2

The Ethics of Neonatal Male Circumcision: Helping Parents to Decide

Leslie Cannold

The ethics of male circumcision has received little attention in the bioethical literature. In one of the few considerations of the subject, Michael and David Benatar (2003) investigate whether the practice can be justified by examining whether circumcision constitutes bodily mutilation, whether the absence of the child's informed consent makes it wrong, the nature and strength of the evidence regarding medical harms and benefits, and what moral weight cultural considerations have. The Benatars argue that a moral assessment of neonatal circumcision cannot be made without considering its medical costs and benefits. Having provided a thorough assessment on these grounds,[1] they conclude, on the basis of the evenly weighted evidence for and against the procedure, that it is a discretionary medical matter best left to parents to decide on the basis of their own values.

I agree with the Benatars' conclusion that neonatal circumcision is a decision rightly left in the hands of parents. To demonstrate that it is not, it would be necessary to show that the procedure was mutilation or otherwise threatened the health and safety of a child to a degree necessary to justify a societal override of what both legal and ethical precedents have long held to be both a parent's right and responsibility: to make judgments based on their own values about what is in their child's best interests. The Benatars' argue persuasively that neither charge, at least on current evidence, can be sustained.[2]

However, claiming that parents should retain the authority to make decisions for their infant boys about circumcision says little about how parents charged with such a decision ought to make it. Circumcision is an invasive medical procedure, and one function of informed consent is to ensure that patients are protected from harm with regard to such procedures. Because

infants cannot themselves consent to circumcision or other medical procedures, parents are charged with giving such consent on their behalf. Ensuring that consent is informed facilitates the fulfillment of their obligation to protect their child's best interests. These interests include the child's present and future physical and psychological health and well-being as well as his stake in becoming an autonomous agent in the future capable of making medical and other important life choices for himself.

In this chapter, I will discuss the range of issues—medical, ethical, social, and religious/cultural—that I believe parents must canvass and weigh up in order to give informed consent to circumcising their neonate.

INFORMED CONSENT AND PROXY DECISION MAKING

The notion of "informed consent" arose to describe decision-making procedures necessary to protect patients and research participants from harm. The U.S. Tuskegee syphilis study and the New Zealand "Unfortunate" cervical cancer experiment are only the most well-known examples of where failure to inform patients about the nature and risks/benefits of medical research or therapy caused serious patient harm. More recently, informed consent has become primarily understood as a means of protecting patient autonomy. If a patient autonomously authorizes her medical practitioner to undertake a particular intervention, then she has given her informed consent. The two important characteristics of a consent that is informed are that it is intentionally given by a patient with "substantial understanding and in substantial absence of control by others" (Beauchamp and Childress 1994, 143).

A proxy decision maker is required when a person lacks, either temporarily or permanently, the competence to consent for herself. In the case of neonates, parents are seen to be the most suitable people to act as proxies because—unless shown otherwise—they are assumed to have their child's best interests at heart. However, because neonates have never been autonomous, parents cannot make the circumcision decision on the basis of what they believe their son *would* want were he competent—a standard of decision making known as *substituted judgment*. Instead, Beauchamp and Childress (1994) argue that parents must make their decisions on the basis of what is in their child's best interests, as assessed by their evaluation of what benefits and burdens the intervention is likely to cause.

Because parents are deciding on circumcision for their neonate, the requirement to give informed consent to the procedure transfers to them. The informed consent requirement mitigates the child-patient's risk by obligating medical professionals to ensure parent-proxies have a substantial understanding of the risks and benefits of the procedure and have freely consented to it. At the same time, it provides parents with a clear standard against which their discharge of their duties as proxy medical decision makers can

be measured. Indeed, Ford (2001) argues that unless parents' consent for their children to have (nonemergency) medical interventions is fully informed, their decisions lack not just ethical but also legal standing.

So what specific issues must a parent gain a substantial understanding of, and give weight to, in order to make an informed decision about circumcising their neonate? In my view, these include considerations of a medical, ethical, social, and religious/cultural nature.

NEONATAL CIRCUMCISION: PARENTAL MOTIVES, PARENTAL CONSIDERATIONS

Parents have different reasons for considering circumcision for their neonate. For some parents, the question of whether or not to circumcise is a medical one, while for others social concerns (ensuring their son will look like his dad) are predominant. Historically, circumcision was a religious and cultural ritual, and both the Jewish and Muslim traditions continue to demand parents circumcise their children as young children.[3]

These different motives mean that not all parents will or should need to consider all the matters that may be of relevance to the decisions of some. To take the most obvious example, while the religious or cultural beliefs or affiliations of Jewish and Moslem parents may be the central, such beliefs and affiliations will not and need not feature in the considerations of parents with no such religious or cultural beliefs or ties. However, some aspects of the circumcision decision should feature in the consideration of all parents. Usually, these have included tangible factors like physical and financial risks, harms, and benefits (Beauchamp and Childress 1989, 171), but can—and insofar as circumcision is concerned, I would argue, should—take in social, psychological, and spiritual risks, benefits, and burdens of the procedure. This means that while requirements for informed consent vary among parents, there exists a minimum suite of considerations which all parents should consider relevant to their child's best interests. Parents must canvass such considerations for them to satisfy their responsibility to make an informed and voluntary decision about neonatal circumcision.

Medical

The position of leading medical organizations in the United States, Canada, New Zealand, and Australia (among others) is that there is no medical indication for routine neonatal circumcision (Circinfo.org 2003; CIRP 2004). Moreover, the review of the medical evidence provided by the Benatars shows that the costs and benefits of circumcision are more or less evenly balanced. How should parents respond to these conclusions, which can be summed up as "there are no medical reasons for or against circumcision"?

Declines in the neonatal circumcision rate in many countries following the medical community's rejection of it as a routine procedure, suggest that for many parents such authoritative conclusions about the procedure's lack of *net* medical value will be decisive.[4] However, this will not be the case for all parents. This is because, in keeping with their obligation to make the decision based on their assessment of their own child's best interests, some parents will find, among the costs and benefits of circumcision, something they deem particularly relevant to the decision they make about their child. For instance, parents of a premature baby forced to endure numerous painful medical interventions in the early weeks of his life may see the primary interest of their child as being the avoidance of further unnecessary pain,[5] and reject neonatal circumcision on this basis. Alternatively, a father with a long history of painful urinary tract infections (UTIs) may be extremely concerned to see his son avoid this burden as in infant. Having noted that existing medical evidence shows circumcision can protect against childhood UTIs, he may deem the procedure to be in his child's best interests.[6]

Ethical

Beauchamp and Childress (1994) argue that unless parents can answer the question "What would the patient want in this circumstance?" they are unable to make decisions for their infant according to the "substituted judgment" standard, or in the way they would for their baby son if he had once been competent. It is because the newborn has never been competent, and therefore that there is no basis for a judgment of autonomous choice, that parents must decide for their infants on the basis of their own assessment of their child's best interests.

However, their newborn's current incompetency does not mean that parental concerns about their child's autonomy and privacy should disappear from their considerations about circumcision. This is because most newborns will one day acquire the competency necessary to make autonomous decisions about circumcision and other medical and life issues. Indeed, as Ross has argued, one of the obligations parents have is to "promote their child's growth and development" so they can become such independent autonomous agents (1993, 1).

Anticircumcision literature abounds with anecdotal evidence that some adult men who are unhappy about being circumcised feel angry about the fact that their parents' assumption of the circumcision decision deprived them of the capacity to make their own autonomous choice about the procedure.[7] The quality of information on this question, even in polling, is low.[8] However, there seems enough evidence to suggest that an indeterminate number of men will express dissatisfaction with their circumcised status, and that among these will be men angry about being compelled to live with

the consequences of a decision they had no input into or control over and which they cannot alter, at least not easily or well.[9]

To answer the charge that parents have no right to make the circumcision decision for their neonate (whether the charge is made by a disgruntled adult son circumcised as a neonate or by organized opponents of neonatal circumcision) requires consideration of the validity of reasons parents have for believing that the decision about circumcision must be made when the child is an infant, and therefore by them on their child's behalf. Certainly there are nonemergency medical decisions that parents are justified—on the grounds of the child's best interests—in making before the child is old enough to give his own consent. The question is, is circumcision one of them?

Before answering this question, it is necessary to discuss the question of child competency. Competency, which Beauchamp and Childress define as "the ability to perform a task," is not an all-or-nothing affair in either children or adults. Instead it makes sense to talk about a person's competency to undertake a particular task: in this case, consenting to circumcision. When might a boy obtain the competence to make the circumcision decision himself? The courts, political decision makers, and society at large have devoted attention to the question of when children are competent to decide about weighty medical manners,[10] because of the challenge antichoice activists consistently pose to the validity of the decisions young women make about abortion.[11] In the landmark English *Gillick* case, the judge ruled that children under 16 should be deemed competent to consent to medical treatment when they are capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed (Devereux 1991). Beauchamp and Childress state the requirements for competence in more detail, but contend similarly that if the child can understand the information material to their decision, make a judgment about it in light of his values, intend a certain outcome, and freely communicate his wishes to his doctor, then he is autonomous enough to make the decision by and for himself. While there is not a great deal of evidence available about the validity of children's consent to medical treatment, one survey found that the capacity of most 14-year-olds to give informed consent was indistinguishable from that of adults (Devereux 1991, 300). Thus, it is likely that, somewhere around the age of 14, boys will be competent to decide for themselves about circumcision.

It seems valid for parents to choose circumcision for their neonate when the benefits of the procedure they hope to gain for their child—and which they believe are in his best interest—will be reaped partially or in total prior to the child becoming competent to make the decision himself. Circumcising to protect their infant and young child from UTIs is a good example of this sort of choice. However, the same cannot be said if the claimed medical advantage parents find compelling is likely to be reaped by their child *after* he becomes competent to decide about circumcision himself. The reduction in

risk of human immunodeficiency virus (HIV) transmission is a good example of this sort of advantage. If there are no compelling reasons why—in order to serve the child's best interests—parents need to circumcise before the child attains competence, then parents should choose to foster their child's future autonomy by refraining from making the circumcision decision for him. Instead, they should wait until he has attained the capacity to decide for himself, and by so doing preserve what Feinberg (1980) calls the child's right to an "open future."[12]

Social

There are two commonly cited social reasons that parents seek circumcision: the belief that the circumcised penis is easier to keep clean,[13] and a desire for the child to "look like dad" or other male family members.[14]

Hygiene

There is no evidence that the uncircumcised penis poses significantly more difficulties either for parents or, as a boy grows, to the child himself, to keep clean. Indeed, in the early years, retraction of the foreskin is contraindicated, making the hygiene requirements of uncircumcised boys identical to those without foreskins. Only as the child grows and can, by himself and with ease, retract the foreskin does this need to be done on a daily basis for cleaning. For most boys, retraction will become possible somewhere between the ages of 5 and 10. The question is, once retractable, are the cleaning requirements of the uncircumcised penis onerous and, if so, does this justify a parents' decision to circumcise?

The claim that the hygiene demands of intact children are more onerous than circumcised ones is highly contestable. Most children have a nightly bath or shower and, when retraction becomes possible, the cleaning process is approximately a 5- to 10-second operation. Given this, it is hard to imagine how either the performing of this task by the parent, or the job parents have to remind the child to do it, could be called onerous (or any more onerous than cleaning, or reminding them to clean, behind their ears!). Thus it seems to me that the belief that hygiene requirements of an uncircumcised boy are more onerous than those of a circumcised child is a false one—and making a decision to circumcise on the basis of it is inadequately informed. Moreover, the solution of circumcision to the parental problem of hygiene may fall foul of demands for consistency. As one five-year-old American boy noted in response to his mother's explanation that some parents circumcised their sons because they worried that if they didn't, their boys wouldn't keep clean: "Well, that's dumb mom!! What are they gonna do? Cut their butts off, too?!"[15]

In addition, parents who choose circumcision to relieve themselves of the burden of caring for a child with an uncircumcised penis may be acting

against their obligation to make the circumcision decision on the basis of their assessment of their child's best interests rather than their own. In instances where there are significant differences in the requirements of caring for a particular child who has or does not have a particular intervention (with one way of proceeding offering outcomes that are significantly less burdensome for parents than others), parents may be able to mount a credible case for or against that intervention on the grounds that their well-being and the child's are interdependent, and therefore what is good for them or the family unit as a whole is, for that reason, also good for the child.[16] However, given the facts about the hygiene requirements of children with foreskins, the circumcision decision clearly doesn't qualify.

Just Like Dad

Logically, there seems no reason for a boy to consider any difference between his penis and that of his Dad or other male family members as any more remarkable or significant that any of the myriad of other physical dissimilarities between himself and these others. Further, there seems no evidence that children younger than three notice genitals at all, nor that those older than this take any notice of their or other men's foreskins or—if they do—attribute significance to these differences.[17] My husband is circumcised, but his brother—only four years younger—is not, due to changes in standard Australian hospital practice around the time of their births. Neither man recalls any issue arising over the difference in the look of their members or over the difference between my husband's brother's intact penis and that of their father, who was circumcised. Anecdotal evidence suggests that many adult men are not even sure whether their fathers are or were circumcised. Where children do notice, the meaning they make of the differences they observe seem highly variable. One father tells how his boy was three before concluding—his foreskin having retracted of its own accord—that he was "just like Daddy." Daddy, however, was circumcised. The boy is now close to five, but according to his father is still unaware that he is "different from Daddy" (Ray 1997).

What this suggests is that it may be Dad's or other male relatives' awareness of and anxiety about the difference that motivate parental decisions to circumcise, rather than anticipation of and worry about the child's anxiety on this question. While again, the interactive nature of parent–child relations makes it possible that an anxious father could transmit this anxiety to his son, circumcising in order to rule out this possibility seems a clear case of treating the wrong patient. It would be better to attempt to educate fathers to see the differences in penile appearance between themselves and their sons as just one of the many that do and will continue to mark both their appearances and characters. For in the same way that decisions to circumcise made to ease the perceived hygiene burden of boys with foreskins violate

parental obligations to make such choices to foster their sons' best interests, so too do decisions made to ease parental anxieties about bodily differences.

Cultural/Religious

A number of religions require circumcision. In Islam there seems to be general agreement that circumcision, while encouraged and widely practiced, is not essential, though in Judaism, circumcision is deemed an essential mark for all males. Those who refuse to mark their children thus or, if they are converts, to be circumcised themselves, will—according to the Torah—be "cut off from their kin."[18] While Jews are increasingly questioning the practice of circumcision, it is fair to say that those who believe there is scriptural justification for not undertaking it and are refusing to do so remain in the minority.[19] Thus, for Jewish parents who believe in the importance of following the biblical injunction to ritually circumcise their son and who want their son to be accepted as a member of the Jewish community, circumcision is—in most instances—required.

What does this mean for Jewish parents seeking to make a decision about circumcision for their son? For devout Jews, a failure to circumcise their infant son would clearly be seen as a dereliction of their duty to foster their child's best interests by ensuring he enters properly—meaning through circumcision on the eighth day of his life—into the covenant with God. However, even for Jews who see the requirement to circumcise neonatally as fatally inconsistent with their other values,[20] or even unjustified on theological grounds, the best-interest requirement can mean they feel compelled to circumcise anyway. This is because refusing to circumcise their child may lead the Jewish community to which they belong and the wider Jewish community to withhold recognition and acceptance of their child as a Jew, to view them as negligent for refusing to circumcise and, consequently, to exclude or marginalize them all.[21] Parents who see Jewish religious beliefs or identity as their child's birthright or valued gift, and themselves as morally obliged to provide such a gift, would be hard-pressed not to see neonatal circumcision to be in their child's best interests.

OBJECTIONS

I have argued that while parents are entitled to make the decision to circumcise their male neonate, they are not without responsibilities in the way they go about making this choice. As proxy decision makers, parents are obliged to give informed consent to the procedure being undertaken and, through doing so, ensure that they only authorize the procedure if it can clearly be shown to be in their particular child's best interests.

Female Genital Mutilation

What does this account suggest about how parents should approach the issue of female genital mutilation (FGM)? Specifically, if the conclusion that parents' religious or cultural beliefs, or parental desires to retain membership in a religious or cultural community, justify male circumcision, doesn't consistency require that parental authorization of FGM be similarly respected?

The simple answer is no. The entitlement parents have to decide about male circumcision is accorded because the procedure is not one that threatens the child's health or well-being. The same cannot be said of FGM, in which anything from part of the clitoris to the entire external female genital organs are excised, leading to—at a minimum—pain for a woman during urination, sex, and/or childbirth, and in a worst-case scenario, the need for surgical intervention in order for a woman to have sex and to give birth. As well, women who have been victims of traditional FGM are at higher risks of pelvic infections, hemorrhaging, obstructed child labor, HIV infection, and even death (Devine et al. 1999). Comparing traditional forms of FGM to male circumcision, according to one commentator, is like equating ear piercing to penectomy (Coleman 1998, 736).

However, the Benatars (2003) argue that the excision of the clitoral prepuce is "anatomically neither more nor less radical a procedure than removal of the penile foreskin," though they do note that while there is some evidence about the medical value of male circumcision, there is none, at least thus far, about the benefits of removing female preputial tissue. *If* it is true that the excision of the clitoral prepuce is analogous to the removal of the penile foreskin, then they are right to suggest that, should evidence of medical benefits for this procedure be discovered, consistency would require that in instances where cultural reasons suffice for undertaking the latter, they should also justify the former. Certainly, I would agree with them that where cultural reasons justify neonatal male circumcision, they would also justify the sort of clitoral "nicking" procedure proposed in the Seattle compromise.[22]

One Parent or Two? How Many Parents Constitute Consent?

I have argued that the only justification for state interference in parents' medical decisions about their children is when those decisions can clearly be shown to threaten the child's health or safety. But what of instances where parents disagree about whether a particular intervention is in their child's best interests? Specifically, when parents disagree about circumcision, is it justified for the state to intervene and, if so, to what end?

Recently, some anticircumcision activists have begun lobbying for legislation requiring doctors to obtain consent from *both* a child's parents before circumcising their neonate. In Australia, the call for two-parent consent

followed a case where an Egyptian father circumcised his two children, ages 5 and 9, against their Australian Aboriginal mother's wishes. The police prosecuted the man for assault, but newspaper reports often failed to reveal that the charges were not grounded in his pursuit of circumcision without his wife's consent, but because a Family Court order existed that specifically prohibited the boy's father from harming them during contact visits.[23] It is hard to escape the feeling that those pursuing such legal change are doing so in order to increase the difficulty parents face in circumcising their child, rather than to protect the best interests of children. While anticircumcision activists would, of course, argue that making it harder for parents to choose circumcision is in the best interests of all male children, acting to whittle away the freedom of parents to make their own informed decisions on the matter is contrary to the ethical and legal requirements of the circumcision decision, which are that parents have the right and responsibility to choose for their own child on the basis of what they believe to be in their particular child's best interests.

However, when parents fail to resolve disagreements about matters of critical importance to the child's health and welfare—and here I would include circumcision—they invite state interference (typically in the form of the Family Court) to examine the evidence and make a ruling. The idea that is at work here, affirmed in numerous U.S. court decisions over the years, is that there is a subjective element to the determination of what constitutes a child's best interests. Indeed, it is this subjective element that has led the courts to leave decisions in which the child's health and safety are not at issue to the parents for them to make according to their own values. But where parents can not agree about serious matters, there is no alternative—and courts should not hesitate—to step in and produce a "trumping" third-party judgment about what is "best."[24]

In one such case, the objection of a secular English mother to the circumcision of her five-year-old son by his religious father was upheld on the basis that she was primarily raising the boy and doing so in a secular fashion, thereby making circumcision against his best interests. The father appealed the case, but lost.[25] However, the court noted that while circumcision was among a "small group" of "important decisions" that requires the consent of both parents, disagreement between parents about such matters would be settled by the courts on the basis of judgments on the individual facts of a case about what constituted a particular child's best interests.[26] Such rulings in other words, do not and should not be understood to be passing blanket judgments on circumcision, but rather to be applying the best-interest test in the absence of an agreement between parents about how to do so. Such an approach suggests that the state has the same responsibility as parents to ensure they gain a substantial understanding of the issues involved in order that it can make an informed and voluntary decision about whether the procedure will serve the particular child's best interests.

CONCLUSION

While parents are legally and ethically responsible for decisions regarding neonatal circumcision, this does not mean they lack responsibilities in regard to their decision. Parents are required to make decisions about the procedure in a substantially informed and voluntary manner, and at a minimum to consider the medical and ethical implications of the procedure for their child. An examination of the full range of motives for parental decisions to circumcise reveals that only some medical and religious or cultural ones seem to meet the requirement that such decisions be made to further the best interest of the child, are not based on false beliefs, and fulfill the ethical requirement that parents assume the decision for their incompetent child only when the benefits they see to be in their child's best interests are to be reaped prior to the child becoming competent to make the decision himself.

NOTES

I am indebted to Neil Levy and Stephen Clarke for helpful comments on earlier drafts.

1. The Benatars consider the issues of neonatal operative and postoperative pain; surgical complications of the procedure; and the relative risks of penile cancer, urinary tracts infections, STDs, HIV, phimosis, and paraphimosis in circumcised and uncircumcised boys. They also look at the evidence for claims that genital hygiene is increased in circumcised men relative to those who have not been circumcised, as are the chances of female partners avoiding cervical cancer.

2. One possible counter to this conclusion would be if it could be conclusively demonstrated that circumcision consistently and significantly reduced male sexual pleasure. In this instance, an argument may be able to be made that the procedure does seriously threaten a child's health and safety and so does constitute an unjustified assault on their person. However, as the Benatars rightly note, there is little objective information about the impact of circumcision on male sexuality, and what does exist is contradictory (with some studies saying circumcision has no impact on male sexual pleasure, others concluding it does, while still others report less sexual dysfunction in circumcised males and a preference for circumcised men among female partners (Laumann, Masi, et al. 1997; Masters and Johnson 1966). As a consequence of this uncertainty, I have left the matter of sexual pleasure to one side of this discussion.

3. The Jewish prescription is for ritual circumcision eight days after the child's birth unless the child is unhealthy, in which case the procedure is prohibited. The Islamist tradition is more flexible. While the preferred time is the seventh day after birth, circumcision can be carried out up to 40 days after the child is born or thereafter until the age of 7 years, depending upon the child's health and circumstances (Islam Online 2004).

4. Patel (1966) argues that where medical practitioners oppose the procedure, approximately 20 percent of neonate boys will be circumcised at the insistence of their parents. It is possible, however, that such figures will vary on a country-by-country basis, with rates likely to be higher, regardless of medical attitudes, in countries with long cultural/religious histories of the practice and lower in those without.

5. Few dispute the ability of newborns to experience pain, or that circumcision—the actual procedure and its aftermath—causes it. While interventions deemed to be effective in relieving the pain of circumcision and the aftermath are available, they are not always used, as disagreement exists about ease of administration, risks involved in use in newborns, and

the amount of pain caused by the interventions themselves (Benatar and Benatar 2003, 36–37).

6. The Benatars' (2003) review of the evidence led them to suggest circumcision provides a "small but real" benefit of lowering the incidence of UTIs.

7. Circumcision Information Australia notes that they have "received many complaints from adult men who are unhappy about having been circumcised as infants or children. . . . Only the owner of the penis has the right to decide if he would like its appearance, structure and function altered by circumcision or any other needless procedure." Or as one man on the British anticircumcision website Norm.UK.org put it, "I've never expressed my outrage to anyone before, but I do know that the realisation in my late teens that I had had a very important bit of me removed unnecessarily at someone's whim, had a profound effect on me."

8. The one study of psychological consequences reported in the literature was done by Hammond (1999). Among the 546 men he surveyed, he found circumcised men reported "emotional distress, manifesting as intrusive thoughts about one's circumcision, included feelings of mutilation (60%), low self-esteem/inferiority to intact men (50%), genital dysmorphia (55%), rage (52%), resentment/depression (59%), violation (46%), or parental betrayal (30%)." However, the recruitment method of the survey, from among men who had contacted anticircumcision organizations, raises serious questions about the applicability of the findings to the general population of circumcised men.

9. There are men who attempt to reconstruct their foreskin using both surgical and nonsurgical methods. For surgical methods, see Greer, Mohl, et al. 1982; Penn 1963; and Goodwin 1990. For nonsurgical, see Bigelow 1995.

10. By age 3 or so, most children are competent to make minor medical decisions like whether or not they want a bandage for a skinned knee. The medical decisions we are discussing here are on the other end of the weightiness scale and therefore require a higher level of competence.

11. My claim here is not that antichoice activists pursue these issues in the court because of sincere concern about the competence of young women to consent to abortion: parental notification/consent laws are a well-established prong of antichoice strategy designed to reduce the incidence of abortion through the creation of all possible legal, bureaucratic, and practical obstacles to women obtaining the procedure "on the ground." All I am arguing here is that when these laws have been challenged, one of the main issues the courts have examined is the competence of the young woman to consent to her own medical treatment: a competence that—if universal—would render such "squeal" laws an unjustified invasion of the woman's entitlement to privacy and/or autonomy. See Puzella 1997 on U.S. law and Devereux 1991 for the situation in the United Kingdom and Australia.

12. One counter to this argument is the contention that neonatal circumcision is a less risky/painful procedure than circumcision done on an older child or adult. However, it seems to me that unless conclusive evidence that this was the case could be presented, which my reading of the current literature suggests it cannot, this argument must fail. Another objection, suggested by Parfit's (1984) example of a man about to undergo painful surgery, might be that even if the pain of circumcision in adulthood is *less* than that experienced by an infant, parents may feel it better to get this pain over with in infancy when the child won't remember it, rather than leave it in the future as pain *to be* experienced and remembered. However, the comparison between past/future benefits (including the experience of pain and memory of that experience) is false because it presumes what is at issue: whether the child, once an adult, will choose circumcision. While it certainly could be the case that an uncircumcised child who decides when he becomes competent that he wants circumcision might resent his parent's failure to have made the choice for him when he was a child because his pain would have been in the past and he would be unable to recollect it, the uncircumcised child who does not wish to be circumcised would not appreciate his parent's decision because even though his pain is in the past and he doesn't recall it, he has been left with the unwanted outcome of their decision: circumcision.

13. Hygiene has both health and social dimensions. Failing to bathe, for instance, may leave you more open to infection, but also makes you smell unpleasant to others. After some consid-

eration, I have decided to describe hygiene as a social consideration because the medical literature does not describe smegma, the creamy yellow sebaceous material that is secreted by the glans and often accumulates in clumps under the foreskin, as a medical problem nor suggest that it indirectly causes any medical problems, little less those that would indicate circumcision. See Simpson 1998.

14. See, for example, Dickey 2002.

15. From http://www.mothersagainstcirc.org/easy.htm.

16. Such discussions arise in discussions of the legitimacy of parents allowing their minor children to become organ donors for relatives. Some experts contend that parents should be allowed to make such proxy decisions about organ donation for their incompetent child grounded not only in the donor child's best interests, but to further the best interests of the family as a whole. See Morley 2002.

17. Freud theorized that somewhere between the ages of 3 and 6, boys become enamored with their mothers and fear castration by their fathers for this love interest and their newfound interest in masturbation. However, Freud's claim is that what boys notice at this age is the difference between their own genitals and those of girls (whom they see as castrated), not differences between their foreskin status and those of other men. Thus, leaving aside the question of the validity of Freudian theory on this point, it is not relevant to the claims I am making here.

18. The relevant passage, from Genesis 17, reads as follows: "As for you, you and your offspring to come throughout the ages shall keep my covenant. Such shall be the covenant between me and you and your offspring to follow, which you shall keep: Every male among you shall be circumcised. You shall circumcise the flesh of your foreskin and that shall be the sign of the covenant between me and you. And throughout the generations every male among you shall be circumcised at the age of eight days. . . . Thus shall my covenant be marked in your flesh as an everlasting pact. And if any male who is uncircumcised fails to circumcise the flesh of his foreskin, that person shall be cut off from his kin. He has broken my covenant."

19. For the religious justifications for not circumcising, see Goldman 1998 and Moss 1991. However, while there is no doubt that a growing number of Jews are rejecting the practice, even Goldman acknowledges that Jewish parents who don't circumcise are in the minority (see Clemente 1998).

20. Jewish parents with feminist beliefs, for instance, can find the practice offensive or unnecessary, given the lack of a similar ceremony by which girls are welcomed into the Jewish community and a sanctified relationship with God. Indeed, in some Jewish communities, alternate nonsurgical ceremonial practices are being developed to serve these purposes for both boy and girl babies (see, for example, Karsenty 1988).

21. I note here that an uncircumcised Jew is still considered a Jew and therefore I am speaking of a social withholding of recognition and acceptance rather than a legal one.

22. The "Seattle compromise" was a procedure developed by a medical center attempting to manage requests from immigrant Somalian mothers to have their daughters circumcised. The procedure, which would have appeased some mothers, was designed to draw blood but not cause any lasting damage to the child's genitals. See Coleman 1998.

There is one important disanalogy between FGM and male circumcision, which is that while FGM is a cultural practice intended to inhibit and/or control the female body and female sexuality, male circumcision is intended as a ritual of inclusion designed to welcome men—and only men—into a special relationship with God. Coleman (1998), a supporter of the Seattle compromise, sees the patriarchal underpinnings of the practice—its essential aim to ensure the physical and cultural domination of women—as the reason why Americanization of the immigrants who practice it will and should lead to it withering away in a few generations (the compromise representing a "transitional" measure). However, I am unable to see how the patriarchal nature of FGM as against circumcision provides grounds for altering my conclusions about the range and limits of parental freedom to choose FGM, clitoral nicking, or male circumcision for their children.

23. For an account of the case by an anticircumcision group, and several newspaper articles in which it was reported, see CIRP 2004.

24. U.S. courts have gone even further than this. In *Bellotti* v. *Baird*, the Supreme Court accorded itself the right to authorize a young woman's abortion, even in cases where one or both parents have refused consent and the woman is deemed incompetent to consent herself, when it believes the procedure is in her best interests. The implied view of such judgments seems to be that in the absence of agreement between parents or between a parent and (older) child about what is in the child's best interests, the courts must and will decide. See Lurvey 1990 and Puzella 1997.

25. Re J (child's religious upbringing and circumcision). Jane Maynard Barrister, Family Court. 1 FCR 307 [2000].

26. One of the judges, Dame Elizabeth Butler-Sloss P., argued that small group of important decisions included sterilization and the change of a child's surname.

REFERENCES

Beauchamp, T. L., and J. F. Childress. 1989. *Principles of biomedical ethics*. 3rd ed. New York: Oxford University Press.

———. 1994. *Principles of biomedical ethics*. 4th ed. New York: Oxford University Press.

Benatar, M., and D. Benatar. 2003. Between prophylaxis and child abuse: The ethics of neonatal male circumcision. *American Journal of Bioethics* 3 (2): 35–48.

Bigelow, J. 1995. *The joy of uncircumcising! Exploring circumcision; History, myths, psychology, restoration, sexual pleasure and human rights*. 2nd ed. Aptos, CA: Hourglass.

Circinfo.org. 2003. Case study: Forced circumcision in Queensland; Middle Eastern father subjects Australian boys to Islamic rite. *Circumcision Information Australia*, "Legal and Ethical Issues," http://www.circinfo.org/ethics.html.

CIRP. 2004. Circumcision: Medical organization official policy statements. December 3. *Circumcision Information and Resource Pages*, http://www.cirp.org/library/statements.

Clemente, A. L. 1998. Circumcision no longer automatic in Jewish households. *Grand Rapids Press*.

Coleman, D. L. 1998. The Seattle compromise: Multicultural sensitivity and Americanization. *Duke Law Journal* 47:717–83.

Devereux, J. 1991. The capacity of a child in Australia to consent to medical treatment: *Gillick* revisited? *Oxford Journal of Legal Studies* 11 (2): 283–302.

Devine, C., C. R. Hansen, R. Wilde, et al. 1999. Female genital mutilation. In *Human rights: The essential reference*, ed. Hilary Poole. Phoenix: Oryx Press.

Dickey, N. 2002. To circumcise or not to circumcise . . . Many parents are asking the question. *Medem*, http://www.medem.com/msphs/msphs_drdickeycolumns_detail.cfm?article_ID=ZZZGMO72B6D.

Feinberg, J. 1980. The right to an open future. In *Whose child? Children's rights, parental authority, and state power*, ed. W. Aiken and H. LaFollette, 124–53. Totowa, NJ: Rowman and Littlefield.

Ford, K.-K. 2001. "First, do no harm": The fiction of legal parental consent to genital-normalizing surgery on intersexed infants. *Yale Law & Policy Review* 19:469–88.

Goldman, R. 1998. *Questioning circumcision: A Jewish perspective*. Boston: Vanguard.

Goodwin, W. 1990. Uncircumcision: A technique for plastic reconstruction of a prepuce after circumcision. *Journal of Urology* 144:1203–05.

Greer, D. M., Jr., P. C. Mohl, et al. 1982. A technique for foreskin reconstruction and some preliminary results. *Journal of Sex Research* 18 (4): 324–30.

Hammond, T. 1999. A preliminary poll of men circumcised in infancy or childhood. *British Journal of Urology International* 83, suppl. 1: 85–92.

Islam Online. 2004. Medical ethics of male circumcision. February 13. http://www.islamonline.com/cgi-bin/news_service/fatwah_story.asp?service_id=196.

Karsenty, N. 1988. A mother questions *brit milla*. *Humanistic Judaism* 16 (3): 14–21.

Laumann, E., C. Masi, et al. 1997. Circumcision in the United States: Prevalence, prophylactic effects, and sexual practice. *Journal of the American Medical Association* 277 (13): 1052–57.
Lurvey, I. 1990. How many parents constitute parental consent? *Family Advocate* (Fall): 52–53.
Masters, W. H., and V. E. Johnson. 1966. *Human sexual response*. Boston: Little, Brown.
Morley, M. 2002. Proxy consent to organ donation by incompetents. *Yale Law Journal* 111 (5): 1215–49.
Moss, L. B. 1991. The Jewish roots of anti-circumcision arguments. Presentation at the Second International Symposium on Circumcision, April 30–May 3, San Francisco, California.
Parfit, D. 1984. *Reasons and persons*. Oxford: Clarendon Press.
Patel, H. 1966. The problem of routine circumcision. *Canadian Medical Association Journal* 95: 576–81.
Penn, J. 1963. Penile reform. *British Journal of Plastic Surgery* 16:287–88.
Puzella, C. 1997. Abortion rights of minors, parental consent and parental notification. *Journal of Contemporary Legal Issues* 11 (642): 642–47.
Ray, M. G. 1997. Like father, like son. http://www.mothersagainstcirc.org/Like-Son.htm.
Ross, L. F. 1993. Moral grounding for the participation of children as organ donors. *Journal of Law, Medicine & Ethics* 21 (2): 251–57.
Simpson, E. T. 1998. The management of the paediatric foreskin. *Australian Family Physician* 27 (5): 381–83.