INFORMED CONSENT FOR NEONATAL CIRCUMCISION: AN ETHICAL AND LEGAL CONUNDRUM

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INTRODUCTION

Neonatal circumcision is the surgery most commonly performed on children, yet reliable information regarding the surgery is not usually made available to parents when they are asked to consent to the procedure for their newborn sons. Often, parents are simply presented with a paper to sign permitting the physician to perform the surgery, without any discussion of the health risks or alternatives. Many medical professionals, medical ethicists and legal scholars now dispute the advisability, and even permissibility, of circumcising newborn boys.[1] Margaret Somerville, a prominent Canadian medical ethicist, recently went so far as to assert that neonatal circumcision constitutes assault under the Canadian criminal code.[2] Numerous legal scholars have

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1. *See generally* R.S. Van Howe, *Consent for Circumcision*, 156 CAN. MED. ASS'N J. 17 (1997); Jeremy Klein, *Circumcision and Consent*, 27 FAM. PRAC. NEWS 13 (1997); M.A. Somerville and D.M. Alwin, *Lidocaine-Prilocaine Cream for Pain during Circumcision*, 337 NEW ENG. J. MED. 568 (1997); D. Keleti, *Lidocaine-Prilocaine Cream for Pain during Circumcision*, 337 NEW ENG. J. MED. 568 (1997); S. L. Bond, *State Laws Criminalizing Female Circumcision: A Violation of the Equal Protection Clause of the Fourteenth Amendment*, 32 J. MARSHALL L. REV. 353 (1999); J. Smith, *Male Circumcision and the Rights of the Child, in Netherlands Institute of Human Rights (SIM), in* SIM SPECIAL NO. 21 TO BAEHR IN OUR MINDS. ESSAYS ON HUMAN RIGHTS FROM THE HEART OF THE NETHERLANDS 475-97 (1999) *at* http://www.law.uu.nl/english/sim/specials/simsp21.asp (last visited Nov. 12, 2000).

2. *See* S. Kirkey, *Circumcising Baby Boys 'Criminal Assault': Ethicist Says Society Must Consider Ban*, THE OTTAWA CITIZEN, Oct. 17, 1997 at 1; *see also* Crim. Code, R.S.C., ch. C-46, §§ 45, 265(1)(a) (2000) (Can.) [hereinafter Criminal Code of Canada].

concluded that routine neonatal circumcision falls within the legal definition of child abuse and violates children's civil and human rights under national and international law.[3] Consent to a procedure that is per se illegal is, of course, invalid regardless of the motives of the consenting party.[4] But even if it were legally and ethically permissible for parents to authorize circumcision of their sons, empirical studies have shown that the manner in which doctors typically obtain "informed consent" for neonatal circumcision from parents falls far below the standard of care required of the medical profession.[5]

This article examines whether and when parental consent to circumcision should be legally effective. It begins by identifying the legal and ethical requirements for consent that apply when medical professionals treat competent adult patients; requirements such as full disclosure, adequate capacity to consent, and voluntariness. It then analyzes how the rules and principles applicable in that context translate into legal and ethical requirements for consent to treatment of incompetent persons, and, in particular, treatment of children. It shows that, under normal circumstances, medical professionals may not prophylactically remove healthy tissue from even consenting adult patients, and that as a general rule, parents, regardless of their religious convictions, may not authorize medically unnecessary procedures on their children. The article then assesses the implications of those requirements for the practice of "routine circumcision" - that is, circumcision of infant males born with normal genitalia. It concludes that, because routine

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3. *See* Smith, *supra* note 1, at http://www.law.uu.nl/english/sim/specials/simsp21.asp; *see also* C. Price, *Male Circumcision: An Ethical and Legal Affront*, 128 BULL. OF MED. ETHICS 13 (May 1997); A.J. Chessler, *Justifying the Unjustifiable: Rite v. Wrong*, 45 BUFF. L. REV. 555 (1997); J. Steven Svoboda, *Routine Infant Male Circumcision: Examining the Human Rights and Constitutional Issues, in* SEXUAL MUTILATIONS: A HUMAN TRAGEDY 205-15, (G.C. Denniston and M.F. Milos, eds. 1997); J.G. Dwyer, *The Children We Abandon: Religious Exemptions to Child Welfare and Education Laws as Denials of Equal Protection to Children of Religious Objectors*, 74 N.C. L. REV. 1321 (1996); C.A. Bonner & M.J. Kinane, *Circumcision: the Legal and Constitutional Issues*, THE TRUTH SEEKER, at S1-S4 (July/Aug. 1989); W.E. Brigman, *Circumcision as Child Abuse: The Legal and Constitutional Issues*, 23 J. FAM. L. 337 (1985).

4. *See, e.g.*, K.M. Harrison, *Law, Order, and the Consent Defense*, 12 ST. LOUIS U. PUB. L. REV. 477, 497 (2000).

5. *See generally* C. Ciesielski-Carlucci et al., *Determinant of Decision-Making for Circumcision*, 5 CAMBRIDGE Q. HEALTHCARE ETHICS 228 (1996).

circumcision causes significant harm while providing no appreciable medical benefits, parental consent to the procedure is invalid. If circumcision can ever ethically and legally be performed, it is only when the male reaches adulthood and is capable of deciding for himself to undergo the procedure.

I. THE PREREQUISITES OF EFFECTIVE CONSENT TO SURGERY

The common law has always recognized battery - violation of a person's right to be free from unwanted touching - as a civil and criminal wrong. In this century, courts have increasingly emphasized the strong interest each person has in being free from nonconsensual invasion of his bodily integrity.[6] Subject to certain exceptions - such as, emergencies posing threats to life or danger of grievous bodily harm, self defense, jostling in a crowd and contact sports - any willful touching of another person is unlawful absent the valid consent of that person or of another person authorized to consent on that person's behalf.[7] If no valid consent exists, even slight physical contact may give rise to liability.[8]

Medical professionals can also be civilly and criminally liable for wrongful violation of bodily integrity, as well as be subject to professional disciplinary action.[9] Surgery has long been recognized as a technical battery that, regardless of the health-care provider's intentions, can be excused only when there is express or implied consent from the patient.[10]

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6. *See, e.g.*, Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977).

7. *See* Queensland Law Reform Commission, Report No. 51, *Consent to Health Care of Young People* 1:15 (1996).

8. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS, § 9 at 41-42 (5th ed. 1984).

9. *See* Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (1914); Bonner v. Moran, 126 F.2d 121, 122 (D.C. Cir. 1941); Queensland Law Reform Commission, *supra* note 7, at 24-44; Family Law Council [of Australia], *Sterilization and Other Medical Procedures on Children*—Discussion Paper 17-25 (Barton, ACT; Oct. 1993); J. Wilson, E. Della Torre and R. Ludbrook, *My Body, My Decision: Children's Consent to Medical Treatment*—Discussion Paper (Sydney: Mar. 1995).

10. *See* Newmark v. Williams, 588 A.2d 1108, 1115-16 (Del. 1991) (holding that an operation without informed consent constitutes battery); *see also* KEETON, *supra* note 8, § 18 at 114; Criminal Code of Canada, *supra* note 2; Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972); *Schloendorff*, 105 N.E. at 93; *Bonner*, 126 F.2d at 122.

As one landmark Canadian court decision held, "any intentional nonconsensual touching which is harmful or offensive to a person's reasonable sense of dignity is actionable."[11] This is true even if the treatment proves to be beneficial or even necessary to preserve a patient's life.[12] Absent effective consent, liability arises simply from the act of touching.

The consent requirement primarily protects the patient's bodily integrity.[13] In the case of competent persons, it also protects personal autonomy. Because of the critical interests at stake, consent must be "informed" in order to be valid: the individual must know to what he is consenting.[14] If the physician has not given the patient all the information that the patient needs to make a knowledgeable decision regarding his medical care, any consent the patient gives is ineffectual.[15] The informed consent requirement applies even to minor surgical procedures with extremely slight risks, such as the removal of a wart.[16]

II. ADULTS

A. How does consent work when the patient is a competent adult?

Competent adult patients are entitled to make the decisions regarding their medical care themselves.[17] This uncontroverted principle is fundamental to medical practice. The entitlement arises from the principle of individual self-determination that lies at the core of our political system and moral beliefs.[18] To facilitate self-determination in the medical setting, a process of "informed consent" has evolved.

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11. Malette v. Shulman [1990] 67 D.L.R. 4th 321, 327 (Can.).

12. *See* Matter of Storar, 420 N.E.2d 64, 71 (N.Y. 1981) (holding that a competent adult has a common-law right to decline or accept medical treatment, a violation of which right results in civil liability for those who administer medical treatment without consent, despite fact that treatment may be beneficial or even necessary to preserve patient's life).

13. *See* Queensland Law Reform Commission, *supra* note 7, at 15.

14. *See* Keogan v. Holy Family Hosp., 622 P.2d 1246, 1252 (Wash. 1980).

15. *See id.*

16. Edward Etchells et al., *Bioethics for Clinicians: 1. Consent,* 155 CAN. MED. ASS'N J. 177 (1996).

17. *See* Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (1914); In re A.C., 573 A.2d 1235, 1247 (D.C. 1990).

18. *See* PRISCILLA ALDERSON, CHILDREN'S CONSENT TO SURGERY 30 (1993).

"[I]nformed consent is an autonomous authorization of medical intervention . . . by individual patients."[19] Proper respect for the individual patient and for his right to control his own life requires that physicians refrain from surgical interventions, unless they are authorized by the patient based on an understanding of the best available information pertaining to a proposed procedure.[20] In legal terms, securing consent without providing adequate information constitutes legally redressable negligence.[21]

Thus, while patients necessarily rely on physicians to find the source of a malady if there is one,[22] once physicians have identified a problem and delineated treatment options, the patient's right of consent requires that the patient actively participate in the process of deciding which option to choose. Accordingly, the physician has a legal and professional duty to engage the patient in the consent process.[23] Specific requirements for informed consent have become increasingly stringent, reflecting modern society's greater skepticism toward medical authority and increased concern with safeguarding bodily integrity and personal autonomy.[24] Today those requirements fall into three categories: disclosure, capacity and voluntariness.[25]

1. Disclosure

The duty of disclosure arises from the principle that an individual's right to self-determination entails a right to know the truth and to receive

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19. Tom L. Beauchamp & Ruth R. Faden, *Informed Consent: II. Meaning and Elements of Informed Consent, in* 3 ENCYCLOPEDIA OF BIOETHICS 1240 (Warren T. Reich ed., rev. ed. 1995).

20. *See* Etchells et al., *supra* note 16, at 187.

21. *See* Bourgeois v. McDonald, 622 So. 2d 684, 688 (La. Ct. App. 1993); *see also* K.A.C. v. Benson, 527 N.W.2d 553, 561 (Minn. 1995); Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

22. R.B. Deber et al., *What Role Do Patients Wish to Play in Treatment Decision Making?*, 156 ARCH. INTERN. MED. 1414, 1416 (1996); *see also Canterbury*, 464 F.2d at 782; *see generally* L.A. Siminoff & J.H. Fetting, *Factors Affecting Treatment Decisions for a Life-Threatening Illness: the Case of Medical Treatment of Breast Cancer*, 32 SOC. SCI. & MED. 813 (1991).

23. *See* Etchells et al., *supra* note 16, at 177-80.

24. *See Canterbury*, 464 F.2d at 793-94 ("physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed . . . for otherwise it might devour the disclosure rule itself.").

25. *See* Etchells et al., *supra* note 16, at 177-80.

any and all information that is available, so that the treatment decision is the individual's own decision rather than someone else's decision.[26] Patients have a relatively high desire for information.[27] An uninformed decision to follow the recommendation or suggestion of a medical professional is in effect a choice coerced by the medical professional. In addition to honoring the patient's right to self-determination, disclosure facilitates the patient's ability to cope with the consequences of the procedure chosen.[28] In contrast, a patient's discovery after the fact that he was not given all the information he would have wanted can undermine his ability to deal effectively and positively with any adverse effects of the procedure.[29]

Medical professionals do not always fulfill this duty of disclosure, even when treating competent adult patients, and with respect to some procedures it may be common practice to give the patient much less information than he or she would need to participate meaningfully in the decision-making. Forty years ago, a physician might have been insulated from liability for non-disclosure if this was the common and accepted practice among medical professionals in connection with the particular procedure.[30] Today, a rule more respectful of patients prevails, requiring disclosure of all information that the patient would deem relevant in reaching a decision without regard to what the traditional common practice has been.[31]

Thus, before obtaining consent to a medical procedure, a physician must provide adequate information to the patient in a manner that the patient can comprehend.[32] "Adequate" means the amount and kind of information that the average person in the patient's position would want

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26. *See generally* Philip C. Hébert et al., *Bioethics for Clinicians: 7. Truth Telling*, 156 CAN. MED. ASS'N J. 225 (1997); Arato v. Avedon, 858 P.2d 598, 606-07 (Cal. 1993) (citing Cobbs v. Grant, 502 P.2d 1, 10-12 (Cal. 1972)).

27. *See* Deber et al., *supra* note 22, at 1417.

28. *See* ALDERSON, *supra* note 18, at 133, 155, 190.

29. *See* McInerney v. MacDonald (1992) 93 D.L.R. 4th 415, 425-26 (Can.).

30. *See, e.g.*, DiFilippo v. Preston, 173 A.2d 333, 339 (Del. 1961); Bolam v. Friern Hosp. Mgmt. Comm., 2 All E.R. 118, 118, 1 W.L.R. 582 (Q.B.D. 1957); P. Parkinson, *Children's Rights and Doctors' Immunities: The Implications of the High Court's Decision In re Marion*, 6 AUSTL. J. FAM. L. 101, 123 (1992).

31. *See* Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

32. *See* Edward Etchells et al., *Bioethics for Clinicians: 2. Disclosure*, 155 CAN. MED. ASS'N J. 387 (1996).

to have in reaching an informed decision.[33] Typically this means that the clinician must fully explain the proposed procedure, the expected short-term risks and long-term consequences, the available alternatives and their risks and benefits and the consequences of declining or delaying treatment.[34] The patient should be made aware of both short-term costs - for example, pain, length of confinement in a hospital, recovery time and potential complications - and long-term costs - such as loss of functioning, restriction of activities and physical scarring. In general, the test "for determining whether a potential peril must be divulged is its materiality to the patient's decision."[35] Physicians must disclose *all* material information, that is, all "information which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject a recommended medical procedure."[36] Importantly, the physician has an obligation to provide all significant information that is available, even if he or she were previously unaware of it. In other words, the duty of disclosure entails an obligation on the part of the physician to acquire information as it becomes available.[37] Naturally, there is a limit to how much and what kind of information medical professionals must provide. The physician's duty is to provide information that the average person would need to make an intelligent decision. This suggests that information that is not relevant need not be provided. Relevant information is that which would have a bearing, from the patient's perspective, on medical care.[38] The materiality criterion suggests that physicians need not provide information that would not influence the average patient's decision-making. However, even very slight risks generally must be disclosed to patients, particularly if the consequences may be severe. In a recent Australian case, for example, a

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33. *See id.*

34. *See id.*; *see also Canterbury*, 464 F.2d at 782.

35. Cobbs v. Grant, 502 P.2d 1, 11 (Cal. 1972) (citing Canterbury, 464 F.2d at 786); *see also* Moore v. Regents of Univ. of Cal., 793 P.2d 479, 493 (1990) (following the "well-established principles" regarding informed consent first set forth in *Cobbs v. Grant*).

36. Arato v. Avedon, 858 P.2d 598, 607 (Cal. 1993).

37. *See* American Medical Association [hereinafter AMA], CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 136 (1996).

38. *See Canterbury*, 464 F.2d at 782; *see also* Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (1914); *see also* Canadian Medical Association, *Code of Ethics of the Canadian Medical Association*, 155 CAN. MED. ASS'N J. 1176A (1996).

patient who underwent an elective operation on her right eye and who had persistently questioned the physician concerning potential complications was never informed that there was a one in 14,000 chance that the operation would leave her blind. The operation did in fact leave her virtually blind.[39] The High Court of Australia ruled that the physician was negligent in not revealing the risk of this complication, even though the risk was slight.[40] This ruling is consistent with patients' expectations; a 1988 study in Australia found that 77% of patients said that they wanted more information about their treatment.[41]

In addition to requirements as to the content of information provided, a physician's duty of disclosure entails a requirement as to *how* he or she provides the information: she must provide the requisite information in a manner conducive to patient comprehension. Studies have found that some form of written disclosure, either alone or in combination with verbal disclosure, imparts greater knowledge than verbal disclosure alone.[42] This suggests that physicians should provide full written

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39. Rogers v. Whitaker (1992) 175 C.L.R. 479 (Austl.).

40. *See id.* at 489-91.

41. Law Reform Commission of Victoria (Report 24), Australian Law Reform Commission (Report 50), and New South Wales Law Reform Commission (Report 62), *Informed Decisions About Medical Procedures* (1989) at 9.

42. *See* Helen Dunkelman, *Patients' Knowledge of Their Condition and Treatment: How It Might Be Improved*, 2 BRIT. MED. J. 311, 311 (1979); *see also* Barrie R. Cassileth et al., *Informed Consent - Why Are Its Goals Imperfectly Realized?*, 302 NEW ENG. J. MED. 896, 896 (1980); S.A. Layton, *Informed Consent in Oral and Maxillofacial Surgery: a Study of Its Efficacy*, 30 BRIT. J. ORAL & MAXILLOFACIAL SURGERY 319, 319, 322 (1992); D. J. Byrne, A. Napier & A. Cuschieri, *How Informed Is Signed Consent?*, 296 BRIT. MED. J. 839, 839-40 (1988); Hyman B. Muss et al., *Written Informed Consent in Patients with Breast Cancer*, 43 CANCER 1549, 1549 (1979); H. J. Sutherland et al., *Are We Getting Informed Consent from Patients with Cancer?*, 83 J. ROYAL SOC'Y MED. 439, 439 (1990); George Robinson & Avraham Merav, *Informed Consent: Recall by Patients Tested Postoperatively*, 22 ANNALS OF THORACIC SURGERY 209, 209 (1976); Terence C. Wade, *Patients May Not Recall Disclosure of Risk of Death: Implications for Informed Consent*, 30 MED., SCI. & L. 259, 259 (1990); Niels Lynöe et al., *Informed Consent: Study of Quality of Information Given to Participants in a Clinical Trial*, 303 BRIT. MED. J. 610, 612 (1991); S. Gibbs et al., *Communicating Information to Patients About Medicine*, 83 J. ROYAL SOC'Y MED. 292, 292 (1990); Kenneth D. Hopper & Harry N. Tyler, *Informed Consent for Intravascular Administration of Contrast Material: How Much Is Enough?*, 171 RADIOLOGY 509, 509 (1989); G. Askew et al., *Informed Consent: Can We Educate*

explanations of procedures to their patients when practicable. Presumably, this would be practicable with respect to any procedures performed routinely or in non-emergency situations.

Exceptions to the disclosure requirement, if any, are legally tenuous. A patient may voluntarily forgo some elements of disclosure, but it is not clear that this "waiver" provides the physician any protection from a negligence suit.[43] The so-called "therapeutic privilege," adopted in the past by the Supreme Court of Canada as sometimes permitting the withholding of information in order to lessen the patient's suffering,[44] is increasingly disfavored, and, in fact, has more recently been ruled unacceptable in that country.[45] The High Court of Australia has similarly ruled, "Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in [complying with legal mandates that require] disclosing the information,

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Patients?, 35 J. R. C. SURGERY EDINB. 308, 308-09 (1990); Rose A. Gates et al., *Patient Acceptance of an Information Sheet About Cardiopulmonary Resuscitation Options*, 8 J. GEN. INTERNAL MED. 679, 679 (1993); A.J. Tymchuk et al., *Medical Decision-Making among Elderly People in Long-Term Care*, 28 GERONTOLOGIST 59 (June supp. 1988); P.J. D. Dawes et al., *Informed Consent: The Assessment of Two Structured Interview Approaches Compared to the Current Approach*, 106 J. LARYNGOLOGY & OTOLOGY 420, 420, 423 (1992); Irwin Kleinman et al., *Effectiveness of Two Methods for Informing Schizophrenic Patients about Neuroleptic Medication*, 44 HOSP. & COMM. PSYCHIATRY 1189, 1189 (1993); S. Layton & J. Korsen, *Informed Consent in Oral and Maxillofacial Surgery: A Study of the Value of Written Warnings*, 32 BRIT. J. ORAL & MAXILLOFACIAL SURGERY, 34, 34 (1994); R. J. Simes et al., *Randomised Comparison of Procedures for Obtaining Informed Consent in Clinical Trials of Treatment for Cancer*, 293 BRIT. MED. J. 1065 (1986); Etchells et al., *supra* note 29, at 387-91.

43. Etchells et al., *supra* note 33, at 387-91.

44. *See* Reibl v. Hughes, (1980) 114 D.L.R. 3d 1, 15-17 (Can.); *see also* Hopp v. Lepp, (1980) 112 D.L.R. 3d 67, 77 (Can.) ("[A] surgeon has some leeway in assessing the emotional condition of the patient and how the prospect of an operation weighs upon him; the apprehension, if any, of the patient... [and] his reluctance, if any, to submit to an operation...."); Margaret A. Somerville, *Therapeutic Privilege: Variation on the theme of Informed Consent*, 12 L., MED. & HEALTH CARE 4, 11 (1984) (proposing that therapeutic privilege be seen as more complex and sophisticated than previously envisioned, and that it be applied in certain circumstances as a qualification of informed consent doctrine which may prevent the latter from causing suffering disproportionate to the benefits it confers.).

45. *See* Meyer Estate v. Rogers, [1991] 78 D.L.R. 4th 307, 316 (Can.).

including the risks attending the proposed treatment."[46] By comparison, the therapeutic privilege doctrine has never received much support in the United States; just a smattering of lower courts have on rare occasions endorsed it.[47] As early as 1972, in the leading case of *Canterbury v. Spence,* the District of Columbia Circuit tersely observed that the "physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed . . . for otherwise it might devour the disclosure rule itself."[48] The rule is that physicians *must* provide accurate and complete information to all patients, even though a small percentage might prefer not to know about the risks of surgery.[49] The only generally recognized exception, which is narrowly construed, applies to situations where, because of the patient's emotional condition, disclosure is very likely to cause physical or mental harm.[50]

2. *Capacity*

Capacity is the patient's ability to understand information relating to treatment decisions and to appreciate the consequences of a decision.[51] The capacity requirement reflects the belief that persons unable to make rational decisions about their medical care should be protected from

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46. *See* Rogers v. Whitaker, (1992) 175 C.L.R. 479, 492 (Austl.).

47. Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

48. *Id.*; *see also* Roberts v. Wood, 206 F. Supp. 579, 583 (S.D. Ala. 1962) (ruling that where a patient was in a fragile emotional state, concerned about the operation, had previously experienced thyroidectomy, and a second gynecological operation was to be performed simultaneously, the physician was not liable for having failed to apprise the patient of all the hazards of thyroidectomy.); Hubert W. Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946) (arguing for therapeutic privilege, while conceding "there is little or no [U.S.] legal authority bearing on the existence of such a privilege"); Marcella J. Mulvaney, *The Therapeutic Privilege: Defense in an Informed Consent Action*, 42 MED. TRIAL TECH. Q. 63 (1996) (arguing that *Arato v. Avedon* resuscitated therapeutic privilege by holding that physicians are not required to disclose statistical life expectancy information to patients).

49. *Id.*; *see also Roberts*, 206 F. Supp. at 583; Mulvaney, *supra* note 48, at 63, Smith, *supra* note 48, at 349.

50. *See Canterbury*, 464 F.2d at 789; *see also* ELLEN I. PICARD, LEGAL LIABILITY OF DOCTORS AND HOSPITALS IN CANADA 99 (2d ed. 1984).

51. *See* Edward Etchells et al., *Bioethics for Clinicians: 3. Capacity*, 155 CAN. MED. ASS'N J. 657 (1996).

making decisions that are harmful or that they would not make if they were able. The requirement imposes on physicians a duty to assess whether a patient is capable of both understanding the relevant medical information and making a rational decision based upon that information. To accomplish this, the clinician should provide full disclosure about a proposed procedure and then evaluate whether the patient does in fact understand the information disclosed. In dealing with competent adults, medical professionals must presume that the adult has the requisite capacity and proceed with full disclosure unless and until they determine that the patient is actually not capable of understanding. Non-disclosure cannot be justified by a suspicion or uncertainty concerning the adult's capacity for understanding.

Unfortunately, a patient's understanding is often limited not so much by his inherent inability to comprehend, but by the clinician's inability to convey information understandably. The capacity requirement precludes doctors from obtaining consent without full disclosure based on the doctor's determination of incapacity, where any incapacity can be cured by reasonably improving the manner in which information is presented. In fact, this requirement suggests a duty on the part of medical professionals to make greater efforts to communicate information when initial efforts are unsuccessful.

3. *Voluntariness*

The voluntariness requirement protects the patient's right to make health care choices free from manipulation or undue influence.[52] Manipulation occurs where medical personnel distort and/or omit information in order to induce the patient's acceptance or rejection of a procedure.[53] Full disclosure can obviate manipulation by omission, but not the danger of manipulation by distortion.

The power imbalance between doctor and patient creates a great danger of undue influence. A patient cannot obtain treatment without an agreeable medical professional, and typically can do little more than respond to treatment proposals the physician offers. Patients are often ill

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52. *See* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 259 (1986).

53. *See* David A. Pendleton & Stephen Bochner, *The Communication of Medical Information in General Practice Consultations as a Function of Patients' Social Class*, 14A SOC. SCI. & MED. 669, 672 (1980); *see also* M.C. Shapiro et al., *Information Control and the Exercise of Power in the Obstetrical Encounter*, 17 SOC. SCI. & MED. 139, 144-45 (1983).

and anxious at the time consent is sought, making them even more vulnerable to influence by medical professionals. Because of the inherent imbalance of power in the physician-patient relationship, the manner and order in which physicians present information can greatly influence the importance patients attach to different considerations and can, intentionally or otherwise, persuade the patient to select the option favored by the physician.

Therefore, the physician has a duty to distance himself as much as possible from his personal preferences and values and to present information in a manner that reflects an objective assessment of the interests at stake for the patient. Physicians also must be sensitive to the fact that patients are likely to interpret a suggestion, or even the mere mention of an option, as a recommendation. To counteract this danger, bioethicists recommend that physicians actively and explicitly *encourage* patients to make decisions independently.[54]

The timing of disclosure is also important. The immediacy of the need for a medical procedure can interfere with the patient making a voluntary decision. The patient may have little time to digest information and reflect on alternatives; he or she is likely to be emotionally overwrought and be especially reliant on the physician to make decisions for him or her. Certainly with an elective procedure that can be performed at any time, it would be inexcusable for a physician not to provide a patient with full disclosure far in advance to allow the patient sufficient time to reflect on whether to undergo the procedure.

In sum, an adult patient's decision to undergo a procedure must truly be *his or her* decision, a true reflection of his or her autonomy and right to self-determination. This will only be true if the physician fully and objectively discloses all information relevant and material to the decision. Doing so ensures that the patient understands the information, encourages the patient to make the decision independently and steers clear of any actions that could amount to undue influence and/or manipulation.[55]

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54. *See* Edward Etchells et al., *Bioethics for Clinicians: 4. Voluntariness*, 155 CAN. MED. ASS'N J. 1083, 1086 (1996).

55. Donald A. Redelmeier et al., *Understanding Patients' Decisions: Cognitive and Emotional Perspectives*, 270 JAMA 72, 72, 75 (1993); *see generally* Code of Medical Ethics, *supra* note 33.

B. *How does informed consent work when competent adults request non-medically indicated procedures?*

A physician's obligation regarding the content of information provided to a patient is even greater in connection with procedures, such as cosmetic surgery, that are not "medically indicated," i.e., that are not undertaken to secure a medical benefit.[56] Because the procedure entails no medical benefit, the only possible *medical* result is harm, so a physician must proceed with particular caution.

The literature addressing consent for cosmetic surgery is fairly sparse; the American Medical Association Code of Ethics, for example, does not address it.[57] However, a general principle running through the limited discussion available holds that the more elective the procedure, the more important the role of full disclosure.[58] Because the patient is often eager to proceed prior to consulting the physician, the physician needs to temper this enthusiasm with a sobering enumeration of all possible complications. The clear disclosure of all significant health considerations is a prerequisite to the patient's ability to make a rational decision about whether to proceed.[59]

Naturally, the physician should also ensure that someone requesting a procedure that is not medically indicated is fully competent and acting voluntarily. It would be particularly troubling if a physician not only failed to ensure fully informed and uncoerced reflection on the potential costs of a non-medically indicated procedure but also in fact *suggested* the procedure or presented information about it in a way that could reasonably be interpreted as a recommendation. Encouraging a patient to undergo a procedure that has no medical benefit is presumptively inconsistent with medical ethics.[60]

A strong concern regarding voluntariness may arise in situations where

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56. *See* FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE 12-64 (2d ed. 1990); Alderson, *supra* note 18, at 188-99.

57. *See* AMA, CODE OF MEDICAL ETHICS, *supra* note 37.

58. *See* Ciesielski-Carlucci, *supra* note 5, at 229; *see also* Tekanawa v. Millican, unreported Botting DCJ, Brisbane District Court, 11 February 1994, no. 1219-92; NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL, GENERAL GUIDELINES FOR MEDICAL PRACTITIONERS ON PROVIDING INFORMATION TO PATIENTS 5, 5-6 (1993) (discussing a higher standard of disclosure of information is required where surgery is purely elective or cosmetic).

59. Merilyn Evans, *Augmentation Mammaplasty: Neither Simple Nor Safe*, 8 AUSTL. J. ADVANCED NURSING 19, 23-24 (1991).

60. *See* AMA, CODE OF MEDICAL ETHICS, *supra* note 37, at 134-35.

the cultural practices of some group dictates that individuals undergo a physical alteration that does not benefit them medically, particularly where those individuals are subordinate within the group. Indeed, a physician will often be ethically and legally barred from performing such procedures that might cause harm and that are without medical benefit.

One example is a Muslim woman's request that a doctor circumcise her daughter. Probably already covered by common law assault statutes, the procedure is now specifically banned by a number of statutes passed in the last few years. Any physician who performs such a procedure violates medical ethics and, in many states, criminal and civil law as well.[61] Recently, a Seattle hospital agreed to perform a minor, largely symbolic, genital cutting on a Muslim woman who requested it, but subsequently reversed itself in the face of public outcry.[62] This event reflects the widespread understanding that doctors should refuse to become complicit in physically harmful cultural practices and that consent should be treated with skepticism when it comes from persons who historically have been less than fully autonomous. At least two authors have noticed the dramatic disparity between the treatment of female genital cutting and circumcision, commenting emphatically on the violation of equal protection created by current statutory law.[63]

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61. *See* George Denniston, *Circumcision and the Code of Ethics*, 12 HUMANE HEALTH CARE INT'L 78 (1996) (arguing that routine infant male circumcision violates all seven principles of the American Medical Association's ethical code). Laws passed in the United States against female genital mutilation include the federal law (18 USC § 116) as well as numerous state statutes in California, Colorado, Delaware, Illinois, Maryland, Minnesota, Nevada, New York, North Dakota, Oregon, Rhode Island, Tennessee, Texas, West Virginia and Wisconsin. Countries that have outlawed the practice include Burkina Faso, Canada, Central African Republic, Cote d'Ivoire, Djibouti, Egypt, Ethiopia, Ghana, Guinea, Kenya, New Zealand, Norway, Senegal, Sweden, Tanzania, Togo, Uganda and the United Kingdom. A complete list of all state and national laws with all citations appears IN ANIKA RAHMAN AND NAHID TOUBIA, FEMALE GENITAL MUTILATION: A GUIDE TO LAWS AND POLICIES WORDLWIDE 101 (1999). *See also* Doriane L. Coleman, *The Seattle Compromise: Multicultural Sensitivity and Americanization*, 47 DUKE L. REV. 717, 751 (1998) (recounting the breakdown of "the Seattle compromise," in which—despite the proposed procedure's apparent consistency with all pertinent laws—public outcry prevented well-meaning doctors at one Seattle hospital from performing even a ceremonial nick of Somali girls' clitorises which would remove no tissue).

62. *See* Doriane L. Coleman, *The Seattle Compromise: Multicultural Sensitivity and Americanization*, 47 DUKE L. REV. 717, 736-37 (1998).

63. *See* Bond, *supra* note 1, at 371-74; *see also* Ross Povenmire, *Do Parents*

C. *Can adults consent to prophylactic removal of healthy tissue?*

What if a procedure is not needed to correct an existing problem, but might reduce or eliminate risk of medical problems in the future? Current practices and attitudes with respect to risk of cancer in women are instructive. Genetic tests can now detect genes that predispose women to breast and ovarian cancer. Women with the relevant mutations would significantly reduce the risk of contracting these cancers if they underwent prophylactic mastectomy and/or oophorectomy. These women could thereby increase their lifespan by an average of 2.9 to 5.3 years.[64] Even in the average woman without these genetic markers, prophylactically removing both breasts and ovaries would result in an average gain of six to eight months in life expectancy.[65] Without providing their reasoning, the authors concluded that "prophylactic surgery is obviously unreasonable for these women."[66] Although such prophylactic surgery is generally deemed inappropriate,[67] given the substantial benefits and assuming fully informed consent could be provided by the patient herself, it may be legally and ethically permissible. By contrast, it clearly would be impermissible in the case of an incompetent individual, where permission would have to be provided by a surrogate.[68]

D. *How does informed consent work in contexts involving incompetent adults?*

Although the doctrine of informed consent is predicated on respect for the autonomy of the patient, the doctrine applies even when the patient is not competent. The effect of applying the doctrine to incompetent adult patients is not to give the physician or anyone else a *right* to decide for the patient.[69] Rather, in such cases, under the principle of "substituted

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Have the Legal Authority to Consent to the Surgical Amputation of Normal, Healthy Tissue from their Infant Children?: the Practice of Circumcision in the United States, 7 J. GENDER SOC. POL'Y & L. 87, 113-14, 119-22 (1998).

64. *See* Deborah Schrag et al., *Decision Analysis—Effects of Prophylactic Mastectomy and Oophrectomy on Life Expectancy among Women with BRCA1 or BRCA2 Mutations*, 336 NEW ENG. J. MED. 1465, 1465 (1997).

65. *See id.*

66. *Id.* at 1470.

67. *See id.* ("Prophylactic surgery is obviously unreasonable for these women.").

68. *See* discussion *infra* Part II.E.

69. *See* In re Quinlan, 355 A.2d 647, 661-62 (N.J. 1976).

judgment," a surrogate for the patient, typically a relative, is legally *permitted* to stand in the place of the patient; this means that the surrogate can make decisions on behalf of the patient in furtherance of the rights *of the patient.*[70] Surrogates are under a legal obligation to decide not on the basis of how *they* want the patient to be treated, but rather on the basis of how *the patient* would choose to be treated if he or she were capable of choosing.[71] As a general rule, the more a surrogate seems influenced in

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70. *See* Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 421, 431 (Mass. 1977); *see also* Hart v. Brown, 289 A.2d 386, 387-390 (Conn. Super. Ct. 1972) (declaring the right of court of equity to act for incompetent recognized as "doctrine of substituted judgment" which is broad enough to cover all matters touching well-being of legally incapacitated persons including infants); Strunk v. Strunk 445 S.W.2d 145, 145-149 (Ky. Ct. App. 1969) (permitting a kidney transplant from 27-year-old incompetent to his 28-year-old brother based on finding that incompetent, who had close relations with recipient, would benefit from continuation of recipient's life); In re Guardianship of Pescinski, 226 N.W.2d 180, 181 (Wis. 1975) (denying request for court application of substituted judgment doctrine and grant of permission for 39-year-old man with mental age of 12 to donate kidney to sister in absence of real consent on his part and in a situation where no benefit to him had been established); Mark R. Tonelli, *Substituted Judgment in Medical Practice: Evidentiary Standards on a Sliding Scale*, 25 J. L. MED. & ETHICS 22, 22 (1997); L.E. Lebit, *Compelled Medical Procedures Involving Minors and Incompetents and Misapplication of the Substituted Judgment Doctrine*, 7 J. L. & HEALTH 107, 107 (1992); Sean M. Dunphy & John H. Cross, *Medical Decisionmaking for Incompetent Persons: The Massachusetts Substituted Judgment Model*, 9 W. NEW ENG. L. REV. 153, 153 (1987); Charles H. Baron, *Medicine and Human Rights: Emerging Substantive Standards and Procedural Protections for Medical Decision-Making within the American Family*, 17 FAM. L. Q. 1, 16 (1983). *But see* William A. Krais, *The Incompetent Developmentally Disabled Person's Right of Self-Determination: Right-to-Die, Sterilization and Institutionalization*, 15 AM. J. L. & MED. 333, 334-35 (1989) (rejecting substituted judgment standard and recommending best interests test).

71. *See* Ex Parte Whitbread in the Matter of Hinde, a Lunatic, 35 ENG. REP. 878, 878 (Ch. 1816) ("the Court will act with reference to the Lunatic, and for his benefit, as it is probable the Lunatic himself would have acted if of sound mind"); *see also Belchertown*, 370 N.E.2d at 424 ("decision in cases such as this should be that which would be made by the incompetent person, if that person were competent."); Matter of Conroy, 486 A.2d 1209, 1229 (N.J. 1985) ("[the] goal of decision-making for incompetent nursing home patients with respect to life-sustaining treatment should be to determine and effectuate, insofar as possible, the decision that the patient would have made if competent."); Conservatorship of Drabick, 245 Cal. Rptr. 840, 852 (Cal. Ct. App. 1988), *cert. denied*, 488 U.S. 958 (1988), *reh'g denied*, 488 U.S. 1023 (1988) (holding that incompetent patients

her decision-making by her personal values and preferences, the less willing a physician should be to accept the surrogate's authorization for a procedure.

Where the patient was formerly competent, the substitute decision-makers typically must present clear and convincing evidence as to the wishes of the patient before he or she became incompetent.[72] For example, where a once-competent adult has become disabled by trauma or old age and is on life support, in order for a court to authorize discontinuation of life support surrogates must demonstrate that, when competent, the patient indicated a preference not to have his or her life prolonged by medical means if there was no hope of recovery.[73] Where such evidence is lacking or where the patient was never competent, the surrogate must provide evidence as to what a rational person would likely want for himself or herself in light of the relevant aspects of the situation.[74] In other words, the patient's best interests must be proved by the surrogate.[75] The substitute decision-maker's judgment is subject to review and challenge if it appears irrational or self-interested.[76]

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retain right to have appropriate medical decisions made on their behalf, and an appropriate medical decision is one that is made in the patient's best interests as opposed to the interests of any other party).

72. *See* Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 284-86 (1990) (concluding that a state may apply a clear and convincing evidence standard in such proceedings and noting that many state courts which have addressed the issue have required a clear and convincing standard of proof); *cf.* Matter of Edna M.F., 563 N.W.2d 485 (Wis. 1997) (using preponderance of evidence standard); *see also* Lebit, *supra* note 70, at 107, 110, 127 (cautioning that substituted judgment has been "tragically misapplied" to achieve what judges believe to be "beneficial" in cases where consent is not available and noting that this results in the confusion of the standards of best interests and substituted judgment).

73. *See* Matter of Storar, 420 N.E.2d 64, 72 (N.Y. 1981); *see also* S. Williams, *Substituted Judgment in Medical Decisionmaking for Incompetent Persons: In re Storar*, 61 WIS. L. REV. 1173, 1173 (1982).

74. *See, e.g.*, In re Grady, 426 A.2d 467, 483 (N.J. 1981) (requiring clear and convincing proof to justify sterilization of nineteen-year-old woman afflicted with Down's syndrome).

75. *See* Matter of C.D.M., 627 P.2d 607, 612 (Alaska 1981) (requiring clear and convincing standard); Matter of A.W., 637 P.2d 366, 375-76 (Colo. 1981) (requiring clear and convincing standard of proof that procedure "medically essential"); Matter of Terwilliger, 450 A.2d 1376, 1383 (Pa. 1982) (requiring clear and convincing standard).

76. Neil M. Lazar et al., *Bioethics for Clinicians: 5. Substitute Decision-Making*, 155 CAN. MED. ASS'N J. 1435 (1996).

The question whether to perform a medical procedure on an adult who has never been competent arises most often when mentally disabled women have guardians who wish to sterilize them.[77] These guardians typically believe that sterilization will benefit the disabled women by preventing a pregnancy that could have serious physical, psychological and social consequences.[78] Nevertheless, in light of the presumption of bodily integrity and the difficulty of attributing contrary preferences to an adult who has never been competent, courts and legislators have become increasingly unwilling to allow such sterilization.[79]

In general, to authorize surgery on an incompetent adult patient, a surrogate must clearly demonstrate that the benefits of the surgery outweigh the short- and long-term costs for the patient. The incompetent person's presumptive right against invasion of his or her bodily integrity places the burden on anyone who would infringe that right to prove that it is necessary for the incompetent person's welfare. Importantly, the costs and benefits relevant to an assessment of an incompetent person's interests in connection with a medical procedure are only temporal, earthly interests such as physical and mental health, social relationships and finances. Assessment of costs and benefits on behalf of an incompetent person cannot justifiably include what the surrogate decision-maker believes to be spiritual or other worldly costs and benefits for the patient. There is no assurance that the patient would share that perception. The law gives no one authority to decide what another person's spiritual interests are, regardless of whether the latter person is or ever has been competent.[80] This principle is rarely tested, but in *In re Quinlan*,[81] which involved a once-competent woman in a persistent vegetative state, the New Jersey Supreme Court invoked the principle to reject a claim by the woman's parents that the hospital must withdraw life support because the claim was inconsistent with the parents' religious

77. *See* Hudson v. Hudson, 373 So. 2d 310, 311-12 (Ala. 1979) (holding that in absence of statutory authority, court lacks power to order sterilization of retarded 16-year-old female); Ruby v. Massey, 452 F. Supp. 361, 366-67 (Conn. 1978) (finding that parents lack authority either to veto or to give valid consent to sterilization of their several mentally retarded and physically handicapped daughters).

78. *See Hudson*, 373 So. 2d at 311-12; *Ruby*, 452 F. Supp. at 366-67.

79. *See Hudson*, 373 So. 2d at 311-12; *Ruby*, 452 F. Supp. at 366-67.

80. *See* In re Quinlan, 355 A.2d 647, 661-62 (N.J. 1976).

81. *Id.*

values.[82] The court stated emphatically that the parents had no right, based on religious freedom or parenthood, to make that decision for their daughter.[83]

Within these constraints the surrogate is legally authorized to *grant permission* (the more precise terminology) to medical intervention for an incompetent adult. However, for a competent adult making decisions regarding his own care, such permission must be informed. The physician's professional and legal duties in this context are at least as stringent as in the case of an autonomous adult. Because the patient—the person with the greatest stake in the operation—is not able himself to insist upon receiving and then evaluating all the relevant information, more care must be taken to ensure that decisions are made in the correct way. Hence, when a surrogate is faced with a decision on whether an incompetent adult should undergo surgery, medical personnel have a duty *to the patient* to fully disclose to the surrogate all available information that a reasonable, competent adult would want before deciding whether to undergo the procedure.[84] Physicians also have a duty to ensure that the surrogate is capable of understanding the information provided and of fully appreciating the consequences of a decision at the moment of decision-making. Likewise, physicians also have an obligation not to manipulate the surrogate by presenting the information in a manner designed to secure permission, rather than facilitating an objective evaluation of the risks and benefits of the procedure. In addition to these requirements, which also arise in securing informed consent from a competent patient, a physician seeking permission for a surgical procedure on an incompetent adult must ensure that the substitute decision-maker is not acting out of self-interest but rather is deciding on the basis of what is best for the patient.

E. Would non-medically indicated surgery be allowed for a non-autonomous adult?

There are few situations in which a surrogate for an incompetent adult requests a non-medically indicated procedure. The most common are similar to the cases indicated above in which a concerned family member seeks to withdraw life support from a patient who is terminally ill or in a

82. *See id.*

83. *See id.*

84. *See* James G. Dwyer, *Parents' Religion and Children's Welfare: Debunking the Doctrine of Parents' Right*, 82 CAL. L. REV. 1371, 1416-21, 1429-32 (1994).

persistent vegetative state, or to take away a mentally disabled woman's ability to procreate.[85] In all of these situations, the surrogate may perceive non-medical benefits for the patient that he or she believes outweigh any medical harm that might result from the decision. However, there is no assurance that the views of surrogates, often close family members, will necessarily be the same as the patient's had he or she been confronted with the situation while competent.[86] As noted above, surrogates in both cases must present strong evidence as to the patient's preferences when competent or as to the patient's best interests.

With respect to the choice of physically invasive procedures, such as sterilization, courts and legislatures have been increasingly resistant to allow them and increasingly concerned that surrogates might choose such procedures out of self-interest rather than out of respect for the incompetent adult. In several states, sterilization is simply not permitted.[87] A doctor today who performs a sterilization operation on an

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85. *See* Ross Povenmire, *Do Parents Have the Legal Authority to Consent to the Surgical Amputation of Normal, Healthy Tissue from the Infant Children?: the Practice of Circumcision in the United States*, 7 J. GENDER SOC. POL'Y & L. 87, 107-08 (1998) (emphasizing the strong similarity between sterilization of incompetents and infant circumcision: both involve surgery on the genitals, since incompetents are treated by the law as minors the parens patriae power applies equally to incompetents and infants, both procedures violate the minor's personal integrity, and while sterilization invokes profound privacy interests in procreative choice not raised by circumcision, circumcision "does involve the radical alteration of a male's most sensitive and private body part which is surely a protected privacy interest.").

86. *See* Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 285-86 (1990).

87. In some States, sterilization is prohibited by statute where a mentally disabled woman is capable of participating in the decision making process and declines to consent. *See, e.g.,* COLO. REV. STAT. § 27-10.5-128(4) (2000). In at least one state, California, the legislature initially passed a statute prohibiting sterilization under any circumstances, but a court ruled the prohibition unconstitutional, on the grounds that incompetent women have reproductive rights that include a right to be sterilized if they want to be and if that is in their best interests. *See* In re Valerie N., 707 P.2d 760, 771-72 (Cal. 1985) (invalidating Ann. Cal. Probate Code § 2356(d)). More commonly, courts have held that sterilization of mentally incompetent women is prohibited in the absence of statutory authority. *See* 53 Am. Jur. 2d Mentally Impaired Persons § 126 (1996); Elizabeth Scott, *Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy*, 1986 DUKE L. J. 806, 817 n.32 (1986). States that do permit courts to authorize sterilization generally require that courts find by clear and convincing evidence that sterilization is in the best interests of the incompetent

incompetent woman without court approval is vulnerable to criminal, civil and professional ethics charges, despite having permission from the woman's parents or other guardians.[88] Typically, if a court chooses to grant approval of the procedure at all, it is only after a determination "that the condition of the conservatee '*requires* the recommended course of medical treatment,'" and that there are no alternative means of protecting the incompetent woman's physical well-being and interests.[89] Consistent with this approach, the California Supreme Court found in *Conservatorship of Valerie N.*[90] that parents of a mentally retarded woman could not have her sterilized, "inasmuch as there was neither evidence of necessity . . . nor sufficient evidence that less intrusive means . . . [were] not presently available to [the conservatee]."[91] The Court based its decision upon the incompetent patient's fundamental "right . . . to be free of intrusive medical and surgical procedures."[92]

Unsurprisingly, courts have not been faced with claims by guardians to have incompetent adults in their care undergo surgery to remove a normal healthy, non-diseased, uninjured part of the body simply for the sake of conforming to cultural norms or as a prophylactic measure to avoid some infinitesimal risk of disease to that part of the body. Were a guardian of an adult to seek such a procedure, doctors and lawyers would inform him without hesitation that his request is inappropriate and legally unsupportable. Imagine, for example, Muslim parents of a woman who was never competent asking a doctor to circumcise her; the doctor surely must refuse. Courts have even been hesitant when removal of healthy tissue has been sought for the purpose of transplantation—that is, to provide a medical benefit to (perhaps even save the life of) another person who may be a close relative of the incompetent adult. They have

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woman. *See* Scott, *supra*, at 817-19. Many require that all less drastic (nonpermanent) contraceptive methods have been found unworkable and that there be no alternative to sterilization. *See id.* at 820 n.43. Significantly, current law precludes courts from considering the interests of parents or other guardians for the incompetent woman in deciding whether to authorize sterilization. *See id.* at 821-22.

88. *See* Re B *(a Minor),* 2 All E.R. 206, 206, 214-15 (H.L. 1987); *see generally Cruzan*, 497 U.S. at 284-86.

89. *See Valerie N.*, 707 P.2d at 771-72 (citing Ann. Cal. Probate Code § 2356(d) (1980)) (emphasis added).

90. *Id.*

91. *See id.* at 405.

92. *See id.* at 403.

held that surrogates may not authorize this type of removal because it does not constitute medical treatment for the incompetent donor.[93] In many such cases, an objective analysis would probably show that a transplant would maximize the overall good and that the average competent person would altruistically agree to donate the tissue or organ, but the law nevertheless prohibits that result because of grave concerns about violating a person's physical integrity without his consent.

The American Medical Association Code of Medical Ethics does not address a physician's ethical obligation in situations where guardians for an incompetent adult seek non-medically indicated medical intervention. However, the Code includes a more general mandate to physicians to help patients "make choices from among the therapeutic alternatives *consistent with good medical practice*."[94] This might be read to imply that a physician must discourage a surrogate from seeking a procedure that would not be medically beneficial to the patient. Certainly, physicians have no affirmative obligation to undertake a non-medically indicated intervention when asked to do so. Therefore, it is no justification for violating an incompetent person's physical integrity that a surrogate asked the physician to do so.[95]

There is also little mention in the legal or ethical literature of physician's *proposing* non-medically indicated procedures to surrogates who have not themselves requested the procedure. This is unsurprising. Such a practice would so clearly offend the canons of ethics of the medical profession as to generate a reaction of horror and recrimination by legal and medical authorities. The prohibition of solicitation by doctors, based upon the impropriety of a physician putting his or her financial welfare above the welfare of the patient,[96] would apply even more stringently to solicitation of surrogates for incompetent adults than it does to solicitation of competent adults. Any physician who proposed to a surrogate for an incompetent adult that the surrogate grant permission for non-medically indicated surgery which the surrogate had not requested would jeopardize his or her license to practice medicine.

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93. *See* Little v. Little, 576 S.W.2d 493, 493-95 (Tex. Civ. App. 1979); In re Richardson, 284 So. 2d 185, 185-87 (La. Ct. App. 1973).

94. *See* AMA, CODE OF MEDICAL ETHICS, *supra* note 37, at 120 (*emphasis added*).

95. Charles Weijer et al., *Bioethics for Clinicians: 16. Dealing with Demands for Inappropriate Treatment*, 159 CAN. MED. ASS'N J. 817 (1998).

96. *See* AMA, *supra* note 37, at 105; Can. Med. Ass'n, *supra* note 38, at 1176A-B.

III. CHILDREN

A. How does consent currently work in contexts involving children?

Parents traditionally have made most medical decisions for their minor children. Like surrogate decision-making for incompetent adults, parental permission for medical procedures on children, when appropriate and properly secured, constitutes an exception to the general requirement of personal consent to medical treatment.[97] Except in an emergency, informed permission by parents is generally required to perform any medical procedure on a child; otherwise, the procedure would be tortious and probably a criminal assault.[98]

In turn, the authority of parents is circumscribed by the welfare of their children; they may not make decisions for their children that are likely to cause them physical harm or otherwise impair their healthy development.[99] As the rights of children as distinct persons have been increasingly recognized in modern times, children's welfare has become an overriding constraint on their medical care, limiting parental discretion.[100] The Queensland Law Reform Commission forcefully stated the limits on parental power to grant permission for children's medical treatment as follows:

> A parent has no authority to consent to the medical treatment of his or her child unless it is in the best interests of the child. This is because implicit in parental consent is understood to be the determination of what is best for the welfare of the child. If a parent purports to consent to a treatment which is not in the best interests of the child, the consent is of no effect and any person acting on such consent would be guilty of assault if any physical interference is involved.[101]

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97. *See* Secretary, Dept. of Health & Comm. Serv. v. J.W.B. & S.M.B. [Marion's Case] (1992) 175 C.L.R. 218, 235-237 (Austl.).

98. *See* Keeton, *supra* note 8, at § 18; Bonner v. Moran, 126 F.2d 121, 122 (D.C. Cir. 1941); *see also* Linda S. Ewald, *Medical Decision-Making for Children: An Analysis of Competing Interests*, 25 ST. LOUIS U. L. J. 689, 689 (1982).

99. *See* Dwyer, *supra* note 3, at 1355; Bonner & Kinane, *supra* note 3, at S1-S2.

100. *See* Marion's Case, 175 C.L.R. at 240; Prince v. Massachusetts, 321 U.S. 158, 167 (1944).

101. *See* Queensland Law Reform Commission, CONSENT TO MEDICAL TREATMENT OF YOUNG PEOPLE: DISCUSSION PAPER 34-35 (1995) (internal citations omitted).

Today, courts clearly have power to insert themselves into decision-making on behalf of children.[102] "Under the doctrine of *parens patriae,* the state has a right, indeed a duty, to protect children. State officials may interfere in family matters to safeguard the child's health, educational development and emotional well being."[103] Thus, the principal limit on parents' decision-making is a legal and moral requirement that they act in the best interests of their children, which triggers state action when parents demonstrably act contrary to interests of the child, as defined by the state.

B. Parents may not sacrifice their children's physical well being for the sake of religious belief

When parents make decisions about their children's medical care that are inconsistent with their children's well-being—that is, decisions not within the range of reasonable alternatives—they commit child abuse or neglect and can be charged accordingly in civil and/or criminal proceedings. Just as is true of adult incompetents, surrogate decisions for children must rest on the temporal interests of the patient, not on supposed spiritual or other worldly interests of the patient or of the surrogate. Thus, parents are neither excused from their obligation to secure necessary medical care for their children nor from their obligation to protect their child's physical integrity from unwarranted medical procedures simply because they have religious beliefs inconsistent with the child's temporal well being.[104]

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102. *See* Dwyer, *supra* note 3, at 1355; *see also* J.L. Rosato, *Putting Square Pegs in a Round Hole: Procedural Due Process and the Effect of Faith Healing Exemptions on the Prosecution of Faith Healing Parent*, 29 U.S. FED. L. REV. 43 (1994).

103. *See Prince*, 321 U.S. at 167.

104. *See id.*; *see also* In re Willmann, 493 N.E.2d 1380, 1389 (Ohio 1986) (ruling that parents' constitutional rights must yield to state authority because "the faith of the parents, as firm and clear as it is, does not permit them, under the law of this state and the nation, to expose [their child] to progressive ill health and death); In re Hamilton, 657 S.W.2d 425, 429 (Tenn. 1983) (finding that "humane considerations and life-saving attempts" in favor of child outweighed father's interest in unlimited practice of his religion); People ex rel. D.L.E., 645 P.2d 271 (Colo. 1982); (holding that when parents refuse medical treatment for their child on religious grounds, the state can meet its heavy burden of proof necessary to override parents' constitutional objections by demonstrating that the child is suffering from a life-threatening medical condition for which there is medical treatment available); In re Ivey, 319 So. 2d 53, 57-59 (Fla. 1975) (concluding that

Numerous judicial decisions have addressed parental power to refuse medically indicated procedures that are contrary to parents' religious beliefs. The reigning legal principle was announced by the United States Supreme Court in *Prince v. Massachusetts*:[105] "Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."[106] This principle is controlling regardless of whether the child's life is in danger: parents are always required by law to proceed in accordance with their child's best interests.[107] In fact, sometimes courts do not require *any* actual harm to justify compelling a medical procedure that parents have refused on religious grounds.[108] The prevailing rule is that the state properly overrides parental objections to care when necessary to avoid physical harm to the child.[109] For example,

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the court is not precluded in case where child's life is threatened from ordering medical services or treatment even where contrary to parents' wishes); Jehovah's Witnesses v. King County Hosp., 278 F. Supp. 488, 505 (W.D. Wash. 1967) (finding that state statutes empowering superior court judges to declare children dependent for purpose of authorizing blood transfusions of children against parents' religious objections not invalid under United States Constitution), *aff'd* per curiam, 390 U.S. 598 (1968); Muhlenberg Hosp. v. Paterson, 320 A.2d 518 (N.J. 1974) (ordering necessary blood transfusions for child when parents' refusal, based on religious beliefs, created danger of grave and irreparable brain damage but not death); In re Clark, 185 N.E.2d 128, 132 (Ohio 1962) (concluding that "when a child's right to live and his parents' religious belief collide, the former is paramount, and the religious doctrine must give way"); Commonwealth v. Barnhart, 497 A.2d 616 (Pa. Super. 1985) (deciding that for purposes of involuntary homicide statute, parents had no choice but to get medical help, despite their religious beliefs, where they faced condition which threatened and eventually ended child's life).

105. 321 U.S. 158 (1944).

106. *Id.* at 170.

107. *See, e.g.*, O.G. v. Baum, 790 S.W.2d 839 (Tex. Ct. App. 1990); In re Cabrera, 552 A.2d 1114 (Pa. Super. Ct. 1989); In re Gregory S., 380 N.Y.S.2d 620 (N.Y. Fam. Ct. 1976); In re Karwath, 199 N.W.2d 147 (Iowa 1972); In re Sampson, 317 N.Y.S.2d 641 (N.Y. Fam. Ct. 1970), *aff'd*, 323 N.Y.S.2d 253 (N.Y. App. Div. 1971), *aff'd*, 278 N.E.2d 918 (N.Y. 1972).

108. *See* In re Eric B., 235 Cal. Rptr. 22, 24-27 (Cal. Ct. App. 1987) (ruling that despite absence of actual harm, threat of harm if child was not periodically monitored for cancer was sufficient to permit juvenile court's jurisdiction to order monitoring).

109. *See generally* In re McCauley, 565 N.E.2d 411 (Mass. 1991) (ruling that

in *Jehovah's Witnesses v. King County Hospital*,[110] the United States Supreme Court, citing *Prince v. Massachusetts,* upheld *per curiam* a Washington federal district court decision that the State of Washington properly ordered necessary blood transfusions for a child whose parents objected to the transfusions on religious grounds.[111]

Moreover, in recent years the very notion of parental entitlement has been increasingly questioned. Recognition of and respect for children as persons distinct from their parents has grown, leading legal scholars and judges to insist that parenthood is a fiduciary role rather than a property-owning one, so that parental authority should be viewed as a limited privilege rather than as a right.[112] In addition, there has been growing support for the view that children themselves possess rights in connection with their upbringing,[113] and that those rights constrain the freedom of parents as well as the power of the state.[114]

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best interests of child, coupled with state's strong interest in securing a life-saving blood transfusion, outweighed parents' constitutional objections); State v. Perricone, 181 A.2d 751 (N.J. 1962), *cert. denied*, 371 U.S. 890 (1962) (holding court-ordered blood transfusion did not violate parents' constitutional rights of religion or parental autonomy when the child's life was in danger); Wallace v. Labrenz, 104 N.E.2d 769 (Ill. 1952), *cert. denied*, 344 U.S. 824 (1952) (finding that when parents refuse medical treatment for their child, the lack of which will almost certainly cause death or, at best, lifelong mental impairment, the child is neglected and the court may order the necessary treatment without violating the parents' constitutional rights); Morrison v. State, 252 S.W.2d 97 (Mo. 1952) (holding that state has power to preserve child's life and health when medical treatment is as necessary for that child's survival as is food); Commonwealth v. Cottam, 616 A.2d 988, 1000 (Pa. Super. Ct. 1992) (ruling that in criminal case against defendant parents over death of children due to neglect, validity and sincerity of religious beliefs of defendants and children are not relevant to issues presented in trial for failing in legal duty to provide for children, resulting in starvation death of son and severe malnutrition of daughter); *see generally* Dwyer, *supra* note 3, at 1355-56.

110. 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd* per curiam, 390 U.S. 598 (1968).

111. *Id.* at 504-05.

112. *See* W. Riddick, *Parents and Life Prospects*, in HAVING CHILDREN: PHILOSOPHICAL AND LEGAL REFLECTIONS ON PARENTHOOD 25 (O. O'Neill & W. Riddick eds. 1979); *see generally* Dwyer, *supra* note 84, at 1374-76.

113. JOEL FEINBERG, 1 THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO OTHERS 37 (1984); *see generally* JAMES G. DWYER, RELIGIOUS SCHOOLS V. CHILDREN'S RIGHTS (1998).

114. *See* James G. Dwyer, *supra* note 84, at 1429-31; *see also* Josette M.

In light of the established limits on parental authority and freedom and the current trend toward greater protection of children against inappropriate parental decision-making, medical personnel cannot simply comply with parental preferences for, or against, a given procedure even when those preferences are grounded in religious belief. As with incompetent adults, the physician owes duties to the child patient himself and those duties in some circumstances require resisting or even refusing

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LeDoux, *Interspousal Liability and the Wrongful Transmission of HIV-AIDS: An Argument for Broadening Legal Avenues for the Injured Spouse and Further Expanding Children's Rights to Sue Their Parents*, 34 NEW ENG. L. REV. 392 (2000) ("the trend in recent law is to recognize a growing need to grant children new rights in order that they may seek legal redress from transgressing parents"); *see also* Walter Wadlington, *Medical Decision Making For and By Children: Tensions Between Parent, State, and Child*, 1994 U. ILL. L. REV. 311, 312 (1994) (noting that "the new cycle of litigation involving children reflects an additional pattern of greater state involvement in protecting children, an intervention which can pose a significant intrusion into family life"). For a sampling of law review articles in recent years arguing for greater rights of children as against their parents in particular contexts, see Susan H. Bitensky, *Spare the Rod, Embrace Our Humanity: Toward a New Legal Regime Prohibiting Corporal Punishment of Children*, 36.31 U. MICH. J.L. REFORM 353 (1998) (arguing that children have a right not to be corporally punished by their parents); Marsha Garrison, *An Evaluation of Two Models of Parental Obligation*, 86 CAL. L. REV. 41 (1998) (arguing for a right of children to a greater share of family resources following divorce than they currently receive); Elizabeth A. Lingle, *Treating Children By Faith: Colliding Constitutional Issues*, 17 J. LEGAL MED. 301, 330 (1996) (arguing against spiritual treatment exemptions to child medical neglect laws); Ann MacLean Massie, *The Religion Clauses and Parental Health Care Decision-Making for Children: Suggestions for a New Approach*, 21 HASTINGS CONST. L.Q. 725, 739 (1994) (arguing against spiritual treatment exemptions to child medical neglect laws); Therese Powers, *Race For Perfection: Children's Rights and Enhancement Drugs*, 13 J.L. & HEALTH 141, 165-167 (1998-99) (arguing for a right of children to receive Ritalin and Human Growth Hormone despite the objection of their parents); Melinda A. Roberts, *Parent and Child in Conflict: Between Liberty and Responsibility*, 10 NOTRE DAME J.L. ETHICS & PUB. POL'Y 485 (1996) (arguing for greater liberty rights for children as against the interests and wishes of parents in a variety of situations). For evidence of the medical professions commitment to protecting the welfare of children even as against the wishes of parents in other contexts, see American Academy of Pediatrics, *Religious Objections to Medical Care*, 99 PEDIATRICS 279, 279 (1997) (stating AAP opposition to spiritual treatment exemptions to child medical neglect laws); Andrew Skolnick, *Religious Exemptions to Child Neglect Laws Still Being Passed Despite Convictions of Parents*, 264 JAMA 1226, 1233 (1990) (stating opposition of AMA to spiritual treatment exemptions to child medical neglect laws).

surrogates' choices.[115] Those duties may be conceptualized as requiring medical professionals to ensure that parents are making the same decision that the child would make if able to do so, or as requiring medical professionals to ensure that parental choices are consistent with what objectively is in the child's best interests. In other words, the professional obligation owed to a child patient is the same as that owed an incompetent adult patient.

C. *Parents may authorize a non-medically indicated procedure only if it is clearly in the child's best interests*

Where parents request a procedure that is *not* medically indicated, courts have taken an even more child-protective stance and required strong evidence that the procedure is in the patient-child's interests. Sometimes courts allow the child's best interests to be determined using the more subjective, substituted judgment standard.[116] On other occasions courts insist on the more objective, "best interests" approach, presumably because the substituted judgment approach might allow parents inappropriately to inject their own preferences into the decision-making process.[117]

While theoretically clear, the distinction between the two standards has a definite tendency to sometimes blur in practice, as courts have demonstrated by invoking the "best interests" language while applying an analytical approach more consonant with the substituted judgment approach.[118] As with incompetent adults, courts do not permit procedures

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115. *See* Christine Harrison et al., *Bioethics for Clinicians: 9. Involving Children in Medical Decisions*, 156 CAN. MED. ASS'N J. 825, 827-828 (1997).

116. *See* Strunk v. Strunk, 445 S.W.2d 145, 148-149 (Ky. 1969); Little v. Little, 576 S.W.2d at 497-98; Hart v. Brown, 289 A.2d at 387-88; Foody v. Manchester Mem. Hosp., 482 A.2d 713, 720-21 (Conn. Super. 1984); In re Estate of Longeway, 549 N.E.2d 292, 298-300 (Ill. 1989).

117. *See* Wentzel v. Montgomery Gen. Hosp., Inc., 447 A.2d 1244, 1253-54 (Md. 1982), *cert. denied*, 459 U.S. 1147 (1983) (applying best interests doctrine to bar sterilization of an incompetent thirteen year old girl); Curran v. Bosze, 566 N.E.2d 1319, 1325-1331 (Ill. 1990); *see generally* Re Jane (1988) 85 A.L.R. 409 (holding parental consent by itself insufficient to authorize hysterectomy on severely mentally disabled but physically healthy seventeen-year-old woman despite apparently good-faith desire to protect her from problems in coping with menstruation and possible pregnancy); *In re Grady*, 426 A.2d 467, 483-86 (N.J. 1981); *In re Richardson*, 284 So. 2d 185, 187 (La. Ct. App. 1973).

118. *See, e.g,* Matter of Doe, 104 A.D.2d 200, 200-01 (N.Y. App. Div. 1984)

to be performed on children when the procedures will only benefit other people and not the patient.[119] This is true even in cases where the potential benefit to a close relative substantially exceeds the risk to the child-patient, and where one might therefore reasonably assume many competent patients would choose to undergo the procedure. For example, in *Little v. Little*[120] the *guardian ad litem* for a 14-year-old mentally incompetent, but otherwise perfectly healthy girl applied on the encouragement of the girl's mother for an order authorizing the mother to grant permission for the removal of a kidney from the girl.[121] The purpose of the procedure was to transplant the kidney into the girl's brother who was suffering from end-stage renal disease. In refusing the request, the Texas Court of Appeals stated that "[t]his power of parents . . . to consent to surgical intrusions upon the person of the minor . . . is limited to the

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(applying substituted judgment analysis to uphold trial court's finding "to reasonable certainty" that bone marrow transplant was in incompetent donor's "best interests" due to benefits of future company and advocacy provided by donee brother's companionship, which were found to outweigh any physical and psychological risk); In re Estate of Greenspan, 558 N.E.2d 1194, 1202 (Ill. 1990) (involving petition for leave to discontinue artificial feeding and hydration of ward in chronically vegetative state, a determination by anyone else of best interests of ward cannot govern ward's imputed choice; if this were permissible, "the substituted-judgment procedure would be vitiated by a best-interests guardianship standard, elevating other parties' assessments of the meaning and value of life over the affected individual's own common law right to refuse medical treatment"); *see also* Lebit, *supra* note 70, at 108 ("Over time courts have come to confuse the best interests standard with the substituted judgment doctrine in certain situations and apply the substituted judgment doctrine to cases in which it is not appropriate").

119. *See* Bonner v. Moran, 126 F.2d 121, 123 (D.C. Cir. 1941) (concluding that skin graft from 15-year-old boy performed without informed consent from him or his mother was entirely for the benefit of the graft recipient and involved sacrifice by the boy, violating the basic consideration of whether the proposed operation is for the benefit of the child); *see also In re A.C.*, 573 A.2d at 1247 (finding that to protect right to bodily integrity against intrusion by others, courts must determine the patient's wishes by any means available and must abide by these wishes unless truly extraordinary or compelling reasons exist to override them); *see generally* Krais, supra note 70, at 333-361 (rejecting substituted judgment standard and recommending best interests test); *see also* Lebit, supra note 70 at 111-12; L.K. Gregory, *Propriety of Surgically Invading Incompetent or Minor for Benefit of Third Party*, 4 A.L.R. 5th 1000 (1992); Walter M. Weber, *Substituted Judgment Doctrine: A Critical Analysis*, 1 ISSUES IN L. & MED. 131 (1985).

120. 576 S.W.2d 493 (Tex. Civ. App. 1979).

121. *See id.* at 493-95.

power to consent to medical 'treatment.'"[122] In other words, the permission is limited to care for an injury, disease or malformation. Similarly, in *In re Richardson*,[123] a Louisiana Court of Appeals ruled that kidney transplant surgery from a mentally retarded child to his sister could not take place because it would contravene the "minor's right to be free in his person from bodily intrusion to the extent of the loss of an organ unless such loss be in the best interest of the minor."[124] The *Richardson* court rejected the substituted judgment test in favor of the best interest test and concluded that the procedure was not in the prospective donor's interest, because any direct benefit was highly speculative.[125] In *Curran v. Bosze*,[126] the Illinois Supreme Court likewise rejected the substituted judgment approach in a case involving a proposal to subject three-and-one-half-year-old twins to blood testing to determine bone marrow compatibility with their half-brother, who was dying of leukemia, reasoning that it was impermissibly speculative for a court of law or anyone else to attempt to ascertain the future intentions of such young children.[127] Most recently, and in a dramatic endorsement of the best interests principle, an English Court of Appeals refused to allow parents of Siamese twin girls to undertake the separation of the twins, where one severely brain-damaged twin was virtually sure to die as a result of the procedure, but where in the absence of the procedure both twins would almost certainly lose their lives within a few years.[128] The court held that parental consent may only be given for treatment which is in the best interests of the child, and that in this case the treatment was not in the weaker child's best interest.[129]

Parents, like substitute decision-makers for incompetent adult patients, should be viewed as agents for their children, required to make decisions regarding medical interventions for their children in a manner consistent

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122. *See id.*

123. 284 So. 2d 185.

124. *See id.* at 185-87.

125. *See id.* at 187; *but cf.* Matter of Doe, 481 N.Y.S.2d 932 (N.Y. App. Div. 1984).

126. 566 N.E.2d 1319 (Ill. 1990).

127. *See id.* at 1325-31.

128. A (Children), Supreme Court of Judicature, Court of Appeal (Civil Division), at §§ II.7 and II.8, http://www.courtservice.gov.uk/info/news_items/siamese.htm (last visited Nov. 12, 2000).

129. *Id.* at §§ III.3 and III.5.

with their children's best interests.[130] Medical professionals owe a duty to their minor patients to assist parents in making decisions that conform to that standard. A recent statement of the American Academy of Pediatrics (AAP) Committee on Bioethics supports the conclusion that physicians are constrained in accepting parental direction regarding medical care for children by the requirement that the care be medically beneficial and that any surgery upon children must be necessary to prevent serious harm. According to the AAP Committee, parental permission for medical intervention can substitute for the child's consent only in situations of clear and immediate medical necessity, such as disease, trauma or deformity.[131] The AAP Committee directs that for non-essential treatments, particularly those that can be deferred without loss of efficacy, the physician and family wait until the child's consent can be obtained.[132] The medical profession in the United Kingdom adheres to similar rules. The United Kingdom Department of Health's guidelines state that

> [t]hose acting for the child can only legally give their consent provided that the intervention is for the benefit of the child. If they are responsible for allowing the child to be subjected to any risk (other than one so insignificant as to be negligible) that is not outweighed by the prospect of medical benefit to the child, they act illegally.[133]

To assist parents in making decisions that comport with their child's best interests, medical professionals must satisfy the same requirements of informed consent/parental permission that apply to decision-making by competent adults and by surrogates for incompetent adults. First, the physician must disclose to parents all relevant information that a competent patient would want to know if the procedure were to be performed on him. Second, the physician must ensure that parents have the capacity to understand and think rationally about the information given to them. Third, the physician must ensure that the parents' decision is voluntary and not manipulated in any way by the manner in which the information is presented or the time at which parents' permission is sought. With respect to interventions that are not medically indicated, it

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130. *See* Dwyer, *supra* note 84, at 1406-23.

131. Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 314-16 (1995).

132. *Id.*

133. DEPARTMENT OF HEALTH, LOCAL RESEARCH ETHICS COMMITTEES, *Department of Health, Local Research Ethics Committees*, § 4.4, London (1991).

is improper at any time for a physician to suggest the procedure to parents who have not inquired about it; such a suggestion would amount to solicitation and would likely be interpreted by parents as a medical recommendation. Just as it would be unethical for a physician to recommend a non-medically indicated intervention to the surrogate of an incompetent adult, it is also unethical to recommend such an intervention to the surrogate of a child.

IV. CIRCUMCISION: A SPECIFIC APPLICATION OF THE CONSENT DOCTRINE

The foregoing discussion of medical consent in general and in the special case of parental permission for procedures on children yields a framework for analyzing circumcision. For simplicity, the analysis below is limited to the standard case of neonatal circumcision on newborn boys with normal genitalia. In 1999, history was made when a United Kingdom family court addressed on the merits a proposed circumcision of a five-year-old boy for religious reasons and unambiguously concluded that an order for circumcision would not be granted as circumcision did not satisfy the "paramountcy of welfare" standard, i.e., it was not in the best interests of the child.[134] Due in part to the pervasive presence of neonatal circumcision in American society, no case addressing the validity of parental permission for a routine circumcision has ever been decided in a United States court. Instead, courts have repeatedly demonstrated their determination to avoid any confrontation with the legal issues raised by neonatal circumcision. In 1987, a lawsuit challenging the legal validity of parental permission for neonatal circumcision was denied by a California trial court and subsequently affirmed by the state appeals court.[135] The California Supreme Court denied the petition for review.[136] More

134. *See* Re J (Child's Religious Upbringing and Circumcision), [1999] 2 F.L.R. 678 (Fam. Div.), *affirmed*, [2000] 1 F.L.R. 571 (C.A.). The Family Division decision is also available at http://www.butterworths.co.uk/academic/fortin/cases/Re_J.htm (last visited Nov. 17, 2000).

135. London v. Glassner, California Court of Appeal, 1st District, No. A032040 (unpublished, petition for review denied); *see also* R. Morris, *The First Circumcision Case*, THE TRUTH SEEKER 47 (July/August, 1989).

136. London v. Glassner, *supra* note 135. Adam London brought the case via his mother, who acted as *guardian ad litem*. The consent form signed by the mother stated that neonatal circumcision had no medical purpose. The issue before the court was whether a parent could grant permission for a surgical procedure that had no medical purpose.

recently, the Eighth Circuit Court of Appeals affirmed a trial court's invocation of lack of standing as a justification for refusing to consider a mother's claim on behalf of her son who was circumcised with his father's consent, but without her consent.[137]

Currently, an ongoing contest in New Jersey is attracting national interest which - like *Re J* - involves two divorcing parents with opposite desires regarding circumcision of their male child, three-year-old Matthew Price. The Price case, in which unlike the British case neither parent claims any religious motives for their desires regarding the circumcision of their son, may in the end become the first recorded American case directly addressing the viability of parental consent to circumcision. Already, the New Jersey Supreme Court has ordered the trial court to hold a rehearing in the matter, and has appointed an experienced children's rights attorney as guardian ad litem.[138]

Despite well-settled precedent supporting the viability of such a claim, which though technically moot is "capable of repetition, yet evading review,"[139] the court ruled, based on the fact that the plaintiff had already had a circumcision performed, that no remedy existed for the plaintiff and the court could not protect him from being circumcised.

Because there is no possibility of obtaining consent from the patient, the issues then become whether parents can give effective permission for the procedure, and what legal and ethical obligations doctors may have in this situation. Doctors do have a strict obligation to ensure that parents receive all material information relating to the risks and benefits of circumcision in a manner that they can comprehend, that any parent giving permission is fully competent to evaluate the information provided and the treatment's potential consequences, and that parents are not in any way unduly influenced by the manner or timing of the disclosure.

The requirements for surrogates are in some respects more stringent than those affecting a patient's own consent. While in certain circumstances patients may themselves be able to provide legally valid consent to prophylactic removal of their own healthy tissue, parents can

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137. *See* Fishbeck v. North Dakota, 115 F.3d 580, 580-81 (8th Cir. 1997). The plaintiffs attempted to challenge a North Dakota law (N.D. Cent. Code § 12.1-36-01 (1997)) prohibiting female genital mutilation on the grounds that the law was unconstitutional for lack of equal protection of males.

138. C. Shoemaker, *Baby M. Lawyer Joins Case on Circumcision*, [Bridgewater, New Jersey] Courier News, Nov. 4, 2000, at D1.

139. *See* S. Pac. Terminal Co. v. Interstate Commerce Comm'n, 219 U.S. 498, 515 (1911); *see also, e.g.*, Roe v. Wade, 410 U.S. 113, 125 (1973).

never grant permission for prophylactic removal of healthy tissue from their children. The benefits of the proposed procedure must clearly outweigh short - and long-term disadvantages, and spiritual costs and benefits may not be incorporated into this analysis. The decision must be made solely for the patient's own benefit; even potentially life-saving assistance for a close family member cannot justify violating a non-consenting patient's right to be free of intrusive medical procedures.

Parents should thus be able to give effective permission for circumcision, and doctors should be permitted to perform a circumcision, only if the procedure is medically necessary, providing urgently needed medical benefits clearly outweigh any attendant costs. As we shall see, the evidence does not support routine circumcision.

A. Does routine circumcision provide urgently needed medical benefits?

Circumcision does not correct an existing injury, disease or harmful malfunction. Thus, even *if* circumcision provides *some* medical benefit, there is no urgency to perform the procedure. General ethical and legal principles concerning surgery on children therefore dictate that the decision whether a male will be circumcised *must* be suspended until the male is capable of making the decision himself. This is even clearer if claimed medical benefits would not be realized until adulthood.

At most, some contend that circumcision is a prophylactic measure, to prevent urinary tract infection (UTI) in boys, penile cancer and sexually transmitted diseases (STDs) in adult males.[140] Thus, the only claimed benefit that males would realize before adulthood is a reduced rate of UTI. It cannot plausibly be maintained that this is an *urgently* needed medical benefit. Moreover, even if urgency were not required, and even if the claimed prophylactic benefit were significant, that benefit would, at a minimum, have to clearly outweigh any harm that circumcision might cause in order to overcome the general, well-established presumption against incursion on a non-consenting person's physical integrity.

In addition, as explained below, the claims that circumcision has prophylactic value have been essentially refuted. These claims are the latest in a long history of claimed benefits from circumcision that have proven to be illusory. In 1896, for example, the medical profession contended that circumcision helps avoid "phimosis, paraphimosis,

140. Edgar J. Schoen, Wiswell TE, Moses S., *New Policy on Circumcision—Cause for Concern*, 105 PEDIATRICS 620, 620-23 (2000).

redundancy (where the prepuce more than covers the glans), adhesions, papillomata, eczema (acute and chronic), oedema, chancre, chancroid, cicatrices, inflammatory thickening, elephantiasis, naevus, epithelioma, gangrene, tuberculosis, preputial calculi, hip-joint disease, hernia,... [o]nanism, seminal emissions, enuresis, dysuria, retention, general nervousness, impotence, convulsions, hystero-epilepsy."[141] All of these claims were ultimately shown to lack scientific foundation. More recent justifications likewise have been shown to lack scientific merit.[142] The evidence regarding the current claims is evaluated below.

1. Phimosis, balanitis, and hygiene concerns do not justify routine circumcision

Although commonly given as justifications for neonatal circumcision,[143] there is no scientific evidence to support these claims. The incidence of phimosis following circumcision (0.3% to 1.0%)[144] is approximately the same as for males never circumcised (0.6% to 0.9%).[145] In comparative studies the incidence of phimosis and balanitis was not significantly different between those circumcised and those not circumcised.[146]

While it has likewise been asserted that a circumcised penis is more hygienic, no studies in the medical literature exist to support such a claim. To the contrary, circumcised boys under the age of three years have been found to have more problems associated with poor hygiene than intact

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141. *See* Editor, *Circumscisus*, 49 MED. REC. 430, 430 (1896).

142. *See* FREDERICK HODGES, *A Short History of the Institutionalization of Involuntary Sexual Mutilation in the United States*, *in* SEXUAL MUTILATIONS: A HUMAN TRAGEDY 17-40 (G.C. Denniston & M.F. Milos eds. 1997).

143. *See* American Academy of Pediatrics, *Report of the Task Force on Circumcision*, 84 PEDIATRICS 388, 388, 390 (1989).

144. *See* Yosef A. Kaweblum et al., *Circumcision Using the Mogen Clamp*, 23 CLINICAL PEDIATRICS 679, 681-82 (1984); *see also* R.S. Van Howe, *Variability in Penile Appearance and Penile Findings: A Prospective Study*, 80 BRIT. J. UROLOGY 776 (1997).

145. *See* K.R. Shankar & A.M.K. Rickwood, *The Incidence of Phimosis in Boys*, 83 (Suppl. 1) BJU INT'L 101, 101 (1999); *see also* A.M.K. Rickwood et al., *Phimosis in Boys*, 52 BRIT. J. UROLOGY 147 (1980).

146. See D.M. Fergusson et al., *Neonatal Circumcision and Penile Problems: An 8-year Longitudinal Study*, 81 PEDIATRICS 537, 537-39 (1988); *see also* Lynn W. Herzog & Susana R. Alvarez, *The Frequency of Foreskin Problems in Uncircumcised Children*, 140 AM. J. DISEASES CHILD. 254, 254-55 (1986); Van Howe, *supra* note 144, at 777-78.

boys.[147]

2. Urinary tract infections do not justify routine circumcision

Of the claimed benefits of circumcision, only one - reduction of UTI - would occur during childhood, before a male is able to decide for himself whether to undergo the procedure. Some studies have suggested a weak association between having a foreskin and developing a UTI[148] a large proportion of UTIs are the result of anatomical defects of the urinary tract and kidney.[149] The connection, however, is extremely tenuous; one study calculates that roughly 195 boys would require circumcision to prevent one UTI occurrence.[150] Even a study by a leading circumcision advocate estimated that circumcision prevents UTI in less than one percent of boys who undergo the procedure.[151] Unfortunately, no one has yet made a viable attempt at producing data demonstrably free of influence from the numerous potential confounding variables. Until a study takes into account the influence of rooming in,[152] breast feeding,[153]

147. *See* Van Howe, *supra* note 144, at 778.

148. Teresa To et al., *Cohort Study on Circumcision of Newborn Boys and Subsequent Risk of Urinary-Tract Infection*, 352 LANCET 1813, 1813, 1815 (1998); J.C. Craig, J.F. Knight, P. Sureshkumar, E. Mantz, L.P. Roy, *Effect of Circumcision on Incidence of Urinary Tract Infection in Preschool Boys*, 128 J. PEDIATRICS 23, 23-27 (1996); Ellen F. Crain, J.C. Gershel, *Urinary Tract Infections in Febrile Infants Younger than 8 weeks of age*, 86 PEDIATRICS 363, 363-67 (1990).

149. Jan Winberg et al., *Epidemiology of Symptomatic Urinary Tract Infection in Childhood*, 252 ACTA PAEDIATRICA SCANDINAVICA SUPPL. 1, 8 (1974); T. Bergström, *Sex Differences in Childhood Urinary Tract Infection*, 47 ARCHIVES OF DISEASE IN CHILDREN 227 (1972); S.R. Saxena, D.C. Bassett, *Sex-related Incidence in Proteus Infection of the Urinary Tract in Childhood*, 50 ARCHIVES OF DISEASE IN CHILDREN 899 (1975); R.J. Hallett et al., *Urinary Infection in Boys: A Three-year Prospective Study*, 2 LANCET 1107 (1976); Linda Pead & Rosalind Maskell, *Study of Urinary Tract Infection in Children in One Health Disctrict*, 309 BRITISH MEDICAL JOURNAL 631, 632 (1994); T. Bergström et al., *Symptomatic Urinary Tract Infection in Boys in the First Year of Life with Special Reference to Scar Formation*, 1 INFECTION 192 (1973).

150. *See* To et al., *supra* note 148, at 1813, 1815 (1998).

151. *See* Thomas E. Wiswell et al., *Declining Frequency of Circumcision: Implications for Changes in the Absolute Incidence and Male to Female Sex Ratio of Urinary Tract Infections in Early Infancy*, 79 PEDIATRICS 338, 341 (1987).

152. *See* Jan Winberg et al., *The Prepuce: A Mistake of Nature?*, 1 LANCET 598, 599 (1989).

153. Alfredo Pisacane et al., *Breastfeeding and Urinary Tract Infection*, 336 LANCET 50, 50 (1990); Alfredo Pisacane et al., *Breast-Feeding and Urinary Tract*

level of parental education,[154] prenatal maternal UTI,[155] premature birth,[156] history of UTI in a first degree relative,[157] hygienic practices,[158] previous bacterial or viral infection,[159] previous course of antibiotics,[160] race,[161] urine collection method[162] and diagnostic criteria,[163] no definitive conclusions are

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Infection, 120 J. PEDIATRICS 87, 87, 89 (1992); Giovanni V. Coppa et al., *Preliminary Study of Breastfeeding and Bacterial Adhesion to Uroepthelial Cells*, 335 LANCET 569, 570 (1990); Staffan Mårild et al., *Breastfeeding and Urinary-Tract Infection* 336 LANCET 942, 942 (1990); Staffan Mårild et al., *Medical Histories of Children with Acute Pyelonephritis Compared with Controls*, 8 PEDIATRIC INFECTIOUS DISEASE J. 511, 515 (1989).

154. *See* D.C.L. Savage et al., *Covert Bacteriuria of Childhood. A Clinical and Epidemiological Study*, 48 ARCHIVES DISEASE CHILDHOOD 8, 14 (1973).

155. *See generally* Marguerite J. Patrick, *Influence of Maternal Renal Infection on the Fetus and Infant*, 42 ARCHIVES DISEASE CHILDHOOD 208 (1967).

156. *See generally* Mustapha Maherzi et al., *Urinary Tract Infection in High-Risk Newborn Infants*, 62 PEDIATRICS 521 (1978); Abdulkareem I. Airede, *Urinary-Tract Infections in African Neonates*, 25 J. INFECTION 55 (1992); A. Eliakim et al., *Urinary Tract Infection in Premature Infants: the Role of Imaging Studies and Prophylactic Therapy*, 17 J. PERINATOLOGY 305 (1997); Chester M. Edelmann Jr. et al., *The Prevalence of Bacteriuria in Full-Term and Premature Newborn Infants*, 82 J. PEDIATRICS 125 (1973).

157. *See* Mårild, *Medical Histories*, *supra* note 153, at 511-15.

158. *See* Peter Malleson, *Prepuce Care*, 77 PEDIATRICS 265, 265 (1986); *see also* Kenneth L. Harkavy, *The Circumcision Debate*, 79 PEDIATRICS 649, 649 (1987); Stan J. Watson, *Care of the Uncircumcised Penis*, 80 PEDIATRICS 765, 765 (1987); Nicholas Cunningham, *Circumcision and Urinary Tract Infections*, 77 PEDIATRICS 267, 267 (1986).

159. *See* Mårild, *Medical Histories*, *supra* note 153, at 511-15.

160. *See id.*

161. *See* Asghar Askari & A.Barry Belman, *Vesicoureteral Reflux in Black Girls*, 127 J. UROLOGY 747 (1982); *see also* Steven J. Skoog & A. Barry Belman, *Primary Vesicoureteral Reflux in the Black Child*, 87 PEDIATRICS 538 (1991); Kathy N. Shaw et et al., *Prevalence of Urinary Tract Infection in Febrile Young Children in the Emergency Department* [Abstract E16], 102 no.2 PEDIATRICS 390 (1998), *also available at* http://www.pediatrics.org/cgi/content/full/102/2/e16 (last visited Nov. 12, 2000); Calvin M. Kunin, *The Natural History of Recurrent Bacteriuria in Schoolgirls*, 282 NEW ENG. J. MED. 1443, 1444 (1970); Calvin M. Kunin, *Epidemiology and Natural History of Urinary Tract Infection in School Age Children*, 18 PEDIATRIC CLINICS N. AM. 509 (1971).

162. *See generally* Theresa A. Schlager et al., *Explanation for False Positive Urine Cultures Obtained by Bag Technique*, 149 ARCHIVES PEDIATRICS & ADOLESCENT MED. 170 (1995); P.M. Fleiss, *Explanation for False Positive Urine Cultures Obtained by Bag Technique*, 149 ARCHIVES PEDIATRICS & ADOLESCENT

possible regarding the protective effects of neonatal circumcision. This list of other possible variables suggests that even if circumcision did have an effect on UTI, a comparable or greater prophylactic effect could be accomplished by less drastic and less intrusive means - for example, by simply teaching parents and children proper hygiene and by encouraging mothers to breastfeed.

Moreover, most UTIs are minor and are easily treated with oral antibiotics. The foreskin has not been linked to the more serious

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MED. 1041 (1995); W.L. Robson & A.K. Leung, *Explanation for False Positive Urine Cultures Obtained by Bag Technique*, 149 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1042 (1995); Jacob Amir et al., *The Reliability of Midstream Urine Culture from Circumcised Male Infants*, 147 AM. J. DISEASES CHILD. 969 (1993); Theresa A. Schlager et al., *Bacterial Contamination Rate of Urine Collected in a Urine Bag from Healthy Non-Toilet-Trained Male Infants*, 116 J. PEDIATRICS 738 (1990); Xavier Saez-Llorens et al., *Bacterial Contamination Rates for Non-Clean-Catch and Clean-Catch Midstream Urine Collections in Uncircumcised Boys*, 114 J. PEDIATRICS 93 (1989); Jacob A. Lohr et al., *Bacterial Contamination Rates for Non-Clean-Catch and Clean-Catch Midstream Urine Collections in Boys*, 109 J. PEDIATRICS 659 (1986); W.A. Bonadio, *Urine Culturing Technique in Febrile Children*, 3 PEDIATRIC EMERGENCY CARE 75 (1987); J.D. Nelson & P.C. Peters, *Suprapubic Aspiration of Urine in Premature and Term Infants*, 36 PEDIATRICS 132 (1965); G.D. Abbott, *Neonatal Bacteriuria—The Value of Bladder Puncture in Resolving Problems of Interpretation Arising from Voided Urine Specimens*, 14 AUSTL. PEDIATRIC J. 83 (1978); John M. McCarthy & Charles V. Pryles, *Clean Voided and Catheter Neonatal Urine Specimens. Bacteriology in the Male and Female Neonate*, 106 AM. J. DISEASES CHILD. 473 (1963); John J. Boehm & James L. Haynes, *Bacteriology of 'Midstream Catch' Urines: Studies in Newborn Infants*, 111 AM. J. DISEASES CHILD. 366 (1966); C.G.H. Newman et al., *Pyuria in Infancy, and the Role of Suprapubic Aspiration of Urine in the Diagnosis of Infections of the Urinary Tract*, 2 BRIT. MED. J. 277 (1967); Ofelia T. Monzon et al., *A Comparison of Bacterial Counts of the Urine Obtained by Needle Aspiration of the Bladder, Catheterization and Midstream-Voided Methods*, 259 NEW ENG. J. MED. 764 (1958); Paul Valenstein & Frederick Meier, *Urine Culture Contamination: A College of Am. Pathologists Q-probes Study of Contaminated Urine Cultures in 906 Institutions*, 122 ARCHIVES PATHOLOGY & LABORATORY MED. 123 (1998); J. Pylkkänen et al., *Diagnostic Value of Symptoms and Clean-Voided Urine Specimens in Childhood Urinary Tract Infection*, 68 ACTA PAEDIATRICA SCANDINAVICA 341 (1979).

163. *See* Alejandro Hoberman & Ellen R. Wald, *Urinary Tract Infections in Young Febrile Children*, 16 PEDIATRIC INFECTIOUS DISEASE J. 11 (1997); *see also* S. Hansson et al., *Low Bacterial Counts in Infants with Urinary Tract Infection*, 132 J. PEDIATRICS 180 (1998).

infections that reach the kidneys.[164] The most common infection-related claim by defenders of circumcision is that males not circumcised will develop renal failure.[165] However, that claim is unsupportable.[166] There is no reliable data on the rate of renal failure in children in the United States.[167] Two Swedish studies have yielded more reliable information.[168] The first study showed that UTI was not responsible for any of the renal failures among children in Sweden.[169] The second study showed that UTI was responsible for only five percent of renal failures among children.[170] Using the highest recorded Swedish national rate of renal failure in

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164. *See* Elizabeth R. Mueller et al., *The Incidence of Genitourinary Abnormalities in Circumcised and Uncircumcised Boys Presenting with an Initial Urinary Tract Infection by 6 Months of Age* [Abstract 121], 100 PEDIATRICS 580, 580 (1997).

165. James A. Roberts, *Neonatal Circumcision: An End to the Controversy?* 89 SOUTHERN MED. J. 167 (1996); James A. Roberts, *Is Routine Circumcision Indicated in the Newborn? An Affirmative View*, 31 J. FAM. PRAC. 185, 186-88 (1990); Thomas E. Wiswell, *Circumcision Circumspection*, 336 NEW ENG. J. MED. 1244, 1244-45 (1997); Thomas E. Wiswell, *Circumcision—An Update*, 22 CURRENT PROBLEMS IN PEDIATRICS 424, 424-25 (1992); Thomas E. Wiswell, *Routine Neonatal Circumcision: A Reappraisal*, 41 AMERICAN FAMILY PHYSICIAN 859, 860 (1990); Thomas E. Wiswell, *Do You Favor... Routine Neonatal Circumcision? Yes*, 84 POSTGRADUATE MEDICINE 98, 98 (1988); Edgar J. Schoen, *The Status of Circumcision of Newborns*, 322 NEW ENG. J. OF MED. 1308, 1309 (1990); Edgar J. Schoen, *Benefits of Newborn Circumcision: Is Europe Ignoring Medical Evidence?* 77 ARCHIVES OF DISEASES IN CHILDHOOD 258 (1997); Edgar J. Schoen et al., *New Policy on Circumcision—Cause for Concern*, 105 PEDIATRICS 620 (2000).

166. *See* Roberts, *supra* note 165, at 168-70 (1996); Schoen, *supra* note 165, at 258; Thomas E. Wiswell, *Do You Favor... Routine Neonatal Circumcision? Yes*, 84 POSTGRADUATE MED. 98, 98-99 (1988); Thomas E. Wiswell & Dietrich W. Geschke, *Risks from Circumcision during the First Month of Life Compared with Those for Uncircumcised Boys*, 83 PEDIATRICS 1011, 1011, 1013 (1989); Thomas E. Wiswell, *Routine Neonatal Circumcision: A Reappraisal*, 41 AM. FAM. PHYSICIAN 859, 859-60 (1990); Thomas E. Wiswell, *Circumcision Circumspection*, 336 NEW ENG. J. MED. 1244, 1244-45 (1997); Thomas E. Wiswell, *Circumcision Questions* [Letters to the Editor- Reply], 93 PEDIATRICS 1021, 1022 (1994).

167. Many of the European countries, through the records kept as part of their national health insurance, keep national registries of disease incidence. No such registries are maintained in the United States.

168. *See generally* Ingemar Helin & Jan Winberg, *Chronic Renal Failure in Swedish Children*, 69 ACTA PAEDIATRICA SCANDINAVICA 607 (1980); E. Esbjörner et al., *Children with Chronic Renal Failure in Sweden 1978-1985*, 4 PEDIATRIC NEPHROLOGY 249 (1990).

169. *See* Helin, *supra* note 168, at 610.

170. *See* Esbjörner, *supra* note 168, at 249.

children and assuming that all cases of renal failure from UTI in boys could be prevented by neonatal circumcision, it would take 476,190 circumcisions to prevent one instance of renal failure. Those 476,190 circumcisions would, as a statistical matter, cause at least 952 life-threatening complications.[171] Circumcising to prevent renal failure is thus clearly irrational.

In short, if circumcision does reduce UTI, it is a woefully ineffective method, especially when weighed against the very significant complications and other disadvantages which are discussed below in further detail. Contrary to the retrospective data gathered elsewhere, a prospective study of 603 Japanese boys, none of whom were circumcised, found that none had ever had a UTI.[172] This result casts doubt upon the American studies from which one would have predicted that between six and twenty-four of these boys (1-4%) would have had a UTI. The Japanese study suggests that either Japanese hygiene is vastly superior or that the American studies are flawed.

3. Penile cancer does not justify routine circumcision

Accurate data on the rates of penile cancer in circumcised and intact men in the United States is not available. There have been no epidemiologic studies of the rate of penile cancer in circumcised males, nor has there been any studies that distinguished on the basis of circumcision status. Claims that routine circumcision has lowered penile cancer rates are therefore difficult to support. Countries such as Japan,[173] Norway,[174] Finland[175] and Denmark,[176] in which circumcision is rare, have

171. *See* William F. Gee & Julian S. Ansell, *Neonatal Circumcision: A Ten-year Overview: With Comparison of the Gomco Clamp and the Plastibell Device*, 58 PEDIATRICS 824, 827 (1976).

172. *See* Hiroyuki Kayaba et al., *Analysis of Shape and Retractibility of the Prepuce in 603 Japanese Boys*, 156 J. UROLOGY 1813 (1996).

173. *See* C.S. Muir & Janine Nectoux, *Epidemiology of Cancer of the Testis and Penis*, National Cancer Institute Monograph 53: Second Symposium on Epidemiology and Cancer Registries in the Pacific Basin 157-64 (1979).

174. *See* T. Iverson et al., *Squamous Cell Carcinoma of the Penis and of the Cervix, Vulva and Vagina in Spouses: Is There Any Relationship? An Epidemiological Study from Norway, 1960-92*, 76 BRIT. J. CANCER 658, 658 (1997).

175. *See* A.G. Maiche, *Epidemiological Aspects of Cancer of the Penis in Finland*, 1 EUR. J. CANCER PREVENTION 153 (1992).

176. *See* M. Frisch et al., *Falling Incidence of Penis Cancer in an Uncircumcised Population (Denmark 1943-90)*, 311 BRIT. MED. J. 1471 (1995).

penile cancer rates that are lower than the estimated rates in the United States.[177] In any event, the rate of penile cancer in all western countries is extremely low; among all males in Japan, Finland, Norway, and Denmark, countries that employ national cancer registries, for example, the rate ranges from 0.5 to 0.8 per 100,000. In the United States, where the cancer incidences are based on estimates, the incidence of penile cancer is approximately 0.8 per 100,000 and accounts for only 0.16% of all cancers in American males.[178]

By way of comparison, the combined rate of ovarian and breast cancer in women is 264 times higher than the rate of penile cancer in men, and breast cancer is much more common in men than penile cancer.[179] As noted above, clear, incontrovertible evidence demonstrates that prophylactic removal of breast and/or ovarian tissue would reduce the likelihood of developing cancer enough to add months to the life expectancy of average patients and several years to the life expectancy of women with genetic markers for breast cancer.[180] Yet, as also noted above, the substantial potential benefit of an oophorectomy and/or mastectomy is universally regarded as inadequate to justify such prophylactic surgery, except in a woman at high-risk for ovarian or breast cancer.[181] It would be unthinkable to perform the surgery on a young girl. If a female were ever to undergo such prophylactic surgery it could not occur until after she both reached adulthood and gave informed consent to the procedure. Even if it were correct that circumcision reduces the risk of penile cancer to a statistically significant degree, it would still be clearly unjustified to use circumcision as a prophylactic. Even if the highest estimates of reduced risk were accurate, it would take over 260,000 circumcisions to prevent a single case of penile cancer. It follows that in 260,000 circumcisions, one would expect 520 life-threatening complications.[182] Routinely amputating healthy tissue in quest of such remote and speculative benefits is irrational and violates both medical ethics and human rights.[183]

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177. *See* P.A. Wingo et al., *Cancer Statistics, 1995*, 45 CAL. CANCER J. FOR CLINICIANS 8-30 (1995).

178. *See id.*

179. *See* S.L. Parker et al., *Cancer Statistics, 1997*, 47 CAL. CANCER J. FOR CLINICIANS 5-27 (1997).

180. See further discussion *supra* Part II.C.

181. See further discussion *supra* Part II.C.

182. *See* Gee, *supra* note 171, at 824-27.

183. *See* Svoboda, *supra* note 3, at 205-15 (routine infant male circumcision

4. Sexually transmitted disease prevention does not justify routine circumcision

The role of circumcision in preventing STDs is even less clear. For each sexually transmitted infection, including HIV, there are contradictory medical studies.[184] Because the epidemiology of STDs involves a mixture of biological, sociological and psychological factors, it is impossible to isolate the foreskin as a factor in the spread of STDs. The available medical literature suggests certain trends, but nothing definitive. Circumcised men actually appear *more* likely to contract urethritis (such as gonorrhea or chlamydia) or viral infections (such as herpes simplex or human papillomavirus). Intact men, on the other hand, appear slightly more prone to genital ulcers (such as chancroid).[185] The role of circumcision in the transmission of HIV is far from decided.[186]

Although several African studies have suggested that circumcision reduces the risk of HIV infection, several others have failed to document any significant influence.[187] A few population surveys have found circumcision to increase the risk of HIV infection.[188] Meta-analysis of the published studies has revealed a significant degree of between-study heterogeneity. The one trend noted is that a foreskin may place an African man who engages in high-risk sexual behaviors at increased risk for HIV infection.[189] For the general population, circumcision does not

violates numerous human rights under a variety of international treaties including the Convention on Civil and Political Rights and the Convention on the Rights of the Child); Denniston, *supra* note 61.

184. R.S. Van Howe, *Does Circumcision Influence Sexually Transmitted Diseases?: A Literature Review*, 83 (Suppl. 1) BJU INT'L 52, 52-62 (1999).

185. *See id.*

186. *See* I. De Vincenzi & T. Mertens, *Male Circumcision: A Role in HIV Prevention?*, 8 AIDS 153 (1994); R.S. Van Howe, *Circumcision and HIV Infection: Meta-analysis and Review of the Medical Literature*, 10 INT'L J. STD & AIDS 8 (1999).

187. *See* Van Howe, *supra* note 186, at 8-16.

188. *See id.*

189. *See* Nigel O'Farrell & Matthias Egger, *Circumcision in Men and the Prevention of HIV Infection: A "Meta-Analysis" Revisited*, 11 INT'L J. STD & AIDS 137, 141 (2000); R. Hayes & H.A. Weiss, *Meta-Analysis on the Relationships between Male Circumcision and HIV Infection* (paper presented at the Thirteenth Meeting of the International Society for Sexually Transmitted Diseases Research, Denver, Colorado, July 13, 1999).

appear to have an impact.[190] Even proponents of circumcision acknowledge that the African experience with HIV does not apply to first world countries.[191] The most effective timing of circumcision is also under dispute. One African study documented that males circumcised before fifteen years of age were at greater risk of contracting HIV,[192] while those circumcised after twelve years of age were at a lower risk.[193] Because genital discharge is more prevalent than genital ulcers, the one consistent trend, from several recent population surveys, is that circumcised men are at greater risk for contracting a STD.[194] It is therefore inappropriate to cite avoidance of STDs as a justification for circumcision.

B. Harm caused by male circumcision

1. Complications

On the cost side, retrospective studies show that rates of immediate complications associated with neonatal circumcision are somewhere between 2.0%[195] and 6.8%.[196] One prospective study, looking only for evidence of hemorrhage, found the rate of hemorrhage following neonatal circumcision was 9.9%.[197] These estimates all exceed the 1.0% to 1.7%

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190. *See* O'Farrell & Egger, *supra* note 189, at 141; Hayes & Weiss, *supra* note 189.

191. *See* Stephen Moses et al., *Analysis of the Scientific Literature on Male Circumcision and Risk for HIV Infection*, 10 INT'L J. STD & AIDS 626 (1999).

192. *See* Maria Quigley et al., *Sexual Behaviour Patterns and Other Risk Factors for HIV Infection in Rural Tanzania: A Case-Control Study*, 11 AIDS 237 (1997).

193. *See* Robert Kelly et al., *Age of Male Circumcision and Risk of Prevalent HIV Infection in Rural Uganda*, 13 AIDS 399, 399 (1999).

194. *See* Jeff Seed et al., *Male Circumcision, Sexually Transmitted Disease, and Risk of HIV*, 8 J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROME & HUMAN RETROVIROLOGY 83 (1995); *see also* Edward O. Laumann et al., *Circumcision in the United States: Prevalence, Prophylactic Effects, and Sexual Practice*, 277 JAMA 1052 (1997); Mark Urassa et al., *Male Circumcision and Susceptibility to HIV Infection among Men in Tanzania*, 11 AIDS 73 (1997); Van Howe, *supra* note 144, at 52-62.

195. *See* Gee, *supra* note 171, at 827.

196. *See* Carlos A. Moreno & Janet P. Realini, *Infant Circumcision in an Outpatient Setting*, 85 TEX. MED. 37, 37 (1989).

197. *See* James M. Sutherland et al., *Hemorrhagic Disease of the Newborn: Breast Feeding as a Necessary Factor in the Pathogenesis*, 113 AM. J. DISEASES IN CHILD. 524 (1967).

rate of complications for circumcisions performed after the first month of life.[198] Complications range from hemorrhage—sometimes to the point of death and frequently necessitating a transfusion;[199] minor infections;[200] life-threatening infections such as sepsis,[201] meningitis,[202] gangrene,[203]

198. *See* Thomas E. Wiswell et al., *Circumcision in Children Beyond the Neonatal Period*, 92 PEDIATRICS 791, 791 (1993); *see also* S. Walfisch et al., *Circumcision of New Immigrants*, 126 HAREFUAH 119 (1994); Venkata R. Jayanthi et al., *Postneonatal Circumcision with Local Anesthesia: A Cost-Effective Alternative*, 161 J. UROLOGY 1301, 1301 (1999).

199. *See* Abdall S. Awidi, *Delivery of Infants with Glanzmann Thrombasthenia and Subsequent Blood Transfusion Requirements: A Follow-up of 39 Patients*, 40 AM. J. HEMATOLOGY 1, 1 (1992); *see generally* G. Steinau et al., *Tageschirurgische (TCH) Eingriffe Im Kindesalter an Einer Chirurgischen Klinik*, 118 ZENTRALBLATT FÜR CHIRURGIE 25 (1993); R.W. Watts and P.A. Stokes, *Secondary Arterial Haemorrhage following Circumcision; An Unusual Cause of Antepartum Haemorrhage*, 26 AUSTL. & N.Z. J. OBSTETRICS & GYNECOLOGY 312 (1986); John Denton et al., *Circumcision Complication: Reaction to Treatment of Local Hemorrhage with Topical Epinephrine in High Concentration*, 17 CLINICAL PEDIATRICS 285, 285 (1978); J.S. Poll & J.E. Prinsen, *Niet-geplande opname na dagverpleging bij kinderen*, 134 NEDERLANDS TIJDSCHRIFT VOOR GENEESKUNDE 1089 (1990); Wolfgang Cyran, *Aus der Praxis einer Gutachterstelle: Schwere Nachblutung nach einer Phimosenoperation*, 88 ZEITSCHRIFT FÜR ÄRZTLICHE FORTBILDUNG 703 (1994); Gee, *supra* note 171, at 824-27; T.M. Tsang & P.K. Tam, *Complications of Circumcision*, 81 BRIT. J. SURGERY 473, 473 (1994); Willson, *Cesarean Section for Threatened Eclampsia and Death of the Child following Circumcision*, 68 AM. J. OBSTETRICS 351 (1913).

200. *See* J. Stranko et al., *Impetigo in Newborn Infants Associated with a Plastic Bell Clamp Circumcision*, 5 PEDIATRIC INFECTIOUS DISEASE 597, 597-98 (1986); *see also* A.B. Zafar, R.C. Butler, D.J. Reese, L.A. Gaydos and P.A. Mennonna, *Use of 0.3% Triclosan (Bacti Stat) to Eradicate an Outbreak of Methicillin Resistant Staphylococcus Aureus in a Neonatal Nursery*, 23 AM. J. INFECTION CONTROL 200, 200 (1995); John D. Nelson et al., *A Prolonged Nursery Epidemic Associated with a Newly Recognized Type of Group A Streptococcus*, 89 J. PEDIATRICS 792, 792 (1976); Thomas E. Wiswell et al., *Staphylococcus Aureus Colonization after Neonatal Circumcision in Relation to Device Used*, 119 J. PEDIATRICS 302, 302 (1991).

201. *See* Barry V. Kirkpatrick & Donald V. Eitzman, *Neonatal Septicemia after Circumcision*, 13 CLINICAL PEDIATRICS 767, 767 (1974); *see also* David Braun, *Neonatal Bacteremia and Circumcision*, 85 PEDIATRICS 135, 135 (1990); R. Southby & N. Myers, *A Case Against Circumcision*, 2 MED. J. AUSTL. 393, 393 (1965); T.G. Cleary & S. Kohl, *Overwhelming Infection with Group B Beta-Hemolytic Streptococcus Associated with Circumcision*, 64 PEDIATRICS 301, 301 (1979).

202. *See* Samuel Menahem, *Complications Arising from Ritual Circumcision:*

staphylococcal scalded skin syndrome,[204] erysipelas[205] and scrotal abscess;[206] acute urinary retention leading to renal failure;[207] penile ischemia;[208] necrosis;[209] buried penis;[210] partial or complete penile

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Pathogenesis and Possible Prevention, 17 ISR. J. MED. SCI. 45, 45 (1981); *see also* J.M. Scurlock & P.J. Pemberton, *Neonatal Meningitis and Circumcision*, 1 MED. J. AUSTL. 332 (1977).

203. *See* D.F. Du Toit and W.T. Villet, *Gangrene of the Penis after Circumcision: A Report of 3 Cases*, 55 S. AFR. MED. J. 521, 521 (1979); *see also* Sidney J. Sussman et al., *Fournier's Syndrome. Report of Three Cases and Review of the Literature*, 132 AM. J. DISEASES IN CHILD. 1189, 1189 (1978); I. Evbuomwan & A.S. Aliu, *Acute Gangrene of the Scrotum in a One Month Old Child*, 36 TROPICAL & GEOGRAPHICAL MED. 299, 299 (1984); Adetunji A. Adeyokunnu, *Fournier's Syndrome in Infants. A Review of Cases from Ibadan, Nigeria*, 22 CLINICAL PEDIATRICS 101, 101 (1983); William G. Hamm & Frank F. Kanthak, *Gangrene of the Penis following Circumcision with High Frequency Current*, 42 S. MED. J. 657, 657 (1949); P. Thorek and P. Egel, *Reconstruction of the Penis with Split-Thickness Skin Graft: A Case of Gangrene following Circumcision for Acute Balanitis*, 4 PLASTIC & RECONSTRUCTIVE SURGERY 469 (1949); S. Ahmed et al., *Penile Reconstruction following Post-Circumcision Penile Gangrene*, 9 PEDIATRIC SURGERY INT'L 295, 295 (1994); S. Kurel, *Iatrogenic Penile Gangrene: 10-Year Follow-Up*, 95 PLASTIC & RECONSTRUCTIVE SURGERY 210, 210 (1995); Edward W. Pinkham Jr & Andrew W. Stevenson Jr., *Unusual Reaction to Local Anesthesia: Gangrene of the Prepuce*, 9 U.S. ARMED FORCES MED. J. 120, 120 (1958); David P. Bliss et al., *Necrotizing Fasciitis after Plastibell Circumcision*, 131 J. PEDIATRICS 459, 459 (1997).

204. *See* Endla K. Anday & Joyce Kobori, *Staphylococcal Scalded Skin Syndrome: A Complication of Circumcision*, 21 CLINICAL PEDIATRICS 420, 420 (1982); David Annunziato & Louis M. Goldblum, *Staphylococcal Scalded Skin Syndrome. A Complication of Circumcision*, 132 AM. J. DISEASES IN CHILD. 1187, 1187 (1978).

205. *See* Binita R. Shah et al., *Clinical Picture*, 4 ARCHIVES FAM. MED. 670, 671 (1995).

206. *See* K. Uwyyed et al., *Scrotal Abscess with Bacteremia Caused by Salmonella Group D after Ritual Circumcision*, 9 PEDIATRIC INFECTIOUS DISEASE J. 65, 65 (1990); *see also* Gabriel Dinari et al., *Umbilical Arteritis and Phlebitis with Scrotal Abscess and Peritonitis*, 6 J. PEDIATRICS SURGERY 176, 176 (1971).

207. *See* J.C. Craig et al., *Acute Obstructive Uropathy—A Rare Complication of Circumcision*, 153 EUR. J. PEDIATRICS 369 (1994); *see generally* J.D. Eason et al., *Male Ritual Circumcision Resulting in Acute Renal Failure*, 309 BRIT. MED. J. 660 (1994); M.G. Ochsner, *Acute Urinary Retention: Causes and Treatment*, 71 POSTGRADUATE MED. 221 (1982); W. Berman, *Letter: Urinary Retention Due to Ritual Circumcision*, 56 PEDIATRICS 621 (1975); M. Frand et al., *Complication of Ritual Circumcision in Isruel*, 54 PEDIATRICS 521 (1974).

208. *See* D.J. Smith et al., *An Uncommon Complication of Circumcision*, 73

amputation;[211] iatrogenic hypospadias;[212] total denudation of the penis;[213]

BRIT. J. UROLOGY 459 (1994).

209. *See* H. Stefan, *Reconstruction of the Penis after Necrosis Due to Circumcision Burn*, 4 EUR. J. PEDIATRICS SURGERY 40 (1994); *see also* J.B. Rosefsky Jr, *Glans Necrosis as a Complication of Circumcision*, 39 PEDIATRICS 774 (1967); J.R. Woodside, *Necrotizing Fasciitis after Neonatal Circumcision*, 134 AM. J. DISEASES IN CHILD. 301 (1980); N. Sterenberg et al., *Necrosis of the Glans Penis following Neonatal Circumcision*, 68 PLASTIC & RECONSTRUCTIVE SURGERY 237 (1981); J.R. Woodside, *How to Lessen Risk of Wound Infection after Circumcision*, 48 MODERN MED. 93 (1980).

210. *See* P.S. Bergeson et al., *The Inconspicuous Penis*, 92 PEDIATRICS 794 (1993); *see generally* J.A. van-der Zee et al., *Een Ernstige Complicatie Ten Gevolge Van Rituele Circumcisie Van Een 'Begraven' Penis*, 135 NEDERLANDS TIJDSCHRIFT VOOR GENEESKUNDE 1604 (1991); J. Radhakrishnan & H.M. Reyes, *Penoplasty for Buried Penis Secondary to "Radical" Circumcision*, 19 J. PEDIATRICS SURGERY 629 (1984); M. Kon, *A Rare Complication following Circumcision: The Concealed Penis*, 130 J. UROLOGY 573 (1983); R.D. Talarico and J.E. Jasaitis, *Concealed Penis: A Complication of Neonatal Circumcision*, 110 J. UROLOGY 732 (1973); W.C. Trier & G.W. Drach, *Concealed Penis. Another Complication of Circumcision*, 125 AM. J. DISEASES IN CHILD. 276 (1973); G.J. Alter et al., *Buried Penis as a Contraindication for Circumcision*, 178 J. AM. COLL. SURGERY 487 (1994); C.E. Horton et al., *Hidden Penis Release: Adjunctive Suprapubic Lipectomy*, 19 ANNALS PLASTIC SURGERY 131 (1987); P.K. Donahoe & M.A. Keating, *Preputial Unfurling to Correct the Buried Penis*, 21 J. PEDIATRICS SURG. 1055 (1986); D.H. Stewart, *The Toad in the Hole Circumcision—a Surgical Bugbear*, 191 BOSTON MED. & SURGERY J. 1216 (1924); S.R. Shapiro, *Surgical Treatment of the 'Buried' Penis*, 30 UROLOGY 554 (1987); M. Maizels et al., *Surgical Correction of the Buried Penis: Description of a Classification System and a Technique to Correct the Disorder*, 136 J. UROLOGY 268 (1986).

211. *See* B.S. Strimling, *Partial Amputation of Glans Penis during Mogen Clamp Circumcision*, 97 PEDIATRICS 906 (1996); *see generally* J. Sherman et al., *Circumcision: Successful Glanular Reconstruction and Survival following Amputation, 156 J. UROLOGY 842 (1996); A.F. Yilmaz et al., Rare Complication of Circumcision: Penile Amputation and Reattachment*, 23 EUR. UROLOGY 423 (1993); D.A. Gilbert et al., *Phallic Construction in Prepubertal and Adolescent Boys*, 149 J. UROLOGY 1521-26 (1993); Menahem, *supra* note 202, at 45-48; S.B. Levitt et al., *Iatrogenic Microphallus Secondary to Circumcision*, 8 UROLOGY 472-74 (1976); G. Audry et al., *Amputation of Penis after Circumcision—Penoplasty Using Expandable Prosthesis*, 4 EUR. J. PEDIATRICS SURGERY 44 (1994); J.P. Gearhart & J.A. Rock, *Total Ablation of the Penis after Circumcision with Electrocautery: A Method of Management and Long-Term Followup*, 142 J. UROLOGY 799-801 (1989); A. Azmy et al., *Successful Reconstruction following Circumcision with Diathermy*, 57 BRIT. J. UROLOGY 587 (1985); K.A. Hanash, *Plastic Reconstruction of Partially Amputated Penis At Circumcision*, 18 UROLOGY

abdominal distension;[214] pneumothorax;[215] plastibell retention;[216] urethral

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291 (1981); A.Y. Izzidien, *Successful Replantation of a Traumatically Amputated Penis in a Neonate*, 16 J. PEDIATRICS SURGERY 202 (1981); J. Money, *Ablatio Penis: Normal Male Infant Sex-Reassigned as a Girl*, 4 ARCHIVES OF SEXUAL BEHAVIOR 65-71 (1975); G.R. Gluckman et al., *Newborn Penile Glans Amputation during Circumcision and Successful Reattachment*, 153 J. UROLOGY 778 (1995); J.B. Brimhall, *Amputation of the Penis following a Unique Method of Preventing Hemorrhage after Circumcision*, 4 ST. PAUL MED. J. 490 (1902); E. Neulander et al., *Amputation of Distal Penile Glans During Neonatal Ritual Circumcision—A Rare Complication*, 77 BRIT. J. UROLOGY 924 (1996); A. Hanukoglu et al., *Serious Complications of Routine Ritual Circumcision in a Neonate: Hydro-ureteronephrosis, Amputation of Glans Penis, and Hyponatraemia*, 154 EUR. J. PEDIATRICS 314 (1995); B.L. Lerner, *Amputation of the Penis as a Complication of Circumcision*, 46 MED. RECORDS & ANNALS 229 (1952).

212. *See generally* M. Cetinkaya et al., *Two Serious Complications of Circumcision. Case Report*, 27 SCANDINAVIAN J. UROLOGY & NEPHROLOGY 121 (1993).

213. *See* J. Orozco-Sanchez & R. Neri-Vela, *Denudacion total del pene por circuncision. Descripcion de una tecnica de plastia del pene para su correccion*, 48 BOL. MED. HOSP. INFANT MEX. 565, 565-69 (1991); *see generally* J.R. Sotolongo Jr. et al., *Penile Denudation Injuries after Circumcision*, 133 J. UROLOGY 102 (1985); P. Smey, *re: Penile Denudation Injuries after Circumcision*, 134 J. UROLOGY 1220 (1985); C.L. Wilson & M.C. Wilson, *Plastic Repair of the Denuded Penis*, 52 S. MED. J. 288-90 (1959); J. Van Duyn & W.S. Warr, *Excessive Penile Skin Loss from Circumcision*, 51 J. MED. ASS'N GA. 394 (1962); J.B. Brown, *Restoration of the Entire Skin of the Penis*, 65 SURGERY, GYNECOLOGY & OBSTETRICS 362 (1937); J.B. Brown & M.P. Fryer, *Surgical Reconstruction of the Penis*, 17 G. P. 104, 104-07 (1958); W.W. Ezell et al., *Mechanical Traumatic Injury to the Genitalia in Children*, 102 J. UROLOGY 788-92 (1969).

214. *See* J. Horwitz et al., *Abdominal Distension following Ritual Circumcision*, 57 PEDIATRICS 579 (1976).

215. *See* M.R. Auerbach & J.W. Scanlon, *Recurrence of Pneumothorax as a Possible Complication of Elective Circumcision*, 132 AM. J. OBSTETRICS & GYNECOLOGY 583 (1978).

216. *See* E.R. Owen & J.L. Kitson, *Plastibell Circumcision*, 44 BRIT. J. CLINICAL PRAC. 661 (1990); *see also* N.S. Datta & N.R. Zinner, *Complication from Plastibell Circumcision Ring*, 9 UROLOGY 57 (1977); R.E. Johnsonbaugh, *Complication of a Circumcision Performed with a Plastic Disposable Circumision Device: Long-Term Follow-Up*, 133 AM. J. DISEASES IN CHILD. 438 (1979); T. Malo & R.J. Bonforte, *Hazards of Plastic Bell Circumcisions*, 33 OBSTETRICS & GYNECOLOGY 869 (1969); G. Jonas, *Retention of a Plastibell Circumcision Ring: Report of a Case*, 24 OBSTETRICS & GYNECOLOGY 835 (1984); M.M. Rubenstein & W.M. Bason, *Complication of Circumcision Done with a Plastic Bell Clamp*, 116 AM. J. DISEASES IN CHILD. 381 (1968).

fistula;[217] meatal ulceration;[218] ruptured bladder;[219] gastric rupture;[220] tachycardia and heart failure;[221] myocardial injury;[222] iatrogenic burns;[223] pulmonary embolism;[224] phimosis;[225] unilateral leg cyanosis;[226] meatitis and

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217. *See generally* J.T. Lackey et al., *Subglanular Urethral Fistula from Infant Circumcision*, 62 J. IND. STATE MED. ASS'N 1305 (1969); J.T. Lackey et al., *Urethral Fistula Following Circumcision*, 206 JAMA 2318 (1968); R.D. Limaye & R.A. Hancock, *Penile Urethral Fistula as a Complication of Circumcision*, 72 J. PEDIATRICS 105 (1968); A. Benchekroun et al., *Fistules urethrales apres circoncision: a propos de 15 cas*, 3 MAROC MED. 715-18 (1981); J.T. Lau & G.B. Ong, *Subglandular Urethral Fistula following Circumcision: Repair by the Advancement Method*, 126 J. UROLOGY 702 (1981); I.W. Shiraki, *Congenital Megalourethra with Urethrocutaneous Fistula following Circumcision: A Case Report*, 109 J. UROLOGY 723 (1973); S.Y. Tennenbaum & L.S. Palmer, *Congenital Urethrocutaneous Fistulas*, 43 UROLOGY 98-99 (1994); A.H. Colodny, *Congenital Urethrocutaneous Fistulas*, 44 UROLOGY 149 (1994); S. Johnson, *Persistent Urethral Fistula following Circumcision: Report of a Case*, 49 U.S. NAVAL MED. BULL. 120-22 (1949).

218. *See* A.R. MacKenzie, *Meatal Ulceration following Neonatal Circumcision*, 28 OBSTETRICS & GYNECOLOGY 221 (1966); *see also* H.F. Meyer, *Meatal Ulcer in the Circumcised Infant*, 99 MED. TIMES 77 (1971).

219. *See generally* L.D. Jee & A.J. Millar, *Ruptured Bladder following Circumcision Using the Plastibell Device*, 65 BRIT. J. UROLOGY 216 (1990).

220. *See generally* K.P. Connelly et al., *Gastric Rupture Associated with Prolonged Crying in a Newborn Undergoing Circumcision*, 31 CLINICAL PEDIATRICS 560 (1992).

221. *See generally* A. Mor et al., *Tachycardia and Heart Failure after Ritual Circumcision*, 62 ARCHIVES DISEASE CHILDHOOD 80 (1987).

222. *See generally* M.L. Ruff et al., *Myocardial Injury following Immediate Postnatal Circumcision*, 144 AM. J. OBSTETRICS & GYNECOLOGY 850 (1982).

223. *See generally* C.K. Pearlman, *Caution Advised on Electrocautery Circumcisions*, 19 UROLOGY 453 (1982); C.K. Pearlman, *Reconstruction following Iatrogenic Burn of the Penis*, 11 J. PEDIATRICS SURGERY 121 (1976).

224. *See* J.E. Curtis, *Circumcision Complicated by Pulmonary Embolism*, 132 NURSING MIRROR MIDWIVES J. 28, 28-30 (1971).

225. *See generally* John F. Redman et al., *Postcircumcision Phimosis and Its Management*, 14 CLINICAL PEDIATRICS 407 (1975); Kaweblum, *supra* note 144; Hawa Patel, *The Problem of Routine Circumcision*, 95 CAN. MED. ASS'N J. 576 (1966); C. Terry Russell & Janet Chaseling, *Topical Anaesthesia in Neonatal Circumcision: A Study of 208 Consecutive Cases*, 25 AUSTL. FAM. PHYSICIAN S30-S34, suppl. 1 (1996); Van Howe, *supra* note 144, at 776.

226. *See* R. Arnon et al., *Unilateral Leg Cyanosis: An Unusual Complication of Circumcision*, 151 EUR. J. PEDIATRICS 716, 716 (1992).

meatal stenosis;[227] penile hair tourniquet;[228] to death.[229]

2. Pain

An additional and generally under-appreciated cost is trauma to the newborn. Research has determined that newborns experience more pain from a given noxious stimuli than do older children and adults.[230] The

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227. *See generally* C.D. Berry Jr. & R.R. Cross Jr., *Urethral Meatal Caliber in Circumcised and Uncircumcised Males*, 92 AM. J. DISEASES CHILD. 621 (1956); A. Steg & G. Allouch, *Stenose du Meat et Circoncision*, 85 J. UROLOGY & NEPHROLOGY 727 (1979); J.D. Frank et al., *Urethral Strictures in Childhood*, 62 BRIT. J. UROLOGY 590 (1988); C. Viville & J. Weltzer, *Les Retrecissements Iatrogenes De Lurethre (R.I.U.) Masculin. A Propos De 50. Observations*, 87 J. UROLOGY 413 (1981); John Graves, *Pinpoint Meatus: Iatrogenic?* 41 PEDIATRICS 1013 (1968); Meyer, *supra* note 176; D.M. Griffiths et al., *A Prospective Survey of the Indications and Morbidity of Circumcision in Children*, 11 EUR. UROLOGY 184 (1985); M.C. Daley, *Circumcision*, 214 JAMA 2195 (1970); Douglas Gairdner, *The Fate of the Foreskin: a Study of Circumcision*, 2 BRIT. MED. J. 1433-37 (1949); Patel, *supra* note 225, at 576; Alexandra Stenram et al., *Circumcision for Phimosis: A Follow-up Study*, 20 SCANDINAVIAN J. UROLOGY & NEPHROLOGY 89-92 (1986); A. Stenram et al., *Circumcision for Phimosis—Indications and Results*, 75 ACTA PAEDIATRICA SCANDINAVICA 321 (1986); R. Persad et al., *Clinical Presentation and Pathophysiology of Meatal Stenosis following Circumcision*, 75 BRIT. J. UROLOGY 91 (1995); A. Ralph Thompson, *Stricture of the External Urinary Meatus*, 1 LANCET 1373-77 (1935); J. Brennemann, *The Ulcerated Meatus in the Circumcised Child*, 21 AM. J. DISEASES IN CHILD. 38-47 (1921); Paul Freud, *The Ulcerated Urethral Meatus in Male Children*, 31 J. PEDIATRICS 131-42 (1947); W.M. Mastin, *Infantile Circumcision a Cause of Contraction of the External Urethral Meatus*, 4 ANNALS ANATOMY & SURGERY 123 (1881); Van Howe, *supra* note 144, at 776.

228. *See generally* A.G. Toguri et al., *Penile Tourniquet Syndrome Caused by Hair*, 72 S. MED. J. 627 (1979); F.S. Haddad, *Penile Strangulation by Human Hair. Report of Three Cases and Review of the Literature*, 37 UROLOGY INT'L 375-88 (1982); Allan J. Pantuck et al., *Hair Strangulation Injury of the Penis*, 13 PEDIATRIC EMER. CARE 423 (1997); M. Aboulola et al., *Plaies de l'urètre par cheveu étrangleur*, 21 CHIRURGIE PÉDIATRIQUE 283 (1980); A.Y. Bashir & M. El-Barbary, *Hair Coil Strangulation of the Penis*, 25 J. ROYAL COLL. SURGERY 47-51 (1980).

229. *See generally* Louis W. Sauer, *Fatal Staphylococcus Bronchopneumonia following Ritual Circumcision*, 46 AM. J. OBSTETRICS & GYNECOLOGY 583 (1943); Willson, *supra* note 199, at 351.

230. *See* K.J.S. Anand & P.R. Hickey, *Pain and Its Effects in the Human Neonate and Fetus*, 317 NEW ENG. J. MED. 1321, 1321-29 (1987).

procedure is *extremely* painful.[231] During circumcision, forceps or other probes are inserted into the delicate foreskin, where they are used to scrape, tear apart and destroy the normal erogenous tissues. The baby's sensitive foreskin is crushed, and the raw flesh is cut with scissors. Circumcision is usually followed by an alteration in sleep pattern marked by prolonged non-rapid eye movement sleep.[232] The procedure frequently causes the newborn to withdraw from his environment thus interfering with his process of bonding with the mother and nursing.[233] General anesthesia is considered too risky for use in the neonatal period, so most neonatal circumcisions are performed without anesthesia.[234] Topical and local anesthetics, which blunt some of the pain, do not adequately protect the infant. Experimental evidence indicates that newborns experience marked pain during circumcision, even when these agents are employed.[235] In 1997, researchers altered the number of subjects enrolled in an infant circumcision pain study because they concluded that inflicting pain on

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231. *See* P. Drake & L. French, *Analgesia during Circumcision*, 45 J. FAM. PRAC. 100 (1997); Janice Lander et al., *Comparison of Ring Block, Dorsal Penile Nerve Block, and Topical Anesthesia for Neonatal Circumcision: A Randomized Controlled Trial*, 278 JAMA 2157-62 (1997).

232. *See* Robert N. Emde et al., *Stress and Neonatal Sleep*, 33 PSYCHOSOMATIC MED. 491, 491-97 (1971).

233. *See* Richard E. Marshall et al., *Circumcision: II. Effects Upon Mother-Infant Interaction*, 7 EARLY HUMAN DEV. 367, 367-74 (1982).

234. *See* Tom Garry, *Circumcision: a Survey of Fees and Practices*, OBG MANAGEMENT 34, 36 (Oct. 1994); *see also* Catherine Kelly et al., *Pediatric Residency Training in the Normal Newborn Nursery: A National Survey*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 511, 511-14 (1997).

235. *See* Robert S. Van Howe, *Anesthesia for Neonatal Circumcision: Who Benefits?*, 12 J. PRENATAL & PERINATAL PSYCHOLOGY & HEALTH 3, 3-4, 6, 9-10, 13 (1997); *see also* Robert S. Van Howe, *Anaesthesia for Circumcision: A Review of the Literature,* MALE AND FEMALE CIRCUMCISION: MEDICAL, LEGAL, AND ETHICAL CONSIDERATIONS IN PEDIATRIC PRACTICE 67, 67, 80, 81-82, 88 (George C. Denniston, Frederick M. Hodges & Marilyn F. Milos eds. 1999); Cynthia R. Howard et al., *Acetaminophen Analgesia in Neonatal Circumcision: The Effect on Pain*, 93 PEDIATRICS 641, 641, 645 (1994); Howard J. Stang et al., *Local Anesthesia for Neonatal Circumcision. Effects on Distress and Cortisol Response*, 259 JAMA 1507, 1507, 1509-10, 1511 (1988); Teresa D. Puthoff et al., *Use of EMLA Prior to Circumcision*, 30 ANNALS PHARMACOTHERAPY 1327, 1328, 1329 (1996); Anna Taddio et al., *Efficacy and Safety of Lidocaine-prilocaine Cream for Pain during Circumcision,* 336 NEW ENG. J. MED. 1197, 1197, 1200-01 (1997); Paul S. Williamson & Nolan D. Evans, *Neonatal Cortisol Response to Circumcision with Anesthesia*, 25 CLINICAL PEDIATRICS 412, 412, 414 (1986).

unanesthetized control patients was unethical.[236]

Circumcision causes trauma to infants who are born with relatively few pain coping mechanisms.[237] Pain causes irreversible changes in the infant's developing brain, heightening his pain perception.[238] These facts strongly support at least delaying circumcision until a male is older, when more can be done to avoid pain because the brain is more developed, thereby reducing the likelihood of permanent damage from the trauma. A prominent pediatric urologist has opined that postponing circumcision until after toilet training may also decrease the high rate of meatal stenosis in circumcised boys.[239]

3. *Loss of Function*

One recent study found that in circumcision approximately 50% of the penile skin sheath is removed, along with thousands of specialized nerve endings that are fundamental to normal sexual response.[240] The sheath provides a natural lubricant and facilitates vaginal penetration during sexual intercourse.[241] As a portion of the male reproductive apparatus,

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236. *See* Lander, *supra* note 231, at 2157, 2159.

237. *See* M. Fitzgerald, *The Birth of Pain*, MRC News 20-23 (Summer 1998).

238. *See* Suzanne Dixon et al., *Behavioral Effects of Circumcision with and without Anesthesia*, 5 J. DEV. & BEHAVIORAL PEDIATRICS 246, 249 (1984); *see also* Anna Taddio et al., *Effect of Neonatal Circumcision on Pain Responses during Vaccination in Boys*, 345 LANCET 291, 292 (1995); Anna Taddio et al., *Effect of Neonatal Circumcision on Pain Response during Subsequent Routine Vaccination*, 349 LANCET 599, 599, 602 (1997).

239. *See* J.D. Frank, *Circumcision, Meatotomy and Meatoplasty*, *in* PEDIATRIC SURGERY 738, 745 (L. Spitz & A.G. Coran eds. 5th ed. 1995).

240. *See* Christopher J. Cold & Kenneth A. McGrath, *Anatomy and Histology of the Penile and Clitoral Prepuce in Primates: Evolutionary Perspective of Specialised Sensory Tissue of the External Genitalia*, *in* MALE AND FEMALE CIRCUMCISION: MEDICAL, LEGAL, AND ETHICAL CONSIDERATIONS IN PEDIATRIC PRACTICE 19, 19-20 (George C. Denniston, Frederick M. Hodges & Marilyn F. Milos eds. 1999); *see also* Steve Scott, *Anatomy and Physiology of the Human Prepuce*, in MALE AND FEMALE CIRCUMCISION: MEDICAL, LEGAL, AND ETHICAL CONSIDERATIONS IN PEDIATRIC PRACTICE 9, 15, 16 (George C. Denniston, Frederick M. Hodges & Marilyn F. Milos eds. 1999); J.R. Taylor et al., *The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision*, 77 BRIT. J. UROLOGY 291, 291 (1996).

241. *See* P.M. Fleiss, *The Case Against Circumcision*, MOTHERING ¶ 23 (Dec. 22, 1997).

the foreskin is clearly not trivial.[242]

4. Loss of Immunological Protection and Physical Protection

The human foreskin serves to protect the glans, an internal structure, from injury. The prepuce also serves valuable immunological functions by providing several defenses against infection.[243] The infant's prepuce has a pronounced tight tip with a sphincter, formed from the whorl of muscle tissue that stays closed to keep out foreign matter but opens to permit the outflow of urine.[244] The sub-preputial wetness contains several secretions that act to destroy harmful microorganisms.[245] The prepuce contains Langerhans cells, which provide the first line of mucosal immunity.[246] Our understanding of mucosal immunity is still in its infancy.[247]

C. Medical Considerations Strongly Disfavor Routine Circumcision

Appropriate decision-making regarding the permissibility of infant circumcision requires balancing a negligible reduction of overall UTI and penile cancer rates against the significant disadvantages of the procedure—loss of functional and highly erogenous tissue, loss of immunological properties of the foreskin, risks of complications and the excruciating pain the newborn experiences. This balancing surely would yield the conclusion that the procedure is medically contra-indicated and not in the best interests of the infant patient.

Numerous medical bodies around the world have recognized that

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242. *See* Ronald S. Immerman & Wade C. Mackey, *A Biocultural Analysis of Circumcision*, 44 SOC. BIOLOGY 265, 265-67, 273 (1997).

243. *See* P.M. Fleiss et al., *Immunological Functions of the Human Prepuce*, 74 SEXUALLY TRANSMITTED INFECTIONS 364, 364 (1998); *see generally* Gregory L. Smith et al., *Circumcision as a Risk Factor for Urethritis in Racial Groups*, 77 AM. J. PUB. HEALTH 452, 452, 454 (1987); Paul M.N. Werker et al., *The Prepuce Free Flap: Dissection Feasibility Study and Clinical Application of a Super-Thin Flap*, 102 PLASTIC & RECONSTRUCTIVE SURGERY 1075 (1998).

244. *See* Geoffrey Jefferson, *The Peripenis Muscle: Some Observations on the Anatomy of Phimosis*, 23 SURGICAL GYNECOLOGY & OBSTETRICS 177, 178 (August, 1916).

245. *See generally* John Money & Jackie Davison, Adult Penile Circumcision: Its Erotosexual and Cosmetic Sequelae, 19 J. SEX RESEARCH 289 (1983).

246. *See* C.J. Cold and J.R. Taylor, *The Prepuce*, 83 (Suppl. 1) BJU INT'L 34, 40 (1999).

247. *See* Fleiss, *supra* note 243, at 364.

routine infant circumcision is not medically justifiable. For example, in 1996, the Australian Association of Pediatric Surgeons announced that it does not support routine infant circumcision, because it is "inappropriate and unnecessary."[248] In 1997, the Australian Medical Association stated that neonatal circumcision should be discouraged by the medical profession.[249] In 1991, the Australian College of Pediatrics likewise discouraged the practice of neonatal circumcision.[250] The National Health and Medical Research Council of Australia has stated that neonatal circumcision has "no medical indication" and that "the hazards of the operation . . . outweigh any possible advantages."[251] The British Medical Association has recommended that male circumcision be performed only when medically necessary, stating that complications, including death, may result from this generally unnecessary surgery.[252] In 1996, the Canadian Pediatric Society recommended that "[c]ircumcision of newborns should not be routinely performed."[253] Significantly, even though circumcision is the most frequently performed urological procedure on children in the United States, a recent review article in an American journal discussing optimal times for performing various urological procedures on children did not mention circumcision.[254]

The AAP has issued a series of statements regarding circumcision. Remarkably, even though the procedure is widespread in the United States and performed by many of the organization's members, the AAP has never endorsed routine infant circumcision. In 1975, the AAP Task Force on Circumcision issued its first policy statement on circumcision,

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248. *See generally* J. Fred Leditschke, Australian Association of Paediatric Surgeons, *Guidelines for Circumcision* 1 (April 1996).

249. *See generally* Australian Medical Association, *Circumcision Deterred*, 6 AUSTL. MED. 5 (1997).

250. *See* Queensland Law Reform Commission, *Research Paper: Circumcision of Male Infants* (Brisbane, Australia: QLRC, 1993), *available at* http://www.cirp.org/library/legal/QLRC (last visited Nov. 12, 2000).

251. *See* NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL, *Report of the Ninety-Fifth Session* 13 (June 1983).

252. *See A Ritual Operation*, 2 BRIT. MED. J. 1458, 1459 (1949); *The Case Against Neonatal Circumcision*, 1 BRIT. MED. J. 1163, 1163 (1979).

253. *See* Fetus and Newborn Committee, Canadian Paediatric Society, *Neonatal Circumcision Revisited*, 154 CAN. MED. ASS'N J. 769, 769 (1996).

254. *See generally* American Academy of Pediatrics, Section on Urology, *Timing of Elective Surgery on the Genitalia of Male Children with Particular Reference to the Risks, Benefits, and Psychological Effects of Surgery and Anesthesia*, 97 PEDIATRICS 590 (1996).

concluding that "[t]here is no absolute medical indication for routine circumcision of the newborn."[255] In 1999, the AAP admitted that scientific evidence does not support routine neonatal circumcision.[256] Apparently unprepared, however, to accept the necessary conclusion that this prevalent practice should stop, the AAP merely stressed the importance of giving parents of male infants accurate and unbiased information and the opportunity to discuss the decision with a doctor.[257] In 1991, the American Academy of Family Physicians took no position other than to state it was a parental decision.[258] Numerous medical bodies have stated their opposition to neonatal circumcision, or have at least acknowledged that the practice is not medically sound.[259] Not a single national or international medical organization in the world recommends the procedure.

D. Can parental permission for circumcision ever be effective?

Given the foregoing, one might wonder how parental permission for routine circumcision could ever be effective, even if physicians comply with the requirements of informed permission. Like all surgical procedures, circumcision should not be subject to authorization by a surrogate for an incompetent patient unless it is medically necessary. While there is some dispute in the American medical community today as to whether routine circumcision provides *any* medical benefit, absolutely no one in the medical community seriously maintains that it is medically necessary or that it corrects an existing injury, disease or malfunction.[260]

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255. *See* Hugh C. Thompson et al., *Report of the Ad Hoc Task Force on Circumcision*, 56 PEDIATRICS 610, 611 (1975).

256. *See* American Academy of Pediatrics, Task Force on Circumcision, *Circumcision Policy Statement*, 103 PEDIATRICS 686, 691 (1999).

257. *See id.*

258. *See* American Academy of Family Physicians, *Fact Sheet for Physicians Regarding Neonatal Circumcision,* 52 AM. FAMILY PHYSICIAN 523, 525 (1995).

259. *See* Am. Academy of Pediatrics Task Force on Circumcision, *supra* note 256, at 686; *see also* Am. Academy of Family Physicians, *supra* note 256, at 523; Thompson, *supra* note 255, at 610; Fetus and Newborn Committee, *supra* note 253, at 769; J. Fred Leditschke, *supra* note 248; Australian Medical Association, *supra* note 249, at 5; British Medical Association, *supra* note 252, at 1163.

260. To make the case that neonatal circumcision is necessary, one would need to demonstrate that it is either indispensable, inevitable, mandatory, unavoidable, or essential for good health. No one has attempted to make the case that all males with foreskins are in poor health. In his pamphlet "Neonatal

Accordingly, the *Queensland Law Reform Commission* in Australia recently stated that "consent by parents to [neonatal circumcision] being performed may be invalid in the light of the common law's restrictions on the ability of parents to consent to the non-therapeutic treatment of children."[261]

Both a best interests and a substituted judgment approach support this conclusion. Recent cost-utility analyses for neonatal circumcision that take as a given the supposed benefits with respect to not only UTIs, but also cancer and STDs, have concluded that over the course of a lifetime, circumcision on the whole either impairs health[262] or has virtually no medical impact.[263] The evidence presented by weighing the costs and benefits suggests that circumcision is, in terms of the physical well-being of a boy, not in his best interests and not something to which a rational and fully informed person would be expected to consent. The inference of what the infant male would choose for himself, if able, receives further support from the actual choices of intact adult males. If the ultimate goal of medical decision-making for an incompetent person is to determine what the patient would decide for himself, if able, the best evidence may be what similarly situated competent persons actually decide for themselves. Of males in the United States that are not circumcised at birth, only 3 in 1,000 choose to have the surgery performed later in life,

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Circumcision IS Necessary" surgeon Gerald N. Weiss gives a string of arguments lauding the advantages of neonatal circumcision, but never makes the case that circumcision is either indispensable or essential for good health.

261. *See* Queensland Law Reform Commission, *supra* note 250; *In re Jane*, 85 A.L.R. 409, 435 (Austl. 1988) (discussing the relevance of its finding by speculating that a contrary conclusion could lead to a wide range of wrongs occurring including female circumcision: "The consequences of a finding that the court's consent is unnecessary are far reaching both for parents and for children. For example, such a principle might be used to justify parental consent to the surgical removal of a girl's clitoris for religious or quasi cultural reasons, or the sterilization of a perfectly healthy girl for misguided, albeit sincere, reasons. Other possibilities might include parental consent to the donation of healthy organs such as a kidney from one sibling to another.").

262. *See* Theodore G. Ganiats et al., *Routine Neonatal Circumcision: A Cost-Utility Analysis*, 11 MED. DECISION MAKING 282, 282-93 (1991); *see also* R.S. Van Howe, *Neonatal Circumcision: a Cost-utility Analysis* [Abstract 98086], October 25-28, 1998 (poster presentation at the 20th Annual Meeting of the Society for Medical Decision-Making, Cambridge, MA.).

263. *See* Frank H. Lawler et al., *Circumcision: A Decision Analysis of Its Medical Value*, 23 FAM. MED. 587, 590 (1991).

suggesting that the overwhelming majority believe that the risks and sequelae of becoming circumcised outweigh any supposed benefits.[264] If doctors followed the AAP Committee's recommendation to delay the decision until the child is old enough to grant consent,[265] circumcisions would rarely be performed in this country, as is the case in most other nations.

One author has noted that parents may authorize overtreatment of a child, even though it provides no medical benefits to the child and may actually cause harm, because it makes the parents feel better that they are purchasing some "care" for their child. The author opines that this is a form of child abuse—causing harm to a child in order to gratify parents—and, perhaps stating the obvious, contends that "the infant's interests should absolutely supersede those of his or her parents."[266]

E. Non-medical reasons including social concerns and religion cannot justify parental permission for circumcision

Many parents choose circumcision for their sons not because they mistakenly believe it is medically beneficial, but rather for non-medical reasons. Most common is a concern that their son may have social difficulties if his genitals do not look exactly like those of his father and those of the majority of his peers.[267] This claimed social benefit for the child is both unsupported and insufficient to justify a non-consensual surgical intervention. It is unsupported because there is no evidence that intact boys undergo any greater social difficulties as a result of the difference between their genitals and those of their fathers or peers. If there were any such risk, any competent parent could easily deal with this

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264. *See* EDWARD WALLERSTEIN, CIRCUMCISION: AN AMERICAN HEALTH FALLACY 131 (1980).

265. *See* Committee on Bioethics, *supra* note 131, at 314.

266. *See* Dale L. Moore, *Challenging Parental Decisions to Overtreat Children*, 5 HEALTH MATRIX 311, 320 (1995).

267. *See* Mark S. Brown & Cheryl A. Brown, *Circumcision Decision: Prominence of Social Concerns*, 80 PEDIATRICS 215, 216, 217 (1987); *see generally* John E. Lovell & James Cox, *Maternal Attitudes Toward Circumcision*, 9 J. FAM. PRAC. 811 (1979). It should be noted that the circumcision rate is already below 50% in a number of states such as California and a number of American ethnic cultures and demographic groups. People of Latino descent, for example, rarely circumcise their male children even if born in the United States. *See* Herzog, *supra* note 146, at 254; *see generally* Dimitri A. Christakis et al., *A Trade-off Analysis of Routine Newborn Circumcision*, 105 PEDIATRICS 246 (2000).

by explaining to their son that his genitals are natural and those of his father and some of his peers were surgically altered when they were babies. These "social concerns" are not sufficient enough to violate the physical integrity of a non-consenting person.

A small percentage of North American parents choose circumcision for religious reasons, and our society is uncomfortable criticizing or countermanding parents who act for their children on the basis of deeply held convictions. As discussed *supra* in Part I.D., it is a mistake, however, for physicians to believe that parents have a right to make their religious beliefs controlling on the question of whether a child is to undergo a non-medically indicated surgical procedure. No court has ever held that parents have a first amendment right to have unnecessary medical procedures performed on their children. To give that power gratuitously to certain parents because they have particular religious beliefs would be to violate one of their children's constitutional and moral rights—the right to equal protection. If the state and the medical profession protect some children against medically inappropriate practices, they must protect against all medically inappropriate practices unless they can demonstrate that denying that protection to some children would be better *for those children* (who themselves have no religious beliefs).[268] As the Supreme Court has stated, parents are free to make martyrs of themselves but not to make martyrs of their children.[269] In other words, parents are not free to force their children to undergo unnecessary and harmful surgery, however well intentioned they might be. A United Kingdom family court recently endorsed the principle that at least where two parents of two different religions disagreed on whether to circumcise, and where a local authority exercising parental responsibility under a care order, a circumcision could not be ordered. The court noted that mainstream medical opinion in the United Kingdom requires both paternal and maternal consent to a circumcision.[270]

F. Informed Consent

Finally, even if non-medically indicated surgery such as circumcision

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268. See *supra* Part III.B.

269. *See generally* Dwyer, *supra* note 3, at 1365-1465.

270. *See* Re J (Child's Religious Upbringing and Circumcision), [1999] 2 F.L.R. 678 (Fam. Div.), *affirmed*, [2000] 1 F.L.R. 571 (C.A.). The Family Division decision is also available at http://www.butterworths.co.uk/academic/fortin/cases/Re_J.htm (last visited Nov. 17, 2000).

were legally and ethically permissible to perform on children, parental authorization for such surgery would still have to comport with the requirements of informed consent. As previously discussed, there are three basic requirements to informed consent: 1) disclosure of all relevant and material information; 2) verifying and fostering the capacity of the decision-maker; and 3) ensuring that the decision is voluntary.

1. Disclosure

Physicians are always under a legal and ethical duty to fully disclose to the decision-maker all available information regarding a proposed procedure. Because the duty requires all *available* information and not just the information a given physician happens to have acquired to be disclosed, physicians are under a duty to acquire all available information pertinent to a surgery that they perform. Physicians who perform circumcisions, therefore, have a legal and ethical duty to their infant patients to obtain and provide to the patients' parents all available medical information regarding circumcision. This includes all pertinent available information about the nature and function of the foreskin, the pain that infants incur when it is removed, the risk of complications from the surgery, and any possible medical benefits and costs that may result from having it removed. A medical practitioner who fails to completely disclose the potential physical costs (and, presumably, other disadvantages) of a procedure is negligent.[271]

a. Nature and purpose of the foreskin

Recent articles in leading medical journals have documented the foreskin's complex structure.[272] Although the foreskin has been described as "the fold of skin covering the glans,"[273] it is actually a complex, junctional tissue similar to the eyelids or the lips. It is designed to protect the glans of the penis, an internal structure, from trauma and infection.[274] It also contains the highest concentration of fine-touch neuroreceptors in the penis. Only lips and fingertips have comparable neuroreceptor

271. *See* Prince v. Massachusetts, 321 U.S. 158, 167, 170 (1943).

272. *See generally* In re A.C., 573 A.2d 1235 (D.C. Ct. App. 1988); *see also* Etchells et al., *supra* note 16, at 178; David Richards, *Male Circumcision: Medical or Ritual?*, 3 J. L. & MED. 371, 374 (1996).

273. *See generally* Taylor, *supra* note 240, at 291; Cold, *supra* note 246, at 34.

274. *See* American Academy of Pediatrics, *supra* note 143, at 388.

densities. By contrast, the glans is a neurologically dumb organ.[275] Due to the foreskin's rich abundance in neuroreceptors and its exquisite specialization as a producer of sexual pleasure, it may, in fact, be the most sensitive part of the infant male's body.[276]

Parents also need to be aware that the anatomically complete penis' involuting structure allows for erection without tightening of the skin over the penile shaft. During coitus the complete skin system of the penis, including the foreskin, allows for non-traumatic intromission and penile movement within the vaginal vault without chafing.[277] Physicians owe a duty to infant male patients to inform their parents of the functionality and sensitivity that their sons will lose for a lifetime if a circumcision is carried out.

b. Pain

Physicians have an obligation to be forthright with parents about the pain that infants endure when their foreskin is removed surgically. Evidence suggests that physicians rarely do so, and this omission is clearly unethical. Many physicians may neglect to discuss the pain with parents because they fear it will be disturbing for the parents. But it *should be* disturbing, and physicians owe a duty to the infant patient to make his parents aware of this disquieting aspect of circumcision. Physicians have a further obligation to make parents aware that adequate and safe anesthesia is not available during the neonatal period. They owe no duty to parents to make them feel better about granting permission for an unnecessary surgery.

c. Risk of Complications

Because healthy, richly innervated, erogenous tissue is removed with every circumcision, the complication rate of circumcision—if "complication" means harmful effect - arguably is 100% because it denies the patient the use and function of this specialized tissue. As mentioned above, the risk of additional immediate complication is between 2% and

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275. *See* Fleiss et al., *supra* note 243, at 364.

276. *See generally* Taylor, *supra* note 240, at 291; Zdenek Halata & Bryce L. Munger, *The Neuroanatomical Basis for the Protopathic Sensibility of the Human Glans Penis*, 371 BRAIN RES. 205-30 (1986); M.Von Frey, *Beitraege zur Physiologie des Schmerzsinns. Zweite Mitt*, 46 AKAD WISS LEIPZIG MATH NATURWISS KL BER 283-96 (1984).

277. *See* Cold, *supra* note 246, at 41.

10%.[278] The danger of a later complication, such as meatal stenosis, represents an additional 5% to 10% likelihood of a harmful complication.[279] Many of the potential immediate and later complications can be quite severe. Physicians are clearly obligated to make parents aware of these complication rates and the nature of the harms that might befall their son.

d. No Significant Medical Benefits

No significant medical benefit has clearly been demonstrated to result from routine neonatal circumcision, and physicians have a duty to inform parents of that fact. As discussed below, studies purporting to demonstrate prophylactic health benefits have fatal flaws in their design and/or focus on maladies that are extremely rare - much rarer than the complications that results from circumcision itself.[280] At best, these studies demonstrate the truism that amputation of healthy tissue can marginally reduce the rate of maladies afflicting the organ from which it was taken, simply because less tissue is available to contract a condition. Naturally, routine prophylactic amputation in children has never been entertained as an ethically or scientifically viable medical procedure. When the proposed benefits and real costs are aggregated, as in a cost-utility analysis, the proposed benefits are insufficient to counter the real costs.[281] A physician who states that neonatal circumcision helps these illnesses without stating that any potential benefits are far outweighed by the real harm perpetrated violates his or her duty to provide accurate, complete information.

e. Are physicians adequately disclosing this information?

Evidence of actual practice reveals that physicians who perform circumcisions themselves know next to nothing about the part of the body that they are removing. A 1975 survey revealed that 47% of physicians who perform circumcisions believed that a non-retractable foreskin in a newborn was an indication for circumcision, when it is perfectly normal

278. *See* K. O'Hara & J. O'Hara, *The Effect of Male Circumcision on the Sexual Enjoyment of the Female Partner*, 83 (Suppl. 1) BJU INT'L 79-84 (1999).

279. *See* N. Williams & L. Kapila, *Complications of Circumcision*, 80 BRIT. J. SURGERY 1231 (1993).

280. *See* Patel, *supra* note 225, at 576; Griffiths, *supra* note 227, at 184; Persad, *supra* note 227, at 91.

281. See discussion Part IV.A and IV.B.

and healthy for a newborn's foreskin to be non-retractable and for the foreskin to become retractable only as a boy approaches adolescence.[282] There is little evidence that physician knowledge has improved since then.[283]

The misinformation promulgated regarding the painfulness of circumcision is unconscionable. Parents who cringe when their baby's heel is pricked for a blood sample are led to believe that their son feels little or no pain when a large part of his penis is cut off. This may be because parents typically believe that anesthesia is used even when it is not, or that if a local anesthesia is in fact used, the anesthesia is highly effective when it is not.

With respect to the risk of complications and the supposed medical benefits associated with circumcision, studies reveal that physicians under-report the risks and exaggerate the supposed benefits. A 1987 study found that physicians routinely inform parents about only a small minority of the medical complications and risks associated with elective circumcisions.[284] The common practice is to mention only pain, infection and bleeding as complications of neonatal circumcision.[285] This is far below the standard level of disclosure for other surgeries, whether medically indicated or cosmetic. The physician should disclose each of the many potential complications mentioned above, addressing the risks of serious bodily harm and even death, the probability of "success," and the alternatives to circumcision, and any risks associated with these alternatives. A study has shown, however, that physicians do not do this.[286] When selecting which medical complications to mention to parents, physicians tend to use a subjective assessment of the frequency and seriousness of complications. The study revealed that the physicians' probability estimates were inaccurately low and that their assessments of

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282. *See* Ganiats, *supra* note 262, at 282; Task Force on Circumcision, *supra* note 256, at 686.

283. *See generally* Martin T. Stein et al., *Routine Neonatal Circumcision: The Gap between Contemporary Policy and Practice*, 15 J. FAM. PRAC. 47 (1982).

284. *See generally* Christopher R. Fletcher, *Circumcision in America in 1998: Attitudes, Beliefs, and Charges of Am. Physicians*, *in* MALE AND FEMALE CIRCUMCISION: MEDICAL, LEGAL, AND ETHICAL CONSIDERATIONS IN PEDIATRIC PRACTICE, 259 (George C. Denniston, Frederick M. Hodges & Marilyn F. Milos eds. 1999).

285. *See* Jay J. Christensen-Szalanski et al., *Circumcision and Informed Consent. Is More Information Always Better?* 25 MED. CARE 856, 856-67 (1987).

286. *See* Fletcher, *supra* note 284, at 259.

the seriousness of potential complications were consistently lower than those expressed by mothers of newborn sons.[287]

There are many reasons why physicians provide inadequate information. Many who discuss the surgery with the mother postpartum assume that the arguments for and against circumcision have already been discussed with a health care provider. Those who meet with the parents well in advance of the birth may simply feel too busy to properly discuss the pros and cons with the parents, and may not have equipped themselves with the literature necessary to adequately present the facts to the parents. Compliance with the medical profession's ethical requirement for obtaining true informed consent is a time-consuming, laborious process. Doubtless, wherever they can, many physicians will cut corners on such a task, especially where, as with circumcision, they may believe some parents would prefer not to learn the full truth regarding potential complications.[288] The current perception that circumcision is "just a little snip" and the cultural prejudice that a child's physical integrity is less important than an adult's physical integrity makes it easier to justify bypassing a full disclosure.

In addition, physicians may simply feel uncomfortable fully discussing with parents the risks of circumcision. Furthermore, many parents choose circumcision for non-medical reasons. Likewise, many physicians see circumcision as a cultural, not a medical, practice. Physicians may believe that discussing the possible complications with parents is more likely to upset the parents than to influence the parents' decision. Parental hostility following complete disclosure is not uncommon.[289] The easiest path, in terms of the physician's own comfort, is to provide sparse information, because the parents will still sign the "consent form" without becoming angry with the provider. Physicians may wish to appease the parents because the parents decide who will provide medical care for their child, and sometimes the fear of losing patients may override the duty to do what is in the best interest of the child.

Edward Etchells et al. suggest that physicians base the content of their discussions with the parents on the perceived motives of each set of parents:

> If the parents' decision is based on strong cultural beliefs and practices, a detailed, impersonal disclosure of all known risks

287. *See* Christensen-Szalansk, *supra* note 285, at 856.

288. *See id.*

289. *See id.* at 864.

> and benefits would probably not be relevant or helpful. However, if the decision is based on personal experiences (e.g., the father was circumcised), a detailed discussion of the risks and benefits would be useful in helping the parents come to a decision.[290]

This approach is simply untenable. Obvious practical and ethical difficulties are created by an approach that requires physicians to determine parental motives and to provide widely diverging types and levels of information depending on this determination. More fundamentally, the authors fail to explain how parental motive alters the risks, the benefits, the treatment options, or the physician's duty to the patient, i.e., the child, to give full disclosure. Tellingly, physicians' positions regarding circumcision are inconsistent with their positions on therapeutic privilege[291] and substitute consent for adult incompetent patients.[292] This suggests a failure to accord proper respect to the interests and rights of the children who are the patients and an improper focus on the interests and desires of parents. The extent of information that parents actually want or feel comfortable receiving is legally and ethically irrelevant to the physician's duty of disclosure.

The misleading presentation medical personnel typically give to parents may also result from a failure to seek out available information. Three years after the release of the 1975 AAP Task Force on Circumcision report, which stated that "[t]here is no absolute medical indication for routine circumcision of the newborn,"[293] only 49% of Chicago area pediatricians, obstetricians and family practitioners were aware of the AAP's position.[294] At that time, 41% recommended routine infant circumcision despite the AAP report, while only 15% recommended the infants forego the practice.[295] The frequency of routine circumcision in Chicago area hospitals (70% to 90%) remained unchanged in the three years following the AAP's statement.[296] Another study in 1975 analyzed a randomly selected group of 92 primary care physicians and 103 parents of

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290. *See id.*

291. *See* Edward Etchells et al., *Consent for Circumcision*, 156 CAN. MED. ASS'N J. 17, 18 (1997).

292. *See* Etchells, *supra* note 32, at 389.

293. *See* Lazar, *supra* note 76, at 1437.

294. *See* Thompson, *supra* note 255, at 611.

295. *See* Daksha A. Patel et al., *Factors Affecting the Practice of Circumcision*, 136 AM. J. DISEASES CHILD. 634 (1982).

296. *Id.*

male infants.[297] Despite the contents of the 1975 AAP report, 65% of the physicians conveyed a positive attitude about routine neonatal circumcision to their patients.[298] Although pediatricians were more likely to have a neutral attitude, both family and general practitioners were more likely to favor routine neonatal circumcision.[299]

A particular physician's attitude towards circumcision may derive more from the result of personal experience and cultural background than from careful study of the medical literature. A physician's gender and circumcision status, for example, appear to affect whether he or she promotes or discourages circumcision. One study found that 100% of the health care providers surveyed who encouraged circumcision were male, while 81% of those discouraging the surgery were female.[300] Another survey found that circumcised physicians were more likely to favor circumcision than those not circumcised.[301] Physicians asked to summarize their opinions regarding circumcision offered a wide variety of opinions, ranging from "personally I appreciated the cosmetic effect" to "barbaric ritual perpetuated for irrational reasons."[302]

The Code of Ethics of the Canadian Medical Association instructs physicians to "inform [their] patient[s] when [their] personal morality would influence the recommendation or practice of any medical procedure the patient needs or wants" and to indicate when their opinion is contrary to the generally held position of the profession.[303] This is undoubtedly sound practice. It suggests that a physician who belongs to a religion that requires male circumcision should disclose this during any discussion with a patient or parent regarding circumcision. Likewise, a physician who recommends neonatal circumcision has an obligation to state, depending on what country he is practicing in, that his national medical organization does not recommend neonatal circumcision. As with any ineffective, outdated treatment, physicians have a sound basis for refusing to perform neonatal circumcision.[304]

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297. *Id.*

298. *See* Stein, *supra* note 283, at 47.

299. *See id.*

300. *See id.*

301. *See* Ciesielski-Carlucci et al., *supra* note 5, at 231.

302. *See* Stein et al., *supra* note 283, at 48, 49 (odds ratio = 9.46, 95% confidence interval = 1.70 - 52.71).

303. *See* Ciesielski-Carlucci, *supra* note 5, at 234.

304. *See* Canadian Medical Association, *supra* note 38, at 1176A-B.

Physicians' failure to adequately inform themselves about circumcision and to pass on all acquired relevant information is reflected in the level of parental knowledge about circumcision when parents give permission for the surgery. A 1979 study surveyed two hundred mothers to determine their attitudes toward and knowledge of neonatal circumcision.[305] Of those that were either doctors or other health care providers, 95% circumcised their sons. Although the mothers offered a wide variety of reasons for granting permission, few of these reasons had any medical validity (let alone sufficient weight to actually make their decision rational). Eighty-seven percent of mothers considered circumcision to be without risk of complications, and 80% of mothers stated that no physician ever explained the risks to them.[306] A 1996 study revealed that 35% of mothers who gave permission for circumcision of their sons believed that neonatal circumcision had no risks involved.[307] Twenty-five percent of the women in this study believed they had not been given enough information.[308]

Finally, the physician is obligated to disclose all personal interests unrelated to the patient's health that he or she may have when obtaining consent to medical treatment.[309] The Supreme Court of California held that a cause of action for lack of informed consent exists where a physician fails to disclose, prior to obtaining the patient's consent to remove his spleen, that the physician has made arrangements to use portions of the spleen for economically beneficial medical research purposes.[310]

In the circumcision context, there arises a particularly egregious, if relatively rare, application of this principle that has drawn significant media attention in recent years - the harvesting of foreskins from living babies and the subsequent use of the foreskins for profit by the medical industry.[311] Clearly such use of foreskins taken from living donors should be prohibited even with parental permission, because it is not related in any way to the circumcision itself and the affected infant male cannot

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305. *See* Weijer, *supra* note 95, at 817.

306. *See* Lovell & Cox, *supra* note 267, at 812.

307. *See id.*

308. *See* Ciesielski-Carlucci, *supra* note 5, at 235.

309. *See id.*

310. *See* Moore v. Regents of Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990).

311. *See id.* at 483.

possibly consent to this use of his formerly healthy, functional tissue.[312] In fact, two American Medical Association (AMA) policy statements appear to explicitly bar such a practice. AMA Policy E-2.08 on "Commercial Use of Human Tissue," requires informed consent from patients for the use of organs or tissues in clinical research, mandates disclosure of potential commercial applications prior to realizing a profit on products developed from biological materials, prohibits the use of human tissue and its products for commercial purposes without the prior informed consent of the patient providing the original cellular material, and demands that diagnostic and therapeutic alternatives offered to patients conform to standards of good medical practice and be free of influence in any way by the commercial potential of the patient's tissue.[313] AMA Policy E-2.167 on "The Use of Minors as Organ and Tissue Donors" requires that all such use have parental approval, that a "clear benefit" to the minor exist, that the minor be the only available source of the tissue, and that minors be allowed to serve as sources of tissue only for close family members.[314] Medical applications of foreskins harvested from live donors are also forbidden under international law pursuant to the European Convention on Human Rights and Biomedicine.[315] Even if such use of circumcised

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312. *See* Karen Wright, *Ready-to-wear Flesh*, DISCOVER, Nov. 1999, at 46, 46; David J. Mooney & Antonios G. Mikos, *Growing New Organs*, SCI. AM., April 1999, at 60, 60 (describing work constructing Apligraf skin product using living human foreskin cells); Roger A. Pedersen, *Embryonic Stem Cells for Medicine*, SCI. AM., April 1999, at 68-69, 71 (detailing Advanced Tissue Sciences' creation of skin construct Dermagraft from discarded foreskins taken from newborn babies); *Skin Paved the Way for Tissue Engineering*, USA TODAY, Aug. 12, 1997, *available at* http://ithaca.rice.edu/kz/USAToday/skinarticle.htm (last visited Sept. 4, 2000); B. Manson, *Forget Pork Bellies, Now It's Foreskins*, SAN DIEGO READER, May 4, 1995 at 255; M.E. Meulders-Klein, *The Right Over One's Own Body: Its Scope and Limits in Comparative Law*, 6 B. C. INT'L & COMP. L. REV. 29, 48 (1983) ("any act which tends to demean even a consenting person is radically illicit and a fortiori if the act is, in addition, immoral and profit-oriented").

313. *See* AMA Policy, *E-2.08 Commercial Use of Human Tissue*, *available at* http://www.ama-assn.org/apps/pf_online (last visited Sept. 4, 2000).

314. *See* AMA Policy, *E-2.167 The Use of Minors as Organ and Tissue Donors*, *available at* http://www.ama-assn.org/apps/pf_online (last visited Sept. 4, 2000).

315. *See* Council of Europe, European Treaty Series, No. 164, Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (April 4, 1997), *available at* http://www.coe.fr/eng/legaltxt/164e.htm (last visited Sept. 5, 2000). Article 19 generally prohibits non-therapeutic removal

foreskins were ethical, physicians would certainly have an obligation to disclose that potential conflict of interests to parents.

2. Capacity

Medical personnel have a duty to the newborn child to ensure that parental surrogates have the capacity to make a rational, reflective decision about circumcision. They should fully disclose all relevant information about the procedure well in advance of the birth, and then evaluate whether the parents understood the information. If the parents do not appear to understand, the physician should attempt to convey the information in another way that is clearer to the parents. Some researchers have contended that parents are less rational in medical decisions concerning their children than they are in medical decisions concerning themselves.[316] Medical personnel may therefore have a heightened duty when dealing with parental surrogates to ensure the surrogate is capable of making a rational decision on behalf of the infant patient.

Several studies have looked into different media for presenting information to parents about circumcision and what effect each would have on the likelihood of parents giving permission. A survey of obstetric clinic patients in a large urban hospital showed that oral communication of the risks involved would significantly reduce the rate of circumcision (72% in the study group versus 94.4% in the control group). The authors concluded that mothers in the population they studied requested circumcision for their sons because of inadequate medical information or strong social motives.[317] Another study showed that videotape counseling modestly reduced parental permission for circumcision when compared with standard oral counseling (70.5% versus 75.9%, OR=0.76, 95%, CI=0.61-0.94). Prior to the study, the circumcision rate at that medical

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of organs or tissue from a living person for transplantation purposes. Article 20 bars organ or tissue removal from a person without the capacity to consent, with certain limited exceptions not applicable here. Article 21 prohibits using the human body and its parts to give rise to financial gain. Article 22 provides that when in the course of an intervention any human body part is removed, it may be stored and used for a purpose other than that for which it was removed only if this is done in conformity with appropriate information and consent procedures.

316. *See* Alderson, *supra* note 18, at 106.

317. See Cynthia S. Rand et al., *The Effect of an Educational Intervention on the Rate of Neonatal Circumcision*, 62 OBSTETRICS & GYNECOLOGY 64, 64 (1983).

center was 90.4%.[318]

Parents may actually be resistant to receiving information about circumcision, and that would certainly diminish their capacity to understand what is presented. One study of oral provision of information to mothers about risks had to be suspended when many mothers became upset and several expressed their unwillingness to have the physician who provided the information care for their children in the future.[319] The obstetrical nurses were also belligerent to the physician who provided the mothers with oral information, because the physician was upsetting their patients.[320] Parents are often irritated by any discussion of circumcision because their minds are already made up.[321] Told that circumcision carries the risk of penile amputation, serious life-threatening infection, and death, parents find their self-esteem challenged by this information, because they do not want to unnecessarily place their children at risk while at the same time often being unwilling to rethink a decision they have already made. In short, they do not want to be confused or unsettled by the facts. As noted previously, the physician's obligation is to the child, not to the parent, and that obligation includes a duty to overcome parental resistance and ensure that parents receive, understand, and take into account all of the facts.[322] Otherwise, their permission for circumcision of their infant cannot be effective.

3. Voluntariness

The voluntariness requirement demands that physicians provide information regarding circumcision to parents in an unbiased fashion well in advance of the birth and that physicians do not themselves propose the procedure to parents. To ensure that any parents who are predisposed to request circumcision receive full disclosure in advance of the birth, the physician might tell parents that he or she will assume, unless the parents indicate otherwise, that the baby is not to be circumcised. If the subject first arises at the time of birth, or if parents do not receive the relevant information about the procedure until the time of birth, the physician should refuse to perform the circumcision until such time as the parents

318. *See* Robert W. Enzenauer et al., *Decreased Circumcision Rate with Videotaped Counseling*, 79 S. MED. J. 717, 718 (1986).

319. *See* Christensen-Szalanski, *supra* note 285, at 856-67.

320. *Id.*

321. *See* E.B. Feehan, *Letter to the Editor*, 60 PEDIATRICS 566 (1977).

322. *See* Committee on Bioethics, *supra* note 131, at 314-16.

have been able to review the information fully and demonstrate to the physician that they understand the information. One group of physicians has suggested simply waiting twelve hours after birth before asking parents about circumcision, in order to provide an opportunity to discuss the procedure's advantages and disadvantages with the parents.[323] However, given the tremendous psychological and physical impact of becoming a parent, this waiting period is inadequate to allow the parent sufficient opportunity to absorb and analyze information regarding the circumcision procedure before making a decision. Some writers have questioned whether, given the perinatal emotional upheaval, parental permission can ever be truly free and informed in the neonatal context.[324] Indeed, one author (Svoboda) has accumulated a significant number of consent forms for neonatal circumcision, not a single one of which adequately discloses all significant risks to the procedure in a manner parallel to the disclosures which are commonly made for other surgeries.[325]

Unfortunately, current practice appears inconsistent with the voluntariness requirement as well. It is routine in the United States to ask a woman during one of the initial prenatal visits whether she desires circumcision for her child if it is a boy.[326] As noted above, offering a medically unnecessary surgery such as circumcision is unethical.[327] It is also a subtle form of coercion; offering circumcision to a mother can easily be interpreted as a recommendation.[328] Mothers are left with the impression that "it must be the thing to do, or our doctor would not have told us about it."[329]

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323. See generally A.G.M. Campbell et al., *Circumcision: A Balanced Report Based on Facts, Not Conjecture*, 5 PATIENT CARE 56 (1971).

324. *See generally* S. Mason, *Obtaining Informed Consent for Neonatal Randomized Controlled Trials—An "Elaborate Ritual"?* 76 ARCHIVES DISEASE CHILDHOOD F143 (1997).

325. Sample consent forms on file at the journal's office.

326. *See* R.S. Van Howe, *Why Does Neonatal Circumcision Persist in the United States?*, *in* SEXUAL MUTILATIONS: A HUMAN TRAGEDY 111 (G.C. Denniston & M.F. Milos eds. 1997).

327. *See* AMA, *supra* note 37, at 105; Canadian Medical Association, *supra* note 38, at 1176A.

328. *See* Van Howe, *supra* note 326, at 234; A. BRIGGS, CIRCUMCISION: WHAT EVERY PARENT SHOULD KNOW, 133-53 (1985).

329. *See generally* D. Hovsepian, The Pros & Cons of Routine Circumcision, 75 CAL. MED. 360 (1951).

Even more troubling is the common occurrence of parents being presented with the circumcision question for the first time when a mother is in labor at a hospital. Surgeon George Kaplan notes that "all too often the consent to circumcise is included in a sheaf of papers that the mother signs hurriedly on her way to the delivery room. No discussion has been held regarding the merits of the procedure or of the inherent risks."[330] Kaplan characterizes this practice as "inexcusable."[331] Raising the circumcision issue for the first time upon the mother's arrival at the hospital to give birth amounts to manipulation and coercion. Because the physician and the hospital benefit financially from the parent's decision, such a practice raises grave concerns about unethical profiteering.

Effective consent to elective, cosmetic surgery cannot arise unless and until the patient himself is capable of giving it. Infant males are clearly incapable of giving voluntary consent (and in fact uniformly howl in protest of the procedure), and without medical necessity and urgency, there is no justification for looking to a surrogate to give permission. Unlike cases involving medical necessity for treatment of a child, in the circumcision context there is simply no predicate for departing from the general rule that the patient himself must give voluntary consent to any incursion on his physical integrity by medical professionals. The AAP Committee on Bioethics sensibly recommends delaying elective, cosmetic surgery until a child is old enough to give consent, and this would apply to circumcision.[332] As previously mentioned, the Australian Association of Pediatric Surgeons has taken this position specifically with respect to circumcision,[333] as have scholars who have considered the issue.[334] Because, as discussed above, no sufficient reasons exist for not deferring the procedure, ethically and legally it *must* be deferred, given the harm caused by the procedure and the probability that as an adult the patient will most likely not desire it.

With all the compelling reasons to delay circumcision, it is necessary to examine why circumcision is performed at such a young age. For many years, two rationales supported the practice of circumcising right after

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330. *See generally* G.W. Kaplan, *Circumcision - An Overview*, 7 CURRENT PROBLEMS PEDIATRICS 1 (1977).

331. *See id.*

332. *See* Committee on Bioethics, *supra* note 131, at 315-17.

333. *See* Leditschke, *supra* note 248, at 1.

334. *See* Alderson, *supra* note 18, at 32.

birth. First, it was once thought that the newborn could not feel pain.[335] Although this has been proven false,[336] and the opposite - that newborns actually feel greater pain from the same trauma than do adults - has been proven true, some physicians still blindly adhere to the old myth.[337] Second, it was regarded as less costly to perform circumcision right after birth because general anesthesia is not used.[338] That rationale might have some force if the first rationale, that babies feel less or no pain, were true, but it is hard to imagine any medical professional seriously espousing this rationale today, when the babies-feel-no-pain myth has been destroyed. One would expect that medical professionals would not use ineffective anesthesia on older children and adults simply because it would be cheaper, and that no parents would knowingly agree to subject their infant to excruciating pain when that could easily be avoided, simply to save money.

But old habits die hard in the medical profession. In the case of children, rationality runs up against an additional obstacle - a pervasive, unconscious view of children as less than full persons and of childhood as simply a time to be gotten through, a prelude to adulthood rather than a period of life having independent worth, which should be as happy a time as society can make it. Medical personnel possessing this attitude may decide that pain in infancy is less cause for concern than pain in later life; adult pain is serious, but infant pain will be gotten over. So it may well be a lack of respect for newborns as persons and a lack of concern for their experience rather than any genuine medical rationale that compel physicians to perform circumcision in the neonatal period.[339]

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335. M. Fitzgerald & N. McIntosh, *Pain and Analgesia in the Newborn*, 64 ARCHIVES OF DISEASES IN CHILDHOOD 441 (1989); *see generally* Nancy Wellington & Michael J. Rieder, *Attitudes and Practices Regarding Analgesia for Newborn Circumcision*, 92 PEDIATRICS 541 (1993) (finding that 12% of physicians did not believe that newborns could feel pain and 35% believed that neonates could not remember pain); William L. Toffler et., *Dorsal Penile Nerve Block during Newborn Circumcision: Underutilization of a Proven Technique?* 3 J. OF THE AMERICAN BOARD OF FAMILY PRACTICE 171 (1990) (concluding that 29% of physicians did not believe the pain response to circumcision was significant).

336. *See* Anand & Hickey,, *supra* note 230, at 1326.

337. *See generally* G.N. Weiss & E.B. Weiss, *A Perspective on Controversies over Neonatal Circumcision*, 33 CLINICAL PEDIATRICS 726 (1994).

338. *See* Jayanthi, *supra* note 198, at 793.

339. *See* Alderson, *supra* note 18, at 30.

CONCLUSION

Infants do not have the capacity to give consent to any aspect of their medical care. Physicians may only obtain legally valid permission from parents to perform procedures on their incompetent children, provided full disclosure of all material information is made to parents who are able to understand the information and to appreciate the consequences of their decision, and provided that the parents are able to decide whether to grant their permission free from any manipulation or undue influence. Moreover, regardless of the motivations and desires of physicians and parents, the only interventions for which parents may grant their permission are those conferring benefits that clearly outweigh the short- and long-term costs for the infant patient.

Consent places physicians in a very delicate position, one that is appropriately governed by stringent ethical norms. Physicians should approach decision-making on behalf of a newborn with the greatest caution and with a strong presumption against intrusive procedures. Amputating a highly sensitive and functional part of the body is extremely intrusive and should be undertaken only in situations of urgent necessity. Neonatal circumcision as it is routinely performed in this country clearly does not satisfy this criterion. It is therefore unethical and unlawful, and no parental permission for the procedure should be effective. Moreover, even if it were permissible for physicians to give effect to parental permission for circumcision, physicians would be under a stringent obligation to their infant patients to ensure that any such permission is informed—voluntarily given based upon competent review of all relevant information. Available evidence suggests that physicians today routinely fail to fulfill this duty. In doing so, they discredit their profession and expose themselves to legal liability.

Consent to neonatal circumcision has not been directly considered by the courts; therefore, our analysis, out of necessity, relies on established legal precedents of cases that share common elements with neonatal circumcision. With near uniformity, these precedents indicate that any consent given for neonatal circumcision would not be valid. Court decisions are in part influenced by the culture in which they occur.[340] However, circumcision has gradually but steadily been falling out of favor in the past few decades. When the balance of public opinion shifts to opposing the practice, the legal system will likely become more accepting of lawsuits and lobbying for the protection of baby boys. Consequently,

340. *See* Svoboda, *supra* note 3, at 206-08.

the legal system will no longer be able to ignore the conflict between this practice and the legal and ethical duties of medical professionals. In the meantime, the medical community ought to hold its members responsible, and every medical professional should personally reexamine the ethics of the practice.

The persistence of routine neonatal circumcision in this country may be explained partly as cultural blindness, a blindness that afflicts medical professionals as much as it does the general population. Part of the explanation also lies in a disregard for the distinct personhood and the dignity of children. The analogy to sterilization of mentally retarded women is most telling; though once done routinely, primarily to avoid the social costs of creating wards of the state and of creating more disabled individuals, sterilization now requires court approval and a strong showing that it would be medically beneficial to the incompetent woman. Even in fairly compelling circumstances, courts have denied permission for sterilization of an incompetent patient. The change came about when we as a society began to respect the mentally disabled as persons and to accord them the dignity they are due as persons. We must now do the same for children, and that will mean ending the practice of routine infant male circumcision.