

Male circumcision: risk versus benefit

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Ancient wall paintings and mummies record the practice of male circumcision 6000 years ago.¹ Its origins remain obscure but are variously derived from religion, ritual and culture.

Today, surgical indications for circumcision are either therapeutic, to treat established conditions such as balanitis xerotica obliterans, or preventive.² In 2012, the American Academy of Pediatrics (AAP) radically changed their original 1999 circumcision policy.³ The AAP now asserts that the preventive health benefits of newborn circumcision outweigh the risks of the procedure, which is well tolerated when performed by trained professionals under sterile conditions with appropriate pain management. The potential derived health benefits highlighted include prevention of urinary tract infection and penile cancer and reduced transmission of some sexually transmitted infections, including HIV. They concluded that the evidence was sufficient to warrant third-party payment for circumcision and it was for parents to decide whether or not circumcision was in the best interests of their newborn male child. This policy statement provoked sharp responses from a number of sources, the Royal Dutch Medical Association and the British Association of Paediatric Urologists (BAPU).⁴ They did not accept the recommendation that the reduction in HIV transmission justified the use of routine newborn circumcision in countries where it was not endemic. BAPU also questioned whether the evidence in relation to the prevention of urinary tract infection justified the routine use of circumcision for that indication.^{5 6} It is clear that there remains considerable controversy about the medical indications for circumcision, particularly when it is used as a preventive measure. Within the National Health Service (NHS) in the UK, it is becoming increasingly common for providers to seek prior approval for therapeutic circumcision. In some European

countries, parental desire to avoid circumcision has resulted in the innovation of foreskin reconstruction during hypospadias repair, with a similar trend in the USA.^{7 8}

The European reluctance to circumcise boys becomes even more apparent when requested for religious or cultural indications. In 2002, Sweden introduced restrictive legislation governing ritual male circumcision. For boys less than 2 months of age it could be performed by appropriately trained non-medical practitioners using topical anaesthesia, but for boys over 2 months old it had to be performed in hospital under general anaesthetic.⁹ Moreover, the Swedish Pediatric Society subsequently called for a complete ban on ritual circumcision.¹⁰

In June 2012, a Regional Court in Cologne banned ritual circumcision. Despite the German Cabinet's temporising reversal of this decision, the issue still needs parliamentary ratification, and a significant number of members advocate a national ban.^{11 12}

Should ritual circumcision be excluded from their national health systems, doctors in mainland Europe and beyond may therefore find themselves in a similar situation to their counterparts in the UK.

In England and Wales, our politicians have chosen not to provide ritual circumcision through the NHS. We have observed that, increasingly, doctors who provide boys with ritual circumcisions in a community setting are falling foul of litigation, or of the General Medical Council (GMC), our regulatory body. In the absence of a clearly defined standard of care for community circumcision to which they can adhere, doctors may desist from providing this service, despite their belief that the procedure is in the best interests of the child. Ritual circumcision of boys in England and Wales may then be placed beyond the reach of any discernable regulation.

When ritual circumcisions were still routinely performed by the NHS in a hospital, ritual circumcision was likely to involve uniform acceptable standards of environmental sterility and analgesia. Before surgery, the child was assessed by both the surgeon and anaesthetist to ensure that the operation was appropriate (excluding anatomical or pathological

contraindications) and safe. The operation was performed in an operating theatre, by a trained surgeon, under a general anaesthetic administered by an anaesthetist. The patient was monitored during the operation and his recovery. The doctors had suitably clean or sterile equipment to deal with both the routine operation and unexpected events, should they occur. Both during and after surgery, analgesia was administered to keep the patient comfortable until the wound healed.

Despite this diligent attention, complications still ensued, and were generally dealt with by the same surgeon, or a close colleague. Some of the complications led eventually to litigation, and the defendant surgeon would then be compared with the objective standard of the reasonable surgeon who performed ritual circumcisions under similar circumstances. This standard was asserted by an expert witness, within whose field of expertise ritual circumcision lay, who would support his or her assertions with evidence from the surgical literature and from professional bodies.

Since 2006, Primary Care Trusts withdrew their funding for ritual circumcisions in England and Wales. By January 2007, only a minority of 30 paediatric surgical units surveyed had continued to provide this service.¹³ Anecdotal evidence suggests that the NHS provision for ritual circumcision has now effectively stopped.

A search of the GMC database from April 2006 reveals 36 cases of doctors who were alleged to have fallen below the reasonable standard of care, in reference to circumcision. Although the reasons for referral are not always recorded, at least 24 of these were undoubtedly prompted by the doctor's performance of ritual circumcisions. At least 14 of these doctors faced allegations in relation to multiple circumcisions, hinting that they had an established practice in ritual circumcision.

We have seen a marked increase in referrals for expert opinion on the standard of care used in circumcisions where the results have disappointed the child's parents. It is indicative of the quandary that litigators and regulators face that they should be seeking expert advice from surgeons who have no experience whatsoever in the ritual community circumcision of a boy; thus our contribution is limited to the causative effects of the alleged substandard care. There are a few doctors practising ritual circumcision who are ready to set the standard for their colleagues, but few are in the position of being able to comment on both liability and causation. This is a highly unusual

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situation in surgical litigation, and may be one reason why it is often difficult to obtain experts for the defence.

The community circumciser may be providing a service that he or she believes is necessary, fearing that a family determined to have their son circumcised will resort to a less proficient person if refused. We must assume that he or she has taken the view that the procedure is in the best interests of the boy, while construing best interests as including the wider interests of the child's family and community. We must also assume either that the family have no alternative to having the circumcision performed in this manner or that their culture and beliefs lead them to choose this as their preferred method.

However, unsupported by the facilities, resources and colleagues in a hospital, the circumcising doctor may be performing this operation at home on a child who is awake, probably with less light than we enjoy in an operating theatre, and certainly without the luxury of operating at the pace of choice. Such doctors will be dealing with both pain relief (local anaesthesia either topically or by infiltration) and surgery, while maintaining a clean or sterile field, and as likely as not, having their efforts observed by the family. Interestingly, one Trust in the UK has seen a trend of increasing admission rates for circumcision complications since they ceased performing ritual circumcisions.¹³

However, it still seems surprising that, in the face of a reported 30 000 ritual circumcisions a year in the UK¹⁴ (now almost exclusively in the community, presumably), relatively few children are subsequently admitted to hospital for the treatment of complications.

Faced with the risk of criticism, to what standard should the doctor who

circumcises a child in the community conform, to ensure that they are acting reasonably? BAPU asserts that all boys should enjoy the same standard of care in circumcision, irrespective of where the procedure is carried out.¹⁵ It is useful that BAPU's advice is detailed, suggesting standards of premises, anaesthesia and analgesia, together with standards for the operator's training, record keeping and audit. It may be possible to replicate some of these processes, but the physical care of the child, from the perspective of anaesthesia and surgery, will inevitably be different when performed by a lone operator, in the child's home. This advice is echoed by the GMC,¹⁶ prescribing premises that are 'fit for purpose'; but can the patient's home (or even a clean room in primary care) ever be as 'fit for purpose' as an operating theatre? We doubt this. Doubtless, innumerable circumcisions are successfully performed in the UK at home every year, but it is the circumcisions that are *not* successful that are scrutinised.

If we accept that 30 000 families will each year continue to insist upon circumcision in the community, should doctors be advised to refrain from involvement, because of the uncontrollable risks that they will encounter in these circumstances, in the shadow of the unflinching standards of the GMC? Is the benefit to the patient exceeded by the burden (of risk) to the doctor's reputation and livelihood?

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