Cutting through red tape: non-therapeutic circumcision and unethical guidelines

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Abstract

Current General Medical Council (GMC) guidelines state that any doctor who does not wish to carry out a non-therapeutic circumcision (NTC) on a boy must invoke conscientious objection. This paper argues that this is illogical, as it is clear that an ethical doctor will object to conducting a clinically unnecessary operation on a child who cannot consent simply because of the parents' religious beliefs. Comparison of the GMC guidelines with the more sensible British Medical Association guidance reveals that both are biased in favour of NTC and subvert standard consent procedures. It is further argued that any doctor who does participate in NTC of a minor may be guilty of negligence and in breach of the Human Rights Act. In fact, the GMC guidance implies that doctors must claim conscientious objection if they do not wish to be negligent. Both sets of guidelines should be changed to ensure an objective consent process and avoid confusion over the ethics of NTC.

Introduction

Both the General Medical Council (GMC) and the British Medical Association (BMA) offer guidance to doctors on the sensitive subject of non-therapeutic circumcision (NTC). This paper will argue that both sets of guidance are flawed and effectively bias the consent process in favour of NTC; another issue is that both recommend conscientious objection for doctors who do not wish to perform NTC, despite the fact that there are perfectly valid grounds for refusal without any need for conscientious objection.

GMC guidance

In March 2008 the GMC released new guidance entitled *Personal Beliefs and Medical Practice*. This attracted some media attention as it affirmed the right of doctors to refuse to perform abortions if they objected on conscientious grounds: 'in such cases you must tell patients of their right to see another doctor with whom they can discuss their situation and ensure that they have sufficient information to exercise that right'.[1]

It seems likely that those who object to circumcision are likely to be non-religious, or at least not adherents of those religions that practise circumcision. Abortion is an example of doctors' beliefs prohibiting them from providing a service, but the GMC guidance provides two examples of cases where patients' beliefs might cause problems: Jehovah's Witnesses refusing blood transfusions and NTC of male children. Of course, it is actually a mistake to categorize the latter under 'patients' personal beliefs', as it is the child who is the patient and the parents who have the personal beliefs; this basic error is indicative of the lack of clarity in the guidance.

The guidance on circumcision is divided into five paragraphs. The first (paragraph 12 of the guidance) sets the scene by briefly reviewing the state of the debate on circumcision:

> 'Many people within the Jewish and Islamic faiths consider male circumcision to be essential to the practice of their religion; they would regard any restriction or ban on male circumcision as an infringement of a fundamental human right. Others, including those who campaign against the practice of male circumcision, strongly believe that, because circumcision carries risks, it is wrong to perform the procedure on children who are not old enough to give informed consent, unless it is undertaken to address a specific clinical condition'.[1]

Several issues are raised by these two sentences. First, those of Jewish or Islamic faiths might well *regard* a restriction on

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circumcision as a breach of human rights, but this does not mean that such a restriction would indeed be a breach. Second, it is unclear from this passage *whose* human right would be infringed. It does not seem likely that there is a fundamental human right to be circumcised, so the appeal is probably to a right to practise one's religion even if doing so involves violating the bodily integrity of a non-believer who happens to have parents of a particular religion. (The parents of the child might well regard the child as a believer, but the fact remains that most candidates for NTC will be too young to truly hold any beliefs.) The second sentence is straightforward, but some might wonder what reason anyone could have for thinking that it could be right to perform an unnecessary operation on an unconsenting child simply because the child's parents wish it. While being circumcised is undoubtedly an important part of many men's religious observance, this fact alone does not simply trump the rights of the child.

The GMC's position is revealed in paragraph 13:

> 'The GMC does not have a position on this issue. We do not have general authority to determine public policy on issues that arise within medical practice – these are matters for society as a whole to determine, through the parliamentary process'.

One might wonder why the GMC does not have a position on this important issue. Normally, operations are only carried out without the patient's consent if there is clinical need, but in this case, there is neither direct consent nor need. This would tend to suggest that the GMC's position should actually be that doctors should not be *permitted* to perform NTC.

Paragraph 14 sets out procedure for a doctor who is asked to circumcise a male child:

> 'If you are asked to circumcise a male child, you must proceed on the basis of the child's best interests and with consent. An assessment of best interests will include the child and/or his parents' cultural, religious or other beliefs and values. You should get the child's consent if he is competent. If he is not, you should get consent from both parents if possible, but otherwise from at least one person with parental responsibility. If parents cannot agree and disputes cannot be resolved informally, you should seek legal advice about whether you should apply to the court'.[1]

Clinically, there is no indication for circumcision, and no major paediatric organizations recommend circumcision except where it is specifically necessary.[2] (Circumcision may have prophylactic effects in terms of preventing HIV transmission, but prophylaxis is a therapeutic aim and irrelevant to the issue of NTC.) Best interests must then come down to the child's and parents' religious beliefs. But the child is very probably too young to have any religious beliefs, which leaves us with the best interests of the child being dictated purely by his parents' religious beliefs.

And the GMC states that doctors must invoke conscientious objection to avoid performing NTC. Paragraph 15 states simply: 'If you are opposed to circumcision except where it is clinically indicated you must explain this to the child (if he can understand) and his parents and follow our advice on conscientious objection'. It is somewhat ironic that doctors can opt out of abortion on the grounds that they conscientiously object to aiding a pregnant patient by harming an unborn child, while doctors opposed to circumcision must conscientiously object to conducting non-beneficial and unnecessary irreversible surgery on a child. Why would a doctor *not* be opposed to circumcision unless clinically indicated? The principle of non-maleficence (do no harm) necessitates avoiding surgery unless there is a clear potential medical benefit to the patient, and this does not apply in the case of NTC. (If parents were to request circumcision on prophylactic grounds, a case could perhaps be made for it, particularly in countries with high HIV prevalence; the BMA and GMC guidelines are UK guidelines.)

The last paragraph on circumcision covers clinical competency in the event of agreeing to perform a circumcision, and again it is unclear why guidance on personal beliefs should also cover advice on the skills and knowledge necessary to perform circumcision. Another error occurs in this paragraph 16, where it is stated that 'If you agree to circumcise a male child, you must . . . explain objectively to the child (if he can understand) and his parents the benefits and risks of the procedure'. But the process of obtaining informed consent necessitates the communication of these benefits and risks long before the doctor agrees to anything. This guidance is perhaps indicative of the GMC's bias towards satisfying the requirements of particular religions, even if this means contravening standard ethical practice.

Personal Beliefs and Medical Practice constitutes the GMC's only guidance on circumcision apart from a brief mention in another document, which states in relation to circumcision that 'Both the GMC and the law permit doctors to undertake procedures that do not offer immediate or obvious therapeutic benefits for children or young people, so long as they are in their best interests'.[3] From 1997 they also offered a guidance document entitled *Guidance for doctors who are asked to circumcise male children*, but this was withdrawn in October 2007. This was probably to clear the way for the new document, but the older one was notably more cautious about the legality of NTC, stating:

> 'Article 24.3 of the UN Convention on the Rights of the Child (ratified by the UK Government in 1991) states that ratifying states should "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children". However, this must be balanced against Article 9.2 of the European Convention on Human Rights, which protects the rights of individuals to practise their religion'.[4]

As we shall see, these competing rights are not in a state of equilibrium.

BMA guidance

The BMA also has guidelines on male circumcision. Though more cogent than the GMC guidance, the

BMA's are similar in many respects and an earlier version of the guidance was criticized for not fully engaging with the ethics of circumcision.[5] The guidance states that 'the medical harms or benefits have not been unequivocally proven', but it is not clear why medical benefits should feature in a paragraph entitled 'non-therapeutic circumcision'.[6] Paralleling the GMC line, it is also stated that 'the BMA believes that parents should be entitled to make choices about how best to promote their children's interests'. Ultimately, however, the BMA guidance is more sensible, concluding that 'it is clear from the list of factors that are relevant to a child's best interests, however, that parental preference alone is not sufficient justification for performing a surgical procedure on a child'. The BMA advice is also considerably more comprehensive, so the following analysis is split into sections.

Consent and coercion

The BMA guidance offers advice on obtaining consent for NTC from children themselves:

> 'Often surgery for non-medical reasons is deferred until children have sufficient maturity and understanding to participate in the decision about what happens to their bodies, and those that are competent to decide are entitled in law to give consent for themselves. When assessing competence to decide, doctors should be aware that parents can exert great influence on their child's view of treatment. That is not to say that decisions made with advice from parents are necessarily in doubt, but that it is important that the decision is the child's own independent choice'.[6]

Two important points emerge here: first, it would be in line with this advice to defer NTC until the child is old enough to make an informed choice for himself. At a more advanced age, the child may have rejected his parent's religion and have no interest whatsoever in circumcision (although it may be more painful later on if he does decide to be circumcised). In a case concerning a 14-year-old Jehovah's Witness who refused a blood transfusion, it was ruled that the child was not 'Gillick competent' because, 'although her beliefs were sincere, they had not been developed through a broad and informed adult experience'.[7] If a 14-year-old is regarded as incompetent because she was brought up in a particular religion, why should a 14-month-old be subjected to unnecessary surgery dictated by beliefs that he might never come to share?

The second point that emerges from the above quote is that parents can coerce children into circumcision. Of course, NTC normally happens at a very young age, where persuasion is not even necessary, but the fact remains that parents who seek NTC suffer from a severe conflict of interest. If parents attempt to coerce a five-year-old into circumcision, a doctor might well detect this and refuse; but if the prospective patient is only five months old, the doctor simply has to do what the parents want, and has no way of knowing if they truly believe that they are doing what is best for their child or are merely satisfying their own preferences. The child would probably be happier if he went home from hospital without having the operation; this is not normally an argument, because medical need normally trumps a child's short-term happiness, but this obviously does not apply in the case of NTC. (The BMA guidelines make it clear that consent must be obtained from both parents before NTC can be carried out.)

Best interests

In order to help doctors decide whether to agree to perform NTC, the BMA guidance provides a checklist of factors to consider when determining what is in the patient's best interests:

- The patient's own ascertainable wishes, feelings and values;
- The patient's ability to understand what is proposed and weigh up the alternatives;
- The patient's potential to participate in the decision, if provided with additional support or explanations;
- The patient's physical and emotional needs;
- The risk of harm or suffering for the patient;
- The views of parents and family;
- The implications for the family of performing, and not performing, the procedure;
- Relevant information about the patient's religious or cultural background;
- The prioritizing of options that maximize the patient's future opportunities and choices.[7]

It is worth mentioning before examining this list that it is substantially different from the standard BMA best interests checklist,[8] which suggests that objective standards may not be being applied in the case of NTC; we shall see that some bias has crept onto this checklist. Let us examine the criteria. For most candidates for NTC, the first three points are irrelevant as they are too young to express wishes, understand or make a decision. The patient's physical and emotional needs will almost always be best served by not conducting the operation; although he might be happy that he was circumcised in 10 or 20 years' time, the doctor must concern himself with more immediate consequences. The same applies to the risk of harm or suffering for the patient: there is no risk if he is not circumcised, but the operation carries a small risk (0.2%) of serious complications as well as a potential decrease in sexual pleasure for both the patient and his sexual partner.[2] (Once again, we are focusing on NTC in the UK; prophylactic circumcision in countries with higher prevalence of sexually transmitted diseases is another matter.)

The next two points both concern the preferences of the parents and family. These two criteria differ from those on the standard BMA best interests checklist. The most obvious change is the addition of 'the implications for the family of performing, and not performing, the procedure', which does not feature at all in the standard list. The implication is that, in the case of NTC, special treatment should be given to the family's interest in having the operation done. This is quite wrong: what is in a child's best interests does not change according to the

implications for his parents of not having a non-therapeutic operation. Another addition is 'and family'; on the standard checklist only the parents' views are mentioned. Again, this seems to be slanting the supposedly objective best interests test in favour of NTC, as other family members are very likely to also be in favour of the operation. We accord great importance to religious beliefs in our society and allow parents great latitude in raising their children, but tend not to allow parents to harm their children in pursuit of non-medical 'best interests'. Jehovah's Witnesses are not allowed to refuse blood transfusions on their children's behalf, despite the fact that from their point of view it is in the child's best interests to die rather than receive blood. NTC is unlikely to result in death, but it is a clinically unnecessary irreversible operation, so the argument that it is in a child's best interests is weak at best.

The penultimate criterion asks doctors to consider the patient's religious or cultural background, which once more differs from the standard checklist. The standard criterion is 'any knowledge of the patient's religious, cultural and other non-medical views that might have an impact on the patient's wishes'. A young child will not have any such views, and the focus on the NTC best interests checklist has shifted to 'religious or cultural background'. This might seem innocuous, but it is not. The sincerely held religious beliefs of an adult patient carry much more weight than the sincerely held religious beliefs of a patient's parents; this is actually a radical shift in the best interests test, and one that introduces an undeniable bias in favour of the parents' preferences.

The final criterion indicates the importance of prioritizing options that will maximize future autonomy. Not performing NTC will increase future options: an uncircumcised man can easily be circumcised, but a circumcised man would only have the option of attempting a clinically difficult circumcision reversal.[9] It has been argued by proponents of NTC that future adults might resent not having been circumcised as children, but this is not a strong argument; they equally might resent having been circumcised, and they can always be circumcised as an adult. It is true that adult circumcision involves more discomfort than it does when performed on a child, but given the current bioethical emphasis on informed consent and maximizing future opportunities, it is clear that NTC has virtually no chance of meeting this last criterion. In fact, it appears that any doctor who performs NTC has either failed to apply the best interests checklist, or has misapplied it: it is difficult to see how any objective consideration of the factors laid down by the BMA could lead to anything but a refusal to perform NTC.

Circumcision and the law

Another difference between the GMC and BMA guidance is that the latter openly admits that NTC may be against the law. After acknowledging that the English Law Commission has called for legislation to clarify the questionable legality of NTC, the guidance states that doctors who perform circumcision may be in breach of the Human Rights Act.[6] The BMA argues that these articles can be used to argue both for and against NTC, in large part because 'the medical evidence is equivocal'. But it is difficult to see the relevance of medical evidence when we are talking about NTC of a child who does not consent, and all of the articles cited in the guidance lend strength to the child's right to not be circumcised. Removal of healthy tissue for non-medical reasons without valid consent could certainly be argued to constitute inhuman or degrading treatment (Article 3) and a violation of liberty and security of the person (Article 5(1)) (even if the parents have consented, the consent might be invalid if the best interests test has been misapplied). Articles 8 and 9(2) might be seen as offering some support to pro-circumcision parents, but it is obvious that respect for family life (the former) is secondary to 'the protection of the rights and freedoms of others' (the latter) – unless it is argued that 'others' refers solely to those outside the family, which is unlikely. Finally, Article 9(1) (the right to freedom of thought, conscience and religion) might also be regarded as supporting NTC, inasmuch as circumcision is indeed an important part of many parents' religions. But this is exactly the point: it is part of *their* religion, not that of their child. The child also has a right to freedom of thought, conscience and religion, and subjecting him to surgery dictated by the beliefs of his parents shows scant regard for this right. It is perhaps because of the obvious ramifications for the legality of NTC that the BMA concedes 'The Human Rights Act may affect the way NTC is viewed by the courts. There has been no reported legal case involving circumcision since the Act came into force. If doctors are in any doubt about the legality of their actions, they should seek legal advice'.

As well as potentially breaching the Human Rights Act, doctors who perform NTC also risk prosecution for negligence and perhaps battery. The latter charge is unlikely to succeed, as battery requires absence of consent, and even a flawed application of the best interests test results in some consent from the parents. Negligence, however, would be relatively easy to prove: doing so would require establishing that there was a duty of care, that there was a breach of the standard of care and that that breach caused injury to the patient. In the case of NTC, it could be argued that no reasonable application of the best interests test (in a particular case) would yield a result in favour of NTC, and that the removal of the foreskin was not justified due to negligence in obtaining consent. Of course, it is unlikely that anyone would bring such a charge, as a lot of time normally passes between NTC and adulthood, during which most men come to accept their circumcised status. This does not change the fact that it may have been negligent to perform NTC in the first place, and some circumcised men have formed organizations devoted to fighting NTC;[10] others have gone so far as to attempt circumcision reversal.[11] If agreeing to perform NTC while having failed to apply or having misapplied the best interests test is

negligent, then the GMC (and to some extent the BMA) guidelines require doctors to conscientiously object to negligent treatment of their patients.

Conscientious objection

The BMA's advice ends with their recommendations on conscientious objection:

> 'Some doctors may refuse to perform non-therapeutic circumcisions for reasons of conscience. Doctors are under no obligation to comply with a request to circumcise a child. If doctors are asked to circumcise a child but have a conscientious objection, they should explain this to the child and his parents. Doctors may also explain the background to their conscientious objection if asked. Clearly where patients or parents request a medical procedure, doctors have an obligation to refer on promptly if they themselves object to it (for example termination of pregnancy). Where the procedure is not therapeutic but a matter of patient or parental choice, there is arguably no ethical obligation to refer on. The family is, of course, free to see another doctor and some doctors may wish to suggest an alternative practitioner'.[6]

The first paragraph of this guidance is broadly similar to the GMC advice on objection. But why should doctors have to invoke conscientious objection if application of the BMA's checklist makes it clear that it is not in the child's best interests to perform the operation? They clearly do not have to do so, as the mandatory test has been failed. A doctor should simply say 'Well, it is clearly not in your child's best interests to be circumcised, as it is simply your religious preference. BMA guidelines state that parental preference alone is not enough'. Is the BMA saying that they must *also* say 'Therefore, since it would clearly be unethical to proceed with an operation that is not in the patient's best interests, I must invoke conscientious objection'? The guidance is unclear on this point. Of course, doctors might think that the best interest test is passed, and still have conscientious reasons for objecting. The problem with the GMC guidance is that it says that any doctor who refuses to perform NTC must invoke conscientious objection, despite the fact that it is quite legitimate to refuse in the face of a failed best interests test. This problem is perhaps due to the GMC's confidence that parents alone can determine what is in the best interests of their children, without any input from the doctor (remember that their guidance stated 'An assessment of best interests will include the child and/or his parents' cultural, religious or other beliefs and values', without making it clear whether any other factors should be considered). The BMA's stance seems a lot more sensible – and ethical.

One last difference between the GMC and BMA advice concerns the duty to refer to another doctor in cases of conscientious objection. As we saw above, the BMA says that there is no obligation to refer on requests for NTC, as the procedure is not clinically indicated (unlike abortion). The GMC advice on refusing NTC simply refers the doctor to the generic advice on conscientious objection, which states that doctors must refer patients on if they are refusing to treat them.[1] While the BMA's advice does not prohibit referring patients for a second opinion, it is clear that the peculiar nature of NTC exempts the doctor from any obligation to do so. If this is the case for conscientious objection, it must also be the case for failures of the best interests test.

Who are doctors to believe, the GMC or the BMA? The BMA advice is a lot more comprehensive, and because of this is much less enthusiastic about NTC than the GMC guidance. Another possible explanation is the GMC's emphasis on protecting patients, which in this particular case ironically seems to have led to increased risk for patients in order to please their parents. In view of the ethical and legal issues discussed in this paper, the prudent doctor will refuse to perform any NTC, and might want to invoke conscientious objection to make things easier, at least until the flawed guidelines are corrected. BMAs seem to be playing catch-up in this regard: the Norwegian Council for Medical Ethics declared in 2001 that NTC is unethical: 'circumcision of boys is not consistent with important principles of medical ethics'.[12] (Though curiously, they also stated that doctors should be allowed to refuse to perform NTC 'as a matter of conscience'. Why should anyone be *allowed* to do it if it breaches ethical principles?) The BMA's ethics committee actually stated in 1998 that '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', but the BMA's council refused to accept this statement.[13]

Potential objections

This paper has suggested that the religious views of parents should not be allowed to trump a child's best interests, and NTC should not be permitted, much less be something that doctors must invoke conscientious objection to avoid. However, it could be argued that parents will simply have their boys circumcised unsafely if doctors do not agree to perform the service, and that it is better for doctors to perform NTC in order to avoid the increased risks of 'backstreet circumcision'. There are several problems with this argument. The parallel with backstreet abortions is not valid, as these are of medical benefit to the women involved, while NTC is exactly that: non-therapeutic. Procedures for consent would have to be changed (as the GMC and BMA seem to have inadvertently done) in order for NTC to meet the best interests test. And finally, imagine a situation where two adherents of a minority religion ask their doctor to pull off their son's thumbnails, as this is part of the religion in which they want to bring up their son. The pain will be transient, and the nails will grow back, but the parents claim that it is an important rite of passage. I think it is reasonable to say that the doctor would send them packing, without recourse to conscientious objection or fear of backstreet nailpulling. In the case of NTC, the foreskin will not grow back; why should this procedure be treated differently

simply because of the weight of religious tradition? The very fact that NTC is also sometimes referred to as 'ritual' circumcision implies that it is something that is done out of unreflective habit. If you ask the father who is requesting NTC for his child why he wants it, the most likely response apart from 'it's my religion' would be 'my father had it done to me'. But this is not a good reason for exposing a child to risk.[14]

Another argument in favour of doctors performing NTC is that it aids the socialization of children into a particular culture, and that children might be rejected if they're not circumcised. Although the cultural background of a child can and should be considered, the possibility that a child might be discriminated against if he is not circumcised is a problem for the culture, not the medical profession. (And once again, they can be circumcised later in life if they want to be.)

As already mentioned, it might be suggested that NTC is something of a misnomer, and it should instead be termed prophylactic circumcision, in that it provides protection against future diseases such as HIV. But this is still a therapeutic aim, and if parents request NTC, even on grounds of 'cleanliness', they are requesting the operation on religious grounds, not medical. (And once again, circumcision is not recommended prophylactically by any paediatric organization.) Of course, this raises the issue of duplicitious parents who seek NTC but claim it is for prophylactic reasons. Doctors cannot really do much about such scenarios, but it is likely that the best interests test would not be passed even if the motivation was truly prophylactic.

Conclusion

This paper has exposed several flaws in the GMC and BMA guidelines on NTC. The GMC guidelines include the illogical requirement that any doctor who does not wish to perform NTC must conscientiously object. The BMA's guidelines contradict this, and say that the best interests test must be applied, but then also imply that conscientious objection is necessary even if the best interests test is failed. Both sets of guidelines are unethical inasmuch as they present flawed consenting procedures for NTC, allowing doctors to cut through ethically essential red tape; both sets of guidelines should be revised. At a minimum, they should be mutually consistent so that doctors are not confused by contradictory advice. At a maximum, they should be thoroughly revised to warn doctors of the ethical and legal risks they take if they perform NTC. Any reference to conscientious objection should be removed, as a truly conscientious doctor will simply apply the test and conclude that NTC is not in the child's best interests.

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