If RNMC is performed for cultural reasons, why continue to characterize it as a medical procedure? Circumcision in Western culture was primarily a religious ritual among Jews and Muslims. It became medicalized in the late-nineteenth century based in part on the theory of reflex neurosis—the belief that diseases are caused by "irritation." Genital irritation or phimosis was believed to cause diseases such as paralysis, reflex muscular contraction, curvature of the spine, and acquired deformity. While parallel procedures on women, such as clitoredecotomy, fell out of favor, circumcision persisted as a sanitary precaution. The underlying conception of clean and dirty was not strictly medical but was loaded with moral, social, and cultural meanings (Gollaher 2000). If the reasons for the medicalization of RNMC are no longer valid and it persists for cultural reasons, might it be preferable to have nonphysicians perform it, provided sufficient safeguards can be established? *Mohels,* Jewish ritual circumcisers, are an example of such an entity. The continued debate about the "medical" costs and benefits of RNMC might reify the procedure and perpetuate its inappropriate medicalization.

In framing their argument, the authors adopt the common analytical structure of balancing the "medical" costs and benefits. The selection of this methodology is problematic. In general, it might inappropriately perpetuate the medicalization of RNMC. In particular, the exclusion of economic costs and the focus on individuals are not justified. Such considerations raise additional factual and ethical issues that could lead to a range of different conclusions. Instead of the authors' conclusion that RNMC is discretionary, one might conclude that it is mandatory to reduce the transmission of HIV. Alternatively, one might agree that it is discretionary but argue that it should not be paid for by Medicaid or even that it should not be performed by physicians. ■

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Circumcision—A Victorian Relic Lacking Ethical, Medical, or Legal Justification

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Michael Benatar and David Benatar (2003) are to be commended for raising the issue of male circumcision for ethical consideration. However, we cannot agree with their conclusion that "nontherapeutic circumcision of infant boys is a suitable matter for parental discretion," nor that "religious and cultural factors, though preferably subject to critical evaluation, may reasonably play a role." Doctors may not properly act as cultural brokers, and male circumcision is not a medically, ethically, or culturally neutral practice, suitable to be left to parental whim, but rather a clear violation of a number of central principles from the disciplines of medicine, ethics, law, and human rights.

In order to protect patients and doctors alike, it is ethically and legally essential that our default assumption

must be against a procedure. This presumption cannot be reversed until we have substantial scientific evidence based on well-established research criteria that the procedure will provide an overall *medical* benefit to the patient. Despite the authors' candid admission that "the evidence for beneficial effects of circumcision is controversial," somehow they nevertheless come out in favor of the procedure. Either the evidence suffices to justify this invasive, painful, unconsented-to procedure, or it does not.

In fact, according to the unanimous opinion of the world's national and international medical organizations, routine circumcision is not justified, and it is the Benatars who are severely out of step with current medical knowledge. Of the at least 16 national and international medical organizations that have spoken on routine neonatal circumcision, not a single group has recommended it. This includes five leading American organizations such as the American Medical Association and the American Academy of Pediatrics.

A further serious difficulty with the Benatars' analysis is their inclusion of only complications and pain as possible disadvantages of the procedure while ignoring the elephant in the room—the inherent value of the intact penis. The authors entirely omit any discussion of the functions of the foreskin, which fall into three main categories: protective, immunological, and erogenous (Fleiss, Hodges, and Van Howe 1998). Moreover, the Benatars go on at length about the alleged benefit of helping prevent the vanishingly rare condition of penile cancer while entirely omitting any discussion of the most serious complication of all: death. Although precise estimates are difficult to give due to, among other factors, concealment of the event when it occurs (NewsNet5 1998), responsible commentators nevertheless place the number of circumcision-caused deaths in the United States annually at well over 200 (Baker 1979).

The Benatars attempt to sanitize circumcision by comparing it with various forms of plastic and cosmetic surgery that presumably are familiar to us—breast reduction, liposuction, and rhinoplasty. The critical distinctions are that these other practices are performed on *adults* who *themselves* give informed consent to the procedure prior to its performance, whereas routine circumcision is performed on nonconsenting infants. For this reason, routine male circumcision violates human-rights principles contained in documents such as the Universal Declaration of Human Rights, The Covenant on Civil and Political Rights, and the Convention on the Rights of the Child, while the other practices considered by the Benatars do not. The United Nations has acknowledged that at least in certain circumstances, male circumcision does constitute a human-rights violation.

Benatar and Benatar point out that prophylactic immunizations of children are acceptable, despite the lack of clear and immediate medical necessity for the child, suggesting a possible parallel that might support circumcision. However, the case of circumcision sharply differs from that of immunization in that the public-health "benefits" of the former are incomparably miniscule compared to the latter, and also in that circumcision constitutes a much more serious invasion of the individual's body (Hodges et al. 2002). Although prophylactic double mastectomy of girls whose family histories place them at high risk of breast cancer might result in substantial health benefits (which in fact would be orders of magnitude greater than circumcision's ostensible "benefits"), no one seriously suggests such an invasive procedure. Female breasts are sacrosanct; the male genitalia is not.

The authors apocryphally suggest that "there are costs to delaying circumcision until adulthood," although the only one they are able to point to is a tentative suggestion that "circumcision might be psychologically unpleasant in adults in ways that it is not in infants." Studies show just the opposite: relative to older children, infants probably suffer *more greatly* from the pain (Fernandez 1986). Moreover, researchers have documented the serious lifelong psychological damage inflicted by the procedure, which can include post-traumatic stress disorder, depression, and a host of other sequelae (Rhinehart 1999).

Benatar and Benatar write that "[p]rior to the last century, it was not medical, but rather cultural and religious reasons for which circumcision was most often performed." In fact, medicalized circumcision began approximately 150 years ago, in response to antimasturbation hysteria (Hodges 1996). It was thought that circumcision—both male *and* female—would stop "self-abuse" and thereby prevent most conditions including epilepsy and clumsiness. As recently as the mid-seventies, it was still possible to read articles in leading popular magazines (Isenberg and Elsberg 1976) and medical journals (Wollman 1973) recommending *female* circumcision. This is a shameful legacy that the medical community would prefer be forgotten.

The Benatars come closer to the truth when they examine circumcision in cultural context. To their credit, they note the strangeness of removal of the foreskin. They even go on to suggest some of the disjunctions between the sharply divergent views in our culture of FGM and circumcision (which also, incidentally, mystify Europeans). Their mention of foot binding is also appropriate, since like FGM and circumcision it was legally and morally justified in its own culture and roundly rejected by outside cultures. Each culture practicing a form of childhood body mutilation fails to see the harm of its own practice while recoiling in horror from other cultures' different practices (Shweder 2002).

Lawsuits over this issue are experiencing increased success in recent years. The ethical problems posed by routine

circumcision are confirmed by a successful legal settlement that occurred as we went to press. The victory was achieved by plaintiff William G. Stowell, who thereby became the first man to be compensated based solely on the predictable medical results of a normal circumcision performed wth both parents' agreement. Male circumcision is drawing the concerned attention of medical ethicists (Somerville 2000), legal scholars (Smith 1998), and the United Nations. As American taxpayers and legislators are coming to realize that tax dollars are being squandered on a worse-than-useless medical procedure, states are refusing to use scarce Medicaid dollars to fund circumcision. In the last year, in fact, five states—Arizona, Missouri, North Carolina, Montana, and Utah—stopped Medicaid funding for circumcision, bringing the total that do not pay for the procedure to eleven. Several more states are expected to follow suit this year.

As judicial, legislative, and public awareness about this medically unjustified and harmful procedure grows, we can anticipate that the Victorian relic of medicalized circumcision will be discarded along with the bleeding of patients and other antiquated practices. In the meantime, given the thicket of ethical, legal, human rights, and medical issues, the most prudent path is to at least defer this procedure until the boy reaches adulthood and can decide for himself as a competent adult. It might be an indication of the procedure's long-term lack of viability that only one out of every 200 intact American men opts for circumcision in adulthood. Time will tell. ■

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Standards for Family Decisions: Replacing Best Interests with Harm Prevention

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Michael Benatar and David Benatar (2003) make a persuasive case for allowing parents to decide whether boy babies should be circumcised. Based on the available data, it is hard to argue that circumcision is clearly in a child's best interests. At the same time, it is hard to argue that the procedure is so detrimental to the child's welfare that medical ethics and law should deem it unacceptable. The Benatars argue that even though circumcision cannot be justified under a strict interpretation of the best-interests standard, the intervention falls within the scope of permissible parental choices.

This analysis is relevant not only to parents' decisions about medical interventions for children, it is also relevant to family decisions about life-sustaining treatment for