the BMA published professional guidance on this subject. Some thought this a pointless exercise; others saw it as an initiative which simply failed to go far enough. Reservations centred on the fact that the BMA's guidance—like that of the statutory body, the General Medical Council—explored the issues without either firmly rejecting or accepting non-therapeutic male circumcision. Was it then a fruitless project or a brave start to grasping the nettle?

This paper is only concerned with circumcision of male children for whom there is no medical indication. This is often known as non-therapeutic or “ritual” male circumcision although some groups object to either term, seeing each as pejorative in different ways.

Readers will be disappointed if they expect this paper to lay out comprehensively all the arguments relating to this form of male circumcision. Rather, the aim is to focus more on the process and the problems of a professional body (in this case the British Medical Association (BMA)) attempting to produce any consensus guidelines for its members on an issue which clearly polarises doctors as much as it divides society as a whole. The legal and ethical considerations of male circumcision are inevitably touched upon here but are actually covered more fully in the BMA's previously published guidance on the subject.^{1,2} It is not our intention to rehearse afresh those arguments.

By way of a preliminary point, it is worth noting that the routine circumcision of male infants and children has been practised worldwide for centuries and thus is deeply embedded in the family life of some populations. Male infant circumcision does not require medical expertise and, indeed, is often done by special practitioners within religious groups who are not medically qualified. Despite this fact, male circumcision has become an issue for medical ethical debate.

The actual extent of non-therapeutic male circumcision in the UK is unquantifiable. At the time when the BMA guidance on male circumcision was written, it was known that over 20 000 male circumcisions occurred in English National Health Service (NHS) hospitals in one year. (In 1999–2000, for example, 205 NHS hospitals in England recorded a total of 21 763 inpatient episodes where the main operation was circumcision.) It is not known, however, how many of these were carried out to rectify a medical condition or how old the patients were. In addition, the rate of circumcisions carried out privately or by religious practitioners is not recorded, although the Jewish and Muslim religions recommend that followers observe the practice and so it is likely to be a common procedure.

Views on the issue have become increasingly polarised over the years, both within society and the medical profession. Various factors have played a role in this, such as the

conflicting evidence of clinical benefit (although that is probably not the main aim nowadays of parents who choose to circumcise their child), growing awareness of children's rights, and the increasing secularisation of some societies. Arguably, another contributing factor to the challenge to routine circumcision has been the growth in medical ethics of the notion of personal autonomy, which lays emphasis on individuals choosing options for themselves wherever possible rather than being pre-empted in their decisions.

Against this backdrop of contention, in 2001, the BMA decided at its annual meeting that it needed to “investigate the issues surrounding the circumcision of male children for whom there is no valid medical indication”. The task was passed to the association's ethics committee which published *The Law and Ethics of Male Circumcision: Guidance for Doctors* in 2003.¹

PROFESSIONAL GUIDANCE—AN EXPLANATION

When professional guidance is issued on such a contentious issue some justification and explanation are required. Not least, it is important to demonstrate the transparent and evidence based approach behind the arguments rehearsed in the guidance and to establish its validity so that it is accepted and used by medical practitioners. Often, the primary purpose of such guidance is to demonstrate best practice in relation to the intervention in question. If there is no clear steer on an issue, however, it is crucial that factors that individual doctors need to consider in practising as diverse, autonomous practitioners are laid out to inform the decisions they make. With this guidance—for example, whilst exploring the issues, the BMA does not come out firmly rejecting or accepting male circumcision in circumstances where there is no medical indication. What it does do is to examine concepts such as “best interests”, and how competing elements of “best interests” might be weighed up against each other.

CONSENSUS ON NON-THERAPEUTIC MALE CIRCUMCISION—SOCIETY, PROFESSIONAL ASSOCIATIONS, AND COMMITTEES

As noted before, debate in society surrounding circumcision of male children is intensely fraught, with individuals and groups holding conflicting positions. This is reflected in diverse media reports and lobbying groups:

Conflicting positions on male circumcision

- support: the celebrations at the Turkish Army's non-therapeutic circumcision of over 90 Afghani boys. A Turkish officer overseeing the event stated that: "Being circumcised is an important rite of passage for any Muslim male...it is accepted even by non-Muslims for health and hygiene reasons, but for us it is part of our faith"³;
- qualified support: the introduction of legislation in Sweden permitting male circumcision for any reason *only* under anaesthesia and with a doctor or nurse present, following the death of a three year old boy during a non-therapeutic circumcision procedure. Although in response, Stockholm's Jewish community has been quoted as saying that as a result of the new legislation "they will not be able to find nurses or doctors to help them perform the ceremony because many health professionals in Sweden view circumcision as a form of mutilation". Furthermore "circumcision impossible to carry out in practice would make the Swedish/Jewish congregation, which is already a small minority in Sweden, feel isolated and vulnerable"⁴;
- opposition: opposition is found in such organisations as the British charity, NORM-UK, that deals with foreskin health and the avoidance of therapeutically unnecessary circumcision, and the USA lobby group, Doctors Opposing Circumcision (DOC). On the latter group's website⁵ the following quote appears from a male who has been circumcised: "fear, pain, crippling, disfigurement and humiliation are the classic ways to break the human spirit. Circumcision includes them all"⁶.

Typically if there is widespread societal controversy regarding a subject, that controversy is also reflected within the multicultural, multifaith BMA membership. This is certainly true of circumcision. Thus merely to achieve some kind of consensus on the subject in the BMA's medical ethics committee (MEC)—a committee comprising doctors, philosophers, lawyers, and theologians—was always going to be a difficult task. Even if such consensus could be reached in such a small group, the task of convincing the BMA's 130 000 members was daunting indeed. Nevertheless, there was strong feeling at the association's 2001 annual meeting that the issue could not simply be shelved.

NON-THERAPEUTIC CIRCUMCISION OF MALE CHILDREN—A MATTER FOR SOCIETY AS A WHOLE TO DECIDE RATHER THAN FOR DOCTORS

On many purely moral and social issues, it is not clear what role—if any—a professional group should play in contributing to the debate. The medical profession—for example, has frequently been criticised for "medicalising" moral debates and defining what is "abnormal".⁷ Indeed the BMA in the mid-1950s had a special committee looking at homosexuality and prostitution which called for treatment to be provided to "help individuals overcome their habits"; and the *BMJ* recently ran a couple of articles on the medicalisation of homosexuality prior to and during the 1970s.^{8,9} Generally such intrusion by the profession is now seen as inappropriate, unless there is a clear medical point to be made. With respect to investigating male circumcision, part of the BMA's

Summary of the key points in the BMA guidance

The welfare of the child patient is paramount and doctors must act in the best interests of the child in each individual case. Furthermore:

- competent children should participate in the decision;
- consent is valid only where the people (or person) giving consent have the authority to do so and understand the implications and risks;
- it is for *parents* to demonstrate that non-therapeutic circumcision is in a child's best interest;
- parental preference alone may not necessarily be sufficient to justify circumcision;
- both parents should give consent before circumcision for non-therapeutic purposes is performed;
- if parents disagree about circumcision, doctors should not proceed without the go ahead of a court;
- assessment of a child's best interests includes physical and emotional needs; the risk of harm or suffering; the views of the parents and family, and the child if he is old enough to participate in the decision; the implications of performing, and not-performing, the procedure, and relevant information about the patient's religious or cultural background, amongst other things.

The full BMA guidance document, *The Law and Ethics of Male Circumcision: Guidance for Doctors*, is available at www.bma.org.uk/ap.nsf/Content/malecircumcision2003

intention was to collect, interpret, and evaluate such medical evidence as exists of clinical harm or benefit.

Some BMA members believe that Association should avoid issues such as male circumcision, arguing that it is not the role of doctors to comment on a practice that is predominantly religious and ritualistic, in the absence of demonstrably significant medical repercussions. To comment may be perceived to be interfering too much in the relationship between parents and their children (if it were proven that the procedure presented only a small risk to the child). From this viewpoint what limits should be imposed on parental choices for their children is a matter for society as a whole to decide. On the other hand, there is a broad awareness that doctors have an important role in advising parents on a wide range of matters which might affect their children's welfare, and they are often asked to carry out the procedure.

DEVELOPMENT OF THE DEBATE IN THE BMA IN PREVIOUS YEARS

- The BMA has had guidelines on male circumcision since 1996, but these earlier guidelines similarly neither accepted nor rejected non-therapeutic male circumcision.
- In 1998 there were attempts to modify these guidelines to incorporate the following statement from the ethics committee: "Where doctors use medical techniques for non-therapeutic purposes on an individual, they must be convinced that to do so confers a clear benefit to that individual. There is a conflict of opinion about the benefits and harms of circumcision, and practitioners should not proceed unless convinced that there is a clear net benefit to the child. Assessment of benefit should include medical, psychological, social, and cultural factors."

- This statement was not accepted by the BMA's council (which is the BMA's central executive) and instead a request was made for the MEC to produce new detailed draft guidelines on male circumcision.
- The BMA council went on to reject these draft guidelines because of continuing disagreement, partly on the status to be given to children's human rights and the rights of their parents to choose for them.
- The controversy over male circumcision within society as a whole, however, grew, accompanied by significant developments within the law and professional guidance. These included:
 - developments in the common law—for example, a case in which parents were in dispute over circumcising their child.¹⁰
 - the implementation of the Human Rights Act 1998, which each side of the debate saw as potentially supportive of its viewpoint.
 - the General Medical Council's 1997 guidance on circumcision of male children.¹¹
- Thus it was essential to revise the 1996 guidelines to reflect these legal and professional changes.

DEVELOPMENT OF NEW BMA GUIDANCE

Given this history of conflicting views and impasse within the BMA, it was not without trepidation that the BMA's ethics department embarked on coordinating a second revision of the 1996 guidelines.¹² Producing the new guidance followed the usual BMA route: first, discussion in the MEC, and then wider consultation within the BMA and with external bodies.

Initial discussion within the MEC on the non-therapeutic male circumcision aspect of the proposed draft guidance showed once again that different views were held on the issue—ranging from the perspective that circumcision is a relatively “neutral” procedure that is not harmful and could convey significant cultural benefits, to the opposite—that circumcision is a potentially harmful procedure which could be equivalent to child abuse and should only be carried out for medical reasons.

Balancing harms and benefits

Central to the issue, and the crux of the controversy, is the balance between “harms” and “benefits” and how these are to be defined and measured. It is now generally accepted, and concurred with in law, that cultural, social, and psychological factors relating to “harm” and “benefit” are pertinent, in addition to medical factors.

How should these harms and benefits be balanced against each other? The balance of harm and benefit within distinct areas—medical, cultural, social, and psychological—is controversial in itself, let alone when these are weighed up against each other. It is not evident, on the face of it—for example, whether there is a net benefit or harm in non-therapeutic circumcision focusing solely on medical benefits and harms. The BMA's board of science and education examined the issue and concluded that “the science on this issue was weak and did not give a clear lead in either direction”. Research into the matter includes the associated harms and benefits in terms of HIV transmission, sensation in the penis, and risks associated with any surgical procedure. In any case, even if there were a clear net medical benefit or harm, how would this balance against an opposing net benefit or net harm, of say, the cultural aspects?

Given the board of science and education's stance that the medical evidence was equivocal, the balancing of harms and benefits turned to the more indefinable, and

Timeline of development of BMA guidance and influencing factors

- 1996—publication of the BMA guidance *Circumcision of Male Infants—Guidance for Doctors*, which outlined the broader ethical, legal, and practical issues raised by therapeutic and non-therapeutic male circumcision.
- 1997—the General Medical Council published guidance for doctors who are asked to circumcise male children.
- 1998—attempts were made to revise the 1996 BMA guidance with a statement from the BMA's medical ethics committee which stressed that practitioners should not proceed with non-therapeutic male circumcisions unless convinced that there was a clear net benefit to the child. Assessment of benefit should include medical, psychological, social, and cultural factors.
- 2000—the case *Re J*, in which parents of a child disagreed over whether their five year old son should be circumcised for religious reasons.
- 2000—the incorporation of the Human Rights Act came fully into force in the UK. It was (and remains) unclear how rights under the act would be engaged and interpreted with respect to male circumcision.
- 2001—a BMA Annual Representatives Meeting resolution was passed to investigate the issues surrounding the circumcision of male children for whom there is no valid medical indication.
- 2003—publication of the new BMA guidance, *The Law and Ethics of Male Circumcision: Guidance for Doctors*.

disputable concepts of harms and benefits—cultural, social, and psychological.

Arguments put forward in BMA discussions that non-therapeutic circumcision of some male children is a net *benefit* focused on concepts such as social integration and cultural acceptance. It is argued—for example, that circumcision of male children is a defining feature of some faiths and thus enhances integration into the chosen faith, for the child and for the parents of that child.

Arguments put forward that non-therapeutic circumcision of male children is a net *harm* focused on the breach of children's rights—the right of the child to be free from physical intrusion and the right of the child to choose in the future.

The legal backdrop

Needless to say, the backdrop against which the complex web of balances between concepts of harm and benefit should be made, is the current legal and professional regulations governing the issue. All BMA guidance needs to refer to and keep within this framework. In most cases this is fairly unambiguous but the incorporation of the bulk of the European Convention on Human Rights into UK law with the Human Rights Act 1998 has brought with it some speculation on certain ethical issues. For example, what rights within the act are engaged, and how the courts will balance any competing rights—non-therapeutic male circumcision is one of these issues where there is speculation. Many dispute—for example, the argument that article 9, the right to “freedom of thought, conscience, and religion,” gives parents automatic rights to choose whether their male child

should be circumcised, and instead argue that it gives children the right to have a choice when they reach sufficient maturity. The current law cannot, therefore, be said to categorically permit or preclude male circumcision. It is therefore prudent for the BMA, when advising doctors on such an issue, to provide guidance which identifies the range of rights that might be relevant, rather than speculating and drawing conclusions about where the balance might lie in the law.

Thus, although the BMA's annual meeting had asked for the matter to be investigated, definitive guidance could not be drawn from the science or the law. Instead it rested on whether agreement could be reached within the BMA on where the balance lies in the weighing of the more moot concepts of cultural, social, and psychological, harms and benefits. Some might say we should not try to obtain consensus in the absence of clear medical evidence on either side and might ask why the BMA persisted. It was not to portray itself as an authority on moral issues but rather to set out clearly for doctors the legal position and the ethical arguments they should consider if asked to circumcise a male infant.

Wider consultation

The draft guidance then went out for wider general consultation within the whole of the BMA, including the appropriate clinical experts. For a more detailed discussion on the methodology adopted by the BMA to address ethical problems see Ann Sommerville's paper in a previous issue of this journal.¹³ Arguments noted in initial BMA committee discussions were, however, mirrored again in the wider consultation and it was soon recognised that a significant consensus on the more moot concepts of harm and benefit within the BMA would not be feasible.

CRITICISMS AND LIMITATIONS OF THE NEW GUIDANCE

The omission of any clear BMA position on non-therapeutic circumcision of male children has been the main criticism of the final guidance, that is to say: it is too neutral, too permissive or too restrictive in its stance. It is evident, therefore, that any adopted position would have been subject to criticism.

Some have commented that the guidance may leave doctors with the impression that the circumcision of a child is "optional", rather than being a defining feature of some faiths. Furthermore, it has been suggested that the guidance should focus on the role of non-doctors carrying out non-therapeutic circumcision, not solely on doctors. In response to these comments, however, there are limitations as to what legitimate contributions the BMA can, or should, make to the debate on non-therapeutic male circumcision and it was not felt appropriate, or within the BMA's expertise, for the BMA's guidance to explain the requirements of different religions in respect of circumcision, or to offer advice and guidance to non-doctors.

FRUITLESS PROJECT OR A BRAVE START AT GRASPING THE NETTLE?

The BMA cannot always remain quiet if doctors might be involved, either by virtue of being approached to carry out, or refer patients for, procedures. Instead, the aim has to be to give helpful advice to practising doctors explaining the legal and ethical position, and thus allow doctors to make informed decisions about the referrals and procedures they undertake.

Indeed it is arguable that guidance for doctors should be non-directive anyway, particularly in this specific case, given the contentious nature of the issue. To produce guidance that

gives weight to either side of an argument could belie the true extent of the contention over the issue, both within society and within the profession.

This could be detrimental in two ways. First, doctors need to be aware of the contention to enable them to advise their patients sensitively and in an informed manner. Second, if consensus is difficult to achieve it is unclear what benefit can be derived from publicising a position that does not truly reflect and represent the diversity of opinion in the profession itself.

So, in reply to the question posed at the beginning of this paper, whether the revision of the BMA's guidance was a fruitless project or a brave start at grasping the nettle, the response is twofold:

Firstly, increasingly doctors are required to explain and justify their decisions on a whole range of issues to a plethora of people. In order to do so they need an understanding of the law and knowledge of professional guidance pertinent to that specific issue to inform their decisions. We have already noted that the law and science on this particular matter are open to interpretation. That fact alone, however, is something doctors need to know and to be able to explain to parents.

Secondly, the BMA's role and standing in medical ethics has grown exponentially over recent years, which ensures that the BMA is able to contribute significantly to the development of public policy on a range of ethical issues. Its guidance and discussion papers have been quoted approvingly by the courts and its views have been influential in parliament and other policy making arenas. In the legal case of non-therapeutic male circumcision, *Re J*¹⁰—for example, the judge referred to the BMA's male circumcision guidance, obtained via the Official Solicitor. The BMA's guidance thus forms an important role in facilitating and encouraging rational debate, among health professionals and the wider society, about issues such as non-therapeutic male circumcision, which are frequently very sensitive and emotive.

This dual approach, of both providing ethical guidance for doctors and contributing to the debate, thus ensures that projects are seldom fruitless. Whether we have truly grasped the nettle in the case of non-therapeutic male circumcision raises the question, however, whether it was ours to grasp in the first place. Arguably, yes. The BMA no longer seeks to pronounce on purely social or moral questions but it cannot remain silent where doctors are involved by virtue of being approached, in a medical context, to advise on or carry out such procedures.

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