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Cultural Bias in American Medicine: The Case of Infant Male Circumcision

Brian D. Earp and David M. Shaw

ABSTRACT

In 2012 the American Academy of Pediatrics (AAP) released a policy statement and technical report stating that the health benefits of newborn male circumcision outweigh the risks. In response, a group of mostly European doctors suggested that this conclusion may have been due to cultural bias among the AAP Task Force on Circumcision, in part because the AAP's conclusion differed from that of international peer organizations despite relying on a similar evidence base. In this article, we evaluate the charge of cultural bias as well as the response to it by the AAP Task Force, focusing on possible sources of subjective judgments that could play into assessments of benefit versus risk. Along the way, we discuss ongoing disagreements about the ethical status of non-therapeutic infant male circumcision and draw some more general lessons about the problem of cultural bias in medicine.

INTRODUCTION

In 2012 the American Academy of Pediatrics (AAP) released a policy statement and technical report in which it concluded that the "health benefits of newborn male circumcision outweigh the risks."[1] In contrast to most policies issued by the AAP, this one proved controversial, not only in the United States but internationally. Part of the reason for the controversy was that its primary conclusion concerning benefits and risks differed from that of previous AAP task forces: while previous task forces had acknowledged both positive and negative aspects to newborn circumcision (with earlier policies recommending against the procedure and later policies adopting a more neutral stance), none had found that the negatives were outweighed by the positives.[2] More striking, however, was the fact that this same conclusion differed from that of all contemporary peer organizations—that is, national pediatric or general medical societies in other countries with comparable public health environments—despite relying on a similar evidence base.[3] Following the release of the AAP documents, international critics raised concerns regarding how the main conclusion had been reached (see table 1).[4]

The most prominent criticism came in the form of an article entitled "Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision," authored by a large group of pediatric and other health authorities from mainland Europe, the United Kingdom, and Canada. According to these authors, "only 1 of the arguments put forward by the [AAP] has some theoretical relevance in relation to infant male circumcision; namely, the pos-

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sible protection against urinary tract infections in infant boys, which can easily be treated with antibiotics without tissue loss."[5] According this view, since approximately 100 circumcisions would be needed to prevent one urinary tract infection (UTI),[6] and since the same theoretical UTI could be treated nonsurgically—as it would be if the child were female—without significantly increasing the absolute risk of serious adverse consequences, most boys with a normally developing anatomy should expect to receive no net medical benefit from circumcision prior to their sexual debut.

The other claimed health benefits, according to the critics, including a reduced risk of female-to-male heterosexually transmitted human immunodeficiency virus (HIV) and penile cancer, "are questionable, weak, and likely to have little public health relevance in a Western context, and they do not represent compelling reasons for surgery before boys are old enough to decide for themselves."[7]

Assessing Benefit and Risk

Let us first assess the empirical disagreement concerning benefits and risks. Bostrom and Ord have proposed a "reversal test" for weighing alternative policy options that is useful for framing such an analysis.[8] Consider the following question: If the AAP had recommended *not* performing circumci-

TABLE 1. Key Reasons for International Skepticism Regarding the 2012 AAP Findings

1. Internal inconsistency
   The AAP technical report states that "the true incidence of complications after newborn circumcision is unknown"—due to such problems as inadequate follow-up and conflicting diagnostic criteria—but nevertheless states that the benefits of the surgery outweigh these unknown risks.[1]
2. Questionable methodology
   The report does not mention any formal procedure used to assign weights or values to individual benefits and risks, nor does it mention any heuristic by which these could be directly and meaningfully compared, suggesting that no such procedure was used. The AAP Task Force stated in a later publication, the "benefits were felt to outweigh the risks."[2]
3. Underestimation of adverse consequences
   The AAP Task Force did not consider the most serious complications associated with circumcision, typically documented in case reports or case series, as these were excluded from their literature review.[3]
4. Inadequate description of penile anatomy
   The AAP Task Force did not describe the anatomy or functions of the foreskin (the part of the penis removed by circumcision), suggesting that it did not consider this genital structure to have any inherent value. If the foreskin does have value, however, its removal is itself a harm, and this must be factored into any benefit-risk analysis.[4]
5. Inappropriate use of research findings
   The AAP Task Force conflated findings from studies assessing the effects of adult circumcision in sub-Saharan Africa (regarding, e.g., HIV transmission and sexual function) with findings pertaining to newborn circumcision in the U.S., without demonstrating that the two procedures or environments are appropriately analogous.[5]

NOTES

1. AAP, "Male Circumcision (Technical Report)," *Pediatrics* 130, no. 3 (2012): e756-85, e757.

2. AAP, "The AAP Task Force on Neonatal Circumcision: A Call for Respectful Dialogue," *Journal of Medical Ethics* 39, no. 7 (2013): 442-43, 442.

3. See, e.g., J.S. Svoboda and R.S. Van Howe, "Out of Step: Fatal Flaws in the Latest AAP Policy Report on Neonatal Circumcision," *Journal of Medical Ethics* 39, no. 7 (2013): 434-4.

4. The implicit perspective of the AAP Task Force appears to be inconsistent with the value typically assigned to the foreskin in societies where most men retain one (and thus have personal experience with the relevant tissue). The foreskin is a highly touch-sensitive, functional sleeve of tissue that can be manipulated during sex and foreplay: it is therefore *prima facie* reasonable to regard it as having value (for extensive discussion, see B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56. The apparent view of the AAP Task Force is also inconsistent with normative medical evaluations regarding other nondiseased body parts: see J.M. Hutson, "Circumcision: A Surgeon's Perspective," *Journal of Medical Ethics* 30, no. 3 (2004): 238-40. Consider the female genital labia, for instance, whose functional, sensory, and other attributes would be fully described in any comparable report discussing the merits and demerits of excising them: see e.g., M.P. Goodman, "Female Genital Cosmetic and Plastic Surgery: A Review," *Journal of Sexual Medicine* 8, no. 6 (2011): 1813-25.

5. M. Frisch et al., "Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision," *Pediatrics* 131, no. 4 (2013): 796-800, 796.; J.A. Bossio, C.F. Pukall, and S. Steele, "Review of the Current State of the Male Circumcision Literature," *Journal of Sexual Medicine* 11, no. 12 (2014): 2847-64.

sion (because its primary health benefit in childhood could be achieved less invasively and in a more targeted manner via treatment with antibiotics, as noted by the critics), would any significant medical harm result to children, on balance, if all physicians followed that advice?

The most likely answer is "no."[9] A recent analysis of 18 years of data from the capital region of Denmark, where nonreligious male circumcision is rarely performed except out of medical necessity, suggests that approximately 99.5 percent of boys will go through infancy, childhood, and adolescence without requiring a circumcision for therapeutic reasons.[10] To put this finding a different way, the data suggest that less than 1 percent of boys in settings comparable to that of the Danish study will face a foreskin-related medical problem requiring circumcision before an age of consent.

By contrast, what would happen if the AAP guidelines were followed? Although the AAP documents do not explicitly recommend newborn circumcision, the "affirmative" position regarding net benefit has been interpreted by some circumcision advocates as entailing a similar conclusion, such that it "should logically result in an increase in infant circumcisions in the United States."[11] If this does occur, the consequence would be that an indeterminate number of boys will have undergone a medically unnecessary genital surgery, the risks of which have not been adequately studied.

For example, with respect to surgical complications, the AAP Task Force states that, due to disagreements about diagnostic criteria and other limitations with the available data, the "true incidence" of surgical complications is currently unknown.[12] Other risks, including psychosexual risks,[13] risks to the developing nervous system, and long-term risks to neuroendocrine and immune system stress responses[14] are even less well studied. Finally, some risks, including feelings of loss or resentment, dissatisfaction with one's penile appearance, body-image problems, *et cetera*, are largely subjective in nature. This inherent subjectivity renders these risks difficult if not impossible to measure using standard scientific modalities.[15] Predicting such outcomes across a range of individual difference variables poses an even greater empirical challenge.[16]

The Importance of Subjective Factors

Whether boys and men regard themselves as having been harmed versus benefited by nontherapeutic circumcision depends on numerous factors. Among them are differences in attitudes concerning, for example, what constitutes a personally relevant benefit or risk when it comes to a medically elective surgery.[17] Recognizing such variability, a member of the AAP Task Force later acknowledged certain difficulties with the methodology employed by the task force in carrying out its risk-benefit assessment. Specifically, there was a "lack of a universally accepted metric to accurately measure or balance the risks and benefits [as well as] insufficient information about the actual incidence and burden of non-acute complications."[18]

Why is there no "universally accepted metric" for balancing risks and benefits? One reason is that any such metric is likely to be influenced, whether consciously or unconsciously, by the beliefs, values, and personal preferences of those applying it to the evidence.[19] As Akim McMath notes, "People disagree over what constitutes a harm and what constitutes a benefit" when it comes to circumcision.[20] For example, "some people believe circumcision benefits the child by bringing him closer to God, while others disagree" (see box 1).[21]

Such divergent prior beliefs, in turn, may influence how one interprets the relevant medical evidence. Consider a person who is committed to circumcising infants on religious grounds. Perhaps believing, on first principles, that God would not endorse a practice that was physically harmful, it is possible that such a person would be less inclined to regard the risks that have been attributed to circumcision as being empirically well supported. This inclination, in turn, could lead a person to give relatively more credence to evidence that appears to suggest a benefit-to-risk ratio in favor of circumcision, at least partially independently of the actual strength of the evidence.[22]

Now consider someone who regards nontherapeutic genital surgery performed on children as immoral, perhaps believing that such surgery violates a child's right to bodily integrity. Compared to a religious supporter of circumcision, this person might evaluate the same evidence rather differently. Since a finding of net medical or other harm would be *prima facie* more congenial to their moral stance, this person might give relatively more credence to evidence that appears to suggest a benefit-to-risk ratio weighing against circumcision, again at least partially independently of the actual strength of the evidence.

Even when there is widespread agreement about what constitutes a harm or benefit, the *weight* to be assigned to the outcome may still differ from person to person. Relevant factors in assigning such weight include one's tolerance for certain types of risk compared to others (for example, risks of omis-

sion versus commission, risks affecting some parts of the body versus others); the availability of alternative risk-reduction or benefit-promoting strategies and how one ranks these compared to the surgical option; and one's preferences and values regarding bodily aesthetics, sexual behavior, and the importance of conforming or not conforming to prevailing sociocultural norms.

To illustrate, some men might be less comfortable taking on the risks of circumcision, an act of commission (for example, glans amputation or loss of sexual function), than they are taking on the risks of failing to undergo circumcision, an act of omission (for example, acquiring a treatable infection or developing a rare form of cancer in old age). For many people, the risks associated with acts of commission, versus acts of omission, loom larger in the mind, creating a greater psychological burden and potential for regret. This asymmetry may obtain even when the absolute likelihood of an "omitted" risk is greater than that of a "committed" risk. Without knowing which type of risk a person is more comfortable taking on, however, it is not possible to determine which one "outweighs" the other.

For another example, consider that some men assign a positive value to the foreskin itself, to sexual

BOX 1. Disagreement about Benefits and Risks: What Are the Ethical Implications?

Faced with the problem of disagreement over what constitutes a benefit or risk when it comes to circumcision, it is often concluded that "the parents should decide." However, this does not necessarily follow. As McMath notes, "the child will have an interest in living according to his own values, which may not reflect those of his parents . . . . Only the child himself, when he is older, can be certain of his values." Thus, "if disagreement over values constitutes a reason to let the parents decide, it constitutes an even stronger reason to postpone the decision until the child himself can decide."[1]

Against this view, it is sometimes argued that infant circumcision is less risky than adult circumcision, such that the two are not equivalent choices. It is true that the two choices are not identical. However, at least two issues need to be clarified before the ethical implications of this fact can be assessed. First, the claim of "less risk" is not uncontroversial. It is based largely upon retrospective comparisons of nonconcurrent studies with results drawn from dissimilar populations, using dissimilar methods and criteria for identifying complications. Therefore, such comparisons do not adequately control for the skill of the practitioner, the specific technique employed, the setting of the surgery, the methods of data collection, and so on.[2]

Second, even if one were to grant an increase in the *relative* risk of complications in adulthood versus infancy, it is the difference in *absolute* risk that is more ethically relevant. Even strong proponents of infant circumcision contend that the absolute likelihood of clinically important, difficult-to-resolve surgical complications associated with circumcision is "low," regardless of the age at which the procedure is performed.[3] Given such a low baseline risk, according to the proponents, the existence of a relative risk reduction in the incidence of adverse events in infancy compared to adulthood is unlikely to be morally decisive. Instead, as the U.S. Centers for Disease Control and Prevention (CDC) states, "Delaying male circumcision until adolescence or adulthood obviates concerns about violation of autonomy" such that any medical disadvantages associated with such a delay "would be ethically compensated to some extent by the respect for the [bodily] integrity and autonomy of the individual."[4]

NOTES

Materials in this box are adapted from B.D. Earp, "Male Circumcision: Who Should Decide?" *Pediatrics* 37, no. 5 (2016): e-letter; B.D. Earp, "Do the Benefits of Male Circumcision Outweigh the Risks? A Critique of the Proposed CDC Guidelines," *Frontiers in Pediatrics* 3, no. 18 (2015): 1-6.; B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56.

1. A. McMath, "Infant Male Circumcision and the Autonomy of the Child: Two Ethical Questions," *Journal of Medical Ethics* 41, no. 8 (2015): 687-90, 689.

2. H.A. Weiss et al., "Complications of Circumcision in Male Neonates, Infants and Children: A Systematic Review," *BMC Urology* 10, no. 2 (2010): 1-13; J.S. Svoboda and R.S. Van Howe, "Circumcision: A Bioethical Challenge," *Journal of Medical Ethics* 40, no. 7 (2013): e-letter.

3. B.J. Morris and E.C. Green, "Circumcision, Male," *Blackwell Encyclopedia of Health, Illness, Behavior, and Society* (Hoboken, N.J.: Wiley-Blackwell, 2014).

4. U.S. Centers for Disease Control and Prevention, "Background, Methods, and Synthesis of Scientific Information Used to Inform the Draft Recommendations for Providers Counseling Male Patients and Parents Regarding Elective Male Circumcision and the Prevention of HIV Infection and Other Adverse Health Outcomes," *U.S. Centers for Disease Control* (2014): 1-61, 39-40.

activities that require manipulation of the foreskin, or to the embodied state of genital intactness (that is, having a surgically unmodified penis).[23] Compared to men who assign a neutral or negative value to the foreskin, perhaps due to differing beliefs or cultural norms, the former are at a far greater risk of losing a good to circumcision: nearly 100 percent for the above-mentioned factors.[24] The magnitude or importance of that risk, in turn, depends on how much value a man places on such factors, which is not something that can be known before he is mentally mature.

Consider, for instance, a recent study of 196 sexually active Canadian adults that found that men who have sex with men (MSM), compared to heterosexual females, "indicated a strong preference toward intact penises for all sexual activities assessed and held more positive beliefs about intact penises."[25] This finding suggests that parents who authorize an elective circumcision for their infant son may risk differentially affecting his future sexual enjoyment depending upon his sexual orientation—something that will not be apparent until years later (see box 2 for further discussion).

To summarize, assessments of the comparative worth or weight of particular benefits and risks come down in large part to what one values or prefers. In asserting that the benefits of circumcision outweigh the risks, therefore, the AAP Task Force appears to have substituted its own subjective preferences and

BOX 2. Dealing with Uncertainty About Infants' Future (Bodily) Preferences

Not knowing a child's future preferences poses a challenge to parental and clinical decision making with respect to a wide range of potential pediatric interventions. When it comes to surgeries that permanently alter the body (for example, by removing nonregenerating tissue), it is sometimes pointed out that, whatever choice they make, parents will foreclose at least one future option for their child. Specifically: "parents who decide in favor of early surgery close off the child's future ability to make his own decision regarding surgery . . . while parents who refrain from early surgery close off the option for the [child] to undergo the surgery *during infancy or early childhood*."[1]

Are these cases symmetrical? Circumcision provides a good illustration. If a noncircumcised adult is considering circumcision, for whatever reason, he can perform his own risk-benefit analysis of the surgery, taking into account his known preferences and the fullness of his social, sexual, and other circumstances. If he then chooses circumcision, he will be secure in the knowledge that he has done so voluntarily, undertaking a certain amount of risk to achieve a desired outcome. In other words, the adult with unmodified genitals—who now prefers that they be altered—has an option available with which to satisfy the preference, even if it is not ideal from his current perspective. By contrast, the man whose early circumcision was not desired, and is now a cause of significant distress, has no comparable remedy. He may attempt artificial foreskin "restoration"—if he has enough remaining penile skin to do so—but this may take years to accomplish, and the result will be a mere approximation of a prepuce, lacking the original tissue and nerve endings. Thus, it appears that the two cases are not symmetrical. In the deferred surgery case, there is far greater leeway for the individual to rectify an undesired situation.

Now, it could be argued that the noncircumcised man who wishes he were circumcised cannot truly satisfy his preference either. He may wish, for example, that the surgery had already taken place, perhaps in infancy, so that he would not now have to face the inconvenience. In this respect, he is not unlike the adult female in a similar social context who decides to undergo elective labial surgery for what she considers to be cosmetic reasons. Perhaps it would have been better—from her current perspective—to have undergone the procedure shortly after birth, so that she likewise would not have to face it now. But very few people in Western medicine would take this possibility as an argument in favor of neonatal labiaplasty. Indeed, such statements as "she won't even remember it," "she'll heal faster," "her future sexual partners will find her genitals to be more appealing," and "it's relatively less risky at this age" (see box 1)—all of which are commonly invoked in defense of infant male circumcision—would be considered problematic. The expectation thus appears to be that girls should be able to make such personal decisions for themselves when they are older and can understand what is at stake.

NOTES

Materials in this box are adapted from text in the essay "Circumcision, Sexual Experience, and Harm," which should be consulted for primary source citations; B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56.

1. A. Carmack, L. Notini, and B.D. Earp, "Should Surgery for Hypospadias Be Performed before an Age of Consent?" *Journal of Sex Research* 53, no. 8 (2016): 1047-58, 1057.

values for unknown, individually and culturally variable preferences and values of future boys and men. It is for this reason that careful consideration of the influences that may have played into those subjective factors is needed.

The Charge of Cultural Bias

Noting that the conclusions of the AAP Task Force were "far from those reached by physicians in most other Western countries,"[26] the authors of the international critique raised the prospect of cultural bias[27] as a possible explanation: "Seen from the outside, cultural bias reflecting the normality of nontherapeutic male circumcision in the United States seems obvious."[28] They went on to state that in "Europe, Canada, and Australia, where infant male circumcision is considerably less common than in the United States, the AAP report is unlikely to influence circumcision practices," because again, "the conclusions of the report and policy statement seem to be strongly culturally biased."[29]

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Recent events appear to support this prediction. For example, the 2015 policy on newborn circumcision from the Canadian Pediatric Society, which has historically endorsed the position of the AAP, instead rejected it, failing to conclude that the benefits of infant circumcision outweigh the risks.[30] Similarly, upon revisiting its 2010 policy in light of the AAP findings, the Royal Australasian College of Physicians reaffirmed its view that "the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand."[31]

In addition, the president of Germany's pediatric society, the Berufsverband der Kinder- und Jugendärzte, stated in a government hearing that "there is no reason from a medical point of view to remove an intact foreskin from underage boys or boys unable to give consent," adding that "the statement from the AAP [has] been graded by almost all other pediatric societies and associations worldwide as being scientifically untenable."[32] And in 2016 the Danish Medical Association released a statement characterizing nontherapeutic male circumcision as being sufficiently risky that it should "only be performed on children when there is a documented medical need."[33]

Nevertheless, the AAP Task Force contested the charge of cultural bias in a response piece. The critical passage from their reply is as follows: "All of [our critics] hail from Europe, where the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis. In contrast, approximately half of US males are circumcised, and half are not. Although that heterogeneity may lead to a more tolerant view toward circumcision in the United States than in Europe, the cultural 'bias' in the United States is much more likely to be a neutral one than that found in Europe, where there is a clear bias against circumcision."[34]

Our aim for the rest of this article is to assess this response by the AAP Task Force. Was the task force successful in dispelling the charge, levied by its international critics, that its evaluation of the medical literature may have been unduly influenced by cultural or other extrascientific factors? We consider the key claims of the AAP Task Force in turn.

DISCUSSION

The first claim of the AAP Task Force concerns differing cultural norms surrounding circumcision between the U.S. and Europe. In this context, we begin by correcting the assertion that all of the authors of the international commentary "hailed from Europe." In fact, one of the signatories was the Canadian pediatrician Noni MacDonald, a member of the Canadian Academy of Health Sciences, founding editor of *Pediatrics & Child Health*, and the first woman to become a dean of medicine in Canada.[35] However, the other signatories were indeed from Europe, where, according to the AAP Task Force

members, "the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis."[36] This claim inspires two observations that require further discussion.

Norms, Values, and Terminology

First, the AAP Task Force uses the term "uncircumcised" to describe whole or intact male genitalia. All normally developing boys are born with a foreskin, and most boys and men around the world do not have a surgically modified penis.[37] Despite this, the term "uncircumcised" frames circumcision as the default status, and recasts the natural penis as the linguistically marked category.[38] For a point of comparison, the AAP does not refer to infant girls' vulvae as "unlabiaplastied."[39] In other words, the choice of terminology employed by the AAP Task Force appears to reflect the prevailing cultural assumption(s) under which it was operating: namely, that the normative status for males is to be circumcised, rather than genitally intact.

The second observation has to do with the AAP Task Force's reference to a "cultural norm" in Europe, which "clearly favors" the intact penis. Given the comparative rarity of nontherapeutic circumcision outside of minority religious groups in European countries,[40] it is certainly possible that a norm exists that favors surgically unmodified male genitalia. However, a similar "norm" exists throughout Europe that favors surgically unmodified female genitalia, as well as surgically unmodified body parts generally. In other words, it is unclear whether the lack of a tendency to excise nondiseased tissue, whether from the body of a child or an adult, is the sort of thing that should be described as a "norm," unless all nonperformed actions are eligible to be called "norms" if their nonperformance is typical in some group.

But let us simply grant that there is a "cultural norm" in Europe that "clearly favors" an intact penis. It does not follow from this, as the AAP Task Force implies, that its European counterparts are "biased" against circumcised penises. This is because, whatever the wider cultural norm concerning circumcision happens to be in Europe, there is also a relevant *medical* norm, not only in Europe, but also in the U.S., which holds that (1) medically unnecessary surgery should generally not be performed on healthy children, and (2) surgery should almost always be a last resort, rather than a first resort, for managing or preventing disease.[41]

Thus, it is not just a matter of two local, arbitrary cultural norms being pitted against one another. Rather, the *shared* norms governing responsible medical practice in Western countries are typically "biased" against such nontherapeutic procedures. Accordingly, by suggesting that a cultural norm that favors the nontherapeutic surgical modification of a child's penis "is somehow on par with, or just as reasonable as, a medical-ethical norm favoring the avoidance of such surgery unless it is absolutely required," the AAP Task Force could be seen as revealing its cultural hand.[42]

Indeed, only the U.S. and Israel, among Western developed nations, maintain a majority practice of routine neonatal male circumcision.[43] In the latter case, the explanation for the practice is predominately religious, being derived from a perceived scriptural mandate along with a historically rooted sense of shared Jewish identity, of which male circumcision in infancy is a symbol.[44] The historical process by which ritual circumcision became "medicalized" in the U.S.—and later entrenched as a wider cultural practice—has been documented elsewhere.[45] The point here is that the unique position of the U.S. medical establishment in favoring the nonreligious circumcision of male newborns suggests that it is the AAP Task Force, rather than its critics, that bears the greater burden in justifying its background cultural norms.

This view is further supported by research on "cultural cognition." As Yale psychologist Dan Kahan explains, a major tenet of cultural theory is that "individuals gravitate toward perceptions of risk that advance the way of life to which they are committed."[46] According to this view, moral concern guides not only response to risk, but also guides the basic faculty of risk perception.[47] Thus, each way of life and associated worldview "has its own typical risk portfolio," that "shuts out perception of some dangers and highlights others" in ways that selectively sustain the norms and practices to which one is most deeply devoted.[48]

With respect to the debate over cultural bias between the members of the AAP Task Force and their international critics, it is difficult to see how "not circumcising" would meet the criteria for being a distinctive component of a "worldview" or a "way of life" that might directly influence the risk perception of the mostly European group of doctors. In other words, while circumcising infant boys is (1) an entrenched birth custom in American culture that is deeply tied up with implicit and explicit notions of "good parenting,"[49] and (2) a central ritual practice within Judaism and Islam, it is less clear in what sense "not circumcising" is (or could be) either an entrenched birth custom or a central ritual practice in "European" culture. In fact, it is by defi-

nition not a practice, but the lack of one. Moreover, this lack of practice is not closely associated with "European" cultural identity in any specific, coherent sense: rather, it is simply one of a large number of rituals and other practices that is not particularly common in Europe.

A Child's Right to Physical Integrity

To see how anomalous the U.S. medical community's support for newborn male circumcision is, it may be useful to consider the nearest anatomical analog, namely, the nontherapeutic surgical modification of female genitalia (for example, for cultural or religious reasons).[50] Not only is such surgery normatively discouraged before an age of consent in Western medicine, but it is strictly forbidden by national and international law, primarily on the grounds that it violates a child's right to physical integrity.[51] According to the World Health Organization (WHO), this right is violated (see box 3) by all medically unnecessary alteration of the female genitalia, no matter how superficial or hygienically performed.[52] As a consequence, Western prohibitions of such genital alteration extend even to those forms that are significantly less invasive than male circumcision. This includes ritual "pricking" of the clitoral hood—FGM WHO Type 4—that does not remove tissue, rarely leads to long-term adverse health consequences, and is often carried out by trained healthcare providers in sterile settings.[53]

To explain this apparent discrepancy in treatment regarding male versus female children, the AAP Task Force argues that "the right to physical integrity is easier to defend in the context of a procedure that offers no potential benefit."[54] This is presumed to be the case for nontherapeutic female genital cutting (FGC). However, this response deserves closer scrutiny.

First, the "potential benefit" to which the AAP Task Force refers in this sentence is "medical benefit" or "health benefit." However, in the case of male circumcision, the AAP Task Force shows a willingness to consider potential nonmedical—that is, sociocultural—benefits as well, stating that "it is reasonable to take these nonmedical benefits . . . into consideration when making a decision about circumcision."[55] As the British Medical Association (BMA) notes, "Where a child is living in a culture in which circumcision is [believed to be] required for all males, [exclusion] may cause harm by, for example, complicating the individual's search for identity and sense of belonging."[56] However, the BMA also notes that "very similar arguments are also used to try and justify very harmful cultural procedures, such as female genital mutilation or ritual scarification. Furthermore, the harm of denying a person the opportunity to choose not to be circumcised must also be taken into account, together with the damage that can be done to the individual's relationship with his parents and the medical profession if he feels harmed by the procedure."[57]

Second, it may never be known whether a minor, sterilized form of FGC—such as neonatal labiaplasty—would offer a "potential benefit" in the sense implied by the AAP Task Force, because it would be illegal to conduct a properly controlled

BOX 3. A Child's Right to Physical Integrity: How Should it Be Applied?

A child's right to physical integrity is not absolute. Interventions that are clearly in the child's best interests, especially if they cannot be delayed until the child is competent to consent or decline (for example, emergency surgery to correct a heart defect) are universally agreed to be permissible. Trivial, superficial, or easily reversible interventions (for example, getting a haircut), or more serious, risky, or permanent interventions to which the child can give age-appropriate consent (for example, cosmetic orthodontia, participating in sports), are also usually permissible. However, the mere fact that children are pre-autonomous and cannot validly consent to most interventions, "medical" or otherwise, that affect their bodies (for example, being forced to eat their vegetables) does not entail that parents have an unfettered right to authorize all such interventions (for example, child sexual abuse). The less clear it is that a bodily encroachment is, all things considered, in the child's best interests (taking into account the child's interest in being able to autonomously make important self-affecting decisions in the future), the more likely it is that the child's bodily integrity rights are being impermissibly violated.

NOTES

Some material in this box is adapted from B.D. Earp, "The AAP Report on Circumcision: Bad Science + Bad Ethics = Bad Medicine," *Practical Ethics*, 29 August 2012, *http://blog.practicalethics.ox.ac.uk/2012/08/the-aap-report-on-circumcision-bad-science-bad-ethics-bad-medicine/*.

scientific study to secure the answer.[58] But one cannot rule the possibility of health benefits out.[59] Cancers of the labia, for instance, might be less likely to occur in someone whose labia have been surgically reduced, due to the decreased surface area of the relevant tissue.[60] Indeed, removing *any* healthy tissue from a child's body would likely reduce the risk of some disease that might otherwise affect that tissue, or other parts of the body through it.[61]

And yet, the mere prospect of some health benefit following from the removal of healthy tissue is not normally seen as sufficient grounds for overriding a child's right to physical integrity.[62] This principle holds true especially when there are alternative ways to achieve the same health benefit that do not involve surgery and its attendant risks—a consideration that applies to all of the health benefits that have been attributed to male circumcision.[63] Adding to this is the "private" nature of the body part in question, about which people have strong and often conflicting emotions (compare with, for example, the tonsils, which are in any case no longer routinely removed).[64] Given such strong emotions, the permanency of circumcision, and the special significance of the penis as compared to other parts of the body, it seems preferable to defer the surgery, all else being equal, until the person whose body will be affected by it is in a position to decide what is best for him.[65]

It is sometimes argued that infant male circumcision meets the "trivial" condition mentioned in box 3, and thus fails to rise to the level of a rights violation. Often, this argument is made by analogy with piercing the ear lobes of female infants: if the latter is permissible, why not the former?[66] There are two ways to respond to this argument. The first way is to suggest that perhaps ear piercing, too, should not be performed before the affected child can weigh in. If she understands that it will be painful, that there are certain risks involved, *et cetera*, and yet this is still something she would like to undertake, then it should be allowed.

The second way is to point out that the two practices—piercing infants' ears and infant male circumcision—are not commensurate. Ear piercing removes no tissue, it (minimally) alters a part of the body that is less sensitive both physically and symbolically, it creates a wound that is much smaller, and it is often reversible: the hole may close up over time if the child later decides that he or she would like to have earlobes free of holes. By contrast, infant male circumcision removes up to half of the motile skin system of the penis[67] (approximately 30 to 50 square centimeters of erogenous tissue in the average adult organ),[68] excises the portion of the penis that is most sensitive to light touch,[69] precludes all sexual activities that require manipulation of the foreskin,[70] and is irreversible: anyone who resents having had his foreskin removed cannot recover what was lost.

Nonmedical Motivations

Most of our discussion thus far has focused on the prospect of health benefits. But this is not the original reason for the practice of male circumcision, nor is it the main reason for its continuance today. As AAP Task Force member Andrew Freedman, MD, stated in a recent editorial: "Most circumcisions are done due to religious and cultural tradition. In the West, although parents may use the conflicting medical literature to buttress their own beliefs and desires, for the most part parents choose what they want for a wide variety of nonmedical reasons. There can be no doubt that religion, culture, aesthetic preference, familial identity, and personal experience all factor into their decision. Few parents when really questioned are doing it solely to lower the risk of urinary tract infections or ulcerative sexually transmitted infections."[71]

In support of this observation, Freedman stated in a separate interview that he had circumcised his own son. "But I did it for religious, not medical reasons," he stated. "I did it because I had 3,000 years of ancestors looking over my shoulder."[72]

What relevance might this statement have for the debate over cultural bias? As Dan Kahan explains, when one's identity or standing in an affinity group depends at least partially on one's stance toward certain empirical matters, this can "generate motivated cognition relating to policy-relevant facts."[73] Such cognition does not require conscious awareness: "Even among modestly partisan individuals, shared ideological or cultural commitments are likely to be intertwined with membership in [certain] communities. . . . If a proposition about some policy-relevant fact comes to be commonly associated with membership in such a group, the prospect that one might form a contrary position can threaten one's standing within it. Thus . . . individuals are unconsciously motivated to resist empirical assertions [if] those assertions run contrary to the dominant belief within their groups."[74]

Consistent with this view, as Jonathan Koehler has described, fabricated research reports that appear to agree with scientists' prior beliefs are judged to be of higher quality than those that disagree, despite controlling for actual quality.[75] One possible explanation for more favorable appraisals in the "agree" condition is that "scientists may "differen-

tially scrutinize" studies that yield belief-congruent versus belief-incongruent findings. Thus, Koehler argues, "Studies that are known to have yielded belief-congruent data may be examined less carefully for having obtained the 'correct' result, and may be presumed to have been conducted properly. On the other hand, when scientists evaluate studies that are not known to have produced 'correct' results . . . their suspicion that something may be wrong with the study is heightened."[76]

In line with this possibility, it is reasonable to think that a prior religious belief in the desirability of circumcision could—at least in principle—unconsciously influence one's perception of a study's relevance, methodological rigor, and clarity of results (as in the Koehler experiments) in such a way that the perceived quality of circumcision-supportive findings, compared to nonsupportive findings, would be inappropriately inflated.[77]

Another potential source of bias stems from the findings of a 2010 survey of 572 Canadian physicians by Andries Muller. "Although most respondents stated that they based their decisions on medical evidence," Muller discovered, "the circumcision status of, especially, the male respondents played a huge role in whether they were in support of circumcisions or not. Another factor that had an influence was the circumcision status of the respondents' sons."[78] Specifically, 68.3 percent of the circumcised males were in support of newborn male circumcision, whereas 68.8 percent of the noncircumcised males were opposed to it. In addition, 77.2 percent of those respondents whose sons were circumcised were in support of circumcision, whereas 64.7 percent of those whose sons were not circumcised were opposed to it.

Motivated Reasoning

How might these findings be explained? One possibility is that a doctor who was himself circumcised before he could consent or decline, or who has had his son circumcised under the same conditions, might be more likely than a doctor to whom these considerations do not apply to engage in a form of "motivated reasoning."[79] Specifically, he may be motivated, whether consciously or unconsciously, to evaluate the murky and heavily contested medical evidence concerning circumcision in such a way that his decision regarding his son—or his own circumcision status—can be independently justified on grounds of net benefit.[80]

This explanation is consistent with the well-supported theory of cognitive dissonance from the field of psychology.[81] If the medical evidence suggests that newborn circumcision is a net harm, or at least not a significant benefit, then a man who has already been circumcised—or who has had his son circumcised—will be confronted with a distressing thought: either that his parents did something to him that they probably ought not to have done (all else being equal), or that he has done something to his own son that he probably ought not to have done (all else being equal), or both.[82]

The key here is that being circumcised (lacking a foreskin), as opposed to not being circumcised (possessing a foreskin), is irreversible. In other words, if something is a net harm, but cannot be undone, cognitive dissonance theory suggests that the mind will do whatever it can to reframe what has taken place as a benefit. By contrast, if something can be undone—such as the state of not being circumcised—then there is much less likely to be cognitive dissonance in the first place in need of resolution, including in the possible form of a motivated interpretation of the empirical literature. Since it is likely that the circumcision status of the American versus European doctors (or that of their sons) is asymmetrical, this theoretical difference in cognitive dissonance may be of relevance to this debate.[83]

The 50-50 Defense

We turn now to a second claim made by the AAP Task Force, namely that "approximately half of US males are circumcised, and half are not" such that any "'bias' regarding circumcision in the United States is much more likely to be a neutral one."[84] How compelling is this response to the charge of cultural bias?

First, it is unclear on what grounds the AAP Task Force members base their assertion that approximately half of U.S. males are circumcised. According to the AAP's own technical report, from 1999 to 2010, the approximate percentage of newborn U.S. males who were circumcised ranged from 55.8 percent to 59.1 percent depending on the source. But these incidence rates "were derived from hospital-based surveys and do not include out-of-hospital circumcisions; thus, these data sources underestimate the actual rate of newborn male circumcision in the first month of life."[85] Such undercounting suggests that the current incidence of circumcision is more likely to be 60 percent or higher. However, that is not the most relevant statistic. More relevant would be the prevalence of circumcision, which factors in older men who were born in earlier decades when circumcision was more common, and whose attitudes would also need to be considered. The fig-

ure for prevalence has most recently been estimated to be more than 80 percent.[86]

But let us just assume, contrary to this evidence, that approximately 50 percent of U.S. males are circumcised, either in terms of the current rate or the current prevalence. It is a *non sequitur* to assert that *attitudes* toward circumcision in the U.S. are 50 percent favorable, equally tolerant of circumcised and noncircumcised penises, or otherwise "neutral" as the AAP Task Force implies. Cultural attitudes take time to change, and the implication of a recent drop in the rate or prevalence of circumcision for prevailing attitudes is unclear.

The more relevant question is narrower in scope. In judging whether the conclusions of the AAP Task Force were biased or unbiased with respect to the medical evidence concerning the circumcision of newborn males, it is not especially informative to allude to the percentage of circumcised men in the population at large. Instead, it seems important to determine the attitudes of the members of the AAP Task Force themselves—that is, the ones who reviewed the literature.

Evidence of such attitudes may be found in the 2016 editorial by Andrew Freedman. Referring explicitly to nonscientific political considerations, Freedman stated that "protecting" the parental option to circumcise "was not an idle concern" in the minds of the AAP Task Force members "at a time when there are serious efforts in both the United States and Europe to ban the procedure outright."[87] The reference appears to be to a failed 2011 ballot initiative in San Francisco that sought to criminalize nontherapeutic circumcision before the age of 18, and to a 2012 Cologne court judgment—later overturned by the German legislature—finding that circumcision of male minors without a medical indication constitutes bodily assault.[88]

In this context, one may wonder whether protecting the parental option to circumcise should in fact have been an idle concern. As we understand it, the remit of the AAP Task Force was to evaluate, as dispassionately as possible, the empirical evidence concerning the benefits and risks associated with newborn circumcision. Whether parents do or should have a right to authorize circumcision is an important and difficult question, and it is one that moral philosophers, bioethicists, legal theorists, and others are attempting to answer. But it seems fair to suggest that it is not a question that should inform, much less consciously and deliberately inform, a scientific report on the medical consequences of newborn male circumcision.

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Liberal societies depend on scientific personnel to provide unbiased, apolitical analyses of "the facts" pertaining to their public deliberations. This goal is difficult to achieve in practice, as scientists are not immune from personal, cultural, and other biasing factors even in the best of circumstances, as we have noted.[89] But it is widely held that scientific analysts should do their best to neutralize such factors, using the most effective means available. Seemingly, a scientific committee that sees itself as engaged, however tangentially, in "protecting" a contested cultural or religious rite (an aim with respect to which a finding of net medical benefit would presumably be auspicious) has not done its best in this regard.

A Note on Ethics—and Equipoise

We are not certain that it is appropriate for the AAP or any similar medical organization to opine on the ethics of circumcising male newborns:[90] if the question is about benefits and risks, these should be documented clearly and thoroughly, based solely upon the empirical data. Moreover, if weights or values are to be assigned, these should be assigned by the person contemplating the surgery in light of his own preferences and values, as we have argued; a policy committee is not best qualified to make such judgments for others.

If, however, an ethical discussion is to be included in a scientific report, it is desirable that more than one perspective be represented. In the context

of a debate that is as polarized as the one on the circumcision of infant males,[91] it is notable that the single bioethicist appointed to the AAP Task Force, Douglas Diekema, MD, had already made his views on the subject clear, previously arguing in favor of the permissibility not only of male forms of circumcision, but also certain female forms of ritualized genital cutting, despite near-universal condemnation of the latter.[92]

This sole appointment is notable because the view that neither male nor female children deserve absolute protection from having their genitals cut for nontherapeutic reasons is an outlier position among policy experts. Moreover, the "harm principle" promoted by Diekema, which explicitly favors expansive parental rights over the advancement of children's best interests, is similarly contentious.[93] It is reasonable to think that a committee with as much influence as the AAP Task Force would strive to include a diversity of voices in its ethical discussions.

There are legitimate arguments to be made that newborn male circumcision should be considered morally and/or legally acceptable.[94] One could even argue that religious circumcision in particular should be tolerated *even if* it is a net (medical) harm, since there are numerous factors at play in such determinations apart from risk-benefit assessments. However, the moral and legal status of nontherapeutic procedures to alter genitals has become increasingly controversial in the past few decades, with a growing contingent of scholars maintaining that all such procedures performed on children (male, female, and intersex) should be discouraged, if not forbidden.[95]

Therefore, to achieve a properly balanced consideration of the opposing viewpoints, future committees in this area should consider appointing at least two ethicists who represent the range of current thinking on the issue. The dialectic between them, it is hoped, would yield a more nuanced and comprehensive ethical discussion than was evidenced in the 2012 AAP documents. As J. Steven Svoboda and Robert Van Howe have stated, these documents

> fail to mention foundational principles from biomedical ethics. Seemingly, such notions as respect for autonomy, a child's right to an open future, and the normally high bar set for surgical interventions on minors would be at least worth *alluding to* in a serious discussion of the moral permissibility of male circumcision. Yet the AAP's repeated, unsupported, alternative suggestion that, "In most situations, parents are granted wide latitude in terms of the decisions they make on behalf of their children" constitutes its entire ethical argument.[96]

Svoboda and Van Howe overstate their case, because the AAP Task Force does mention that parents and physicians have an "ethical duty to the child to attempt to secure the child's best interests and well-being."[97] However, the immediate next move of the AAP Task Force is to emphasize that reasonable people disagree as to what is in a child's best interests (see box 1), leading them to the "alternative suggestion" mentioned by Svoboda and Van Howe. In other words, given that people have different judgements about what best promotes a child's well-being, the AAP Task Force suggests that parents should normally be allowed to take or authorize any action whatsoever toward their child, unless it is "clearly contrary to the best interests of the child or places the child's health, well-being, or life at significant risk of serious harm."[98]

A problem with this view is that, just as reasonable people may disagree about what is in a child's best interests, reasonable people may also disagree about what is clearly *contrary* to a child's best interests, and about what places the child's health, *et cetera*, at "significant risk of serious harm." Removing part of a child's genitals in the absence of a clear medical need is the sort of thing that many reasonable people do regard as a serious harm, regardless of whether there may also be certain modest health benefits that follow from such removal.[99] So what does this analysis suggest about the limits, if any, there should be on parental behavior? If reasonable people may disagree not only about "best interests," but also about "serious harm," then a practical implication of the AAP's proposal seems to be that parental decision making should remain essentially unfettered.

It is commonly accepted that, "in most situations," parents are (and should be) permitted to make decisions on behalf of their children (see box 3). But in the context of Western medicine at least, one could also argue that nontherapeutic genital surgery is not "most situations." In other words, while it may be accurate to say that parents generally have "wide latitude" in bringing up their children as they see fit, it is also true that societies may justifiably place certain restrictions on parental actions, particularly when it comes to irreversible body modifications that a child may later regard as a harm.

To illustrate: in some jurisdictions, tattooing a child's body is not permitted, even when the parents believe that being tattooed is in a child's best

interests. With respect to the United Kingdom, for instance, as James Chegwidden notes, "the common law is very cautious before treating [even] children's consent as justifying any non-therapeutic body alteration."[100] Indeed, in British parliamentary debates regarding a proposed ban on tattooing prior to age 18, concerns were raised that "apply almost *identically* to the arguments voiced about circumcision, namely: the existence of persons who later regret having the procedure done; the difficulty of reversing the procedure; the danger of infections and other complications arising from the tattooing procedure; [. . .] the embarrassment felt by those tattooed who later regret it; the unhygienic conditions in which some tattooing is performed [and so on]."[101]

Failure to consistently apply this reasoning may lead to peculiar results. For instance, while parents would not be allowed to tattoo their son's foreskin for nontherapeutic reasons in such jurisdictions, they *would* be allowed to have his foreskin completely removed for nontherapeutic reasons, and then tattooed. This example provides further evidence that newborn male circumcision occupies an anomalous position in Western (medical) culture.

Perhaps even more relevant than tattooing, however, as we have already noted, is the practice of nontherapeutic FGC. In Western societies, including the U.S., parents may not cut into, much less excise, any part of a female child's genitalia when it is deemed medically unnecessary to do so. Crucially, this is the case even when (1) the cutting is less extensive, risky, or harmful than male circumcision; (2) the parents sincerely believe it is required by their religion; and (3) it is likely to confer significant social benefit on the child, due to the prevailing beliefs, attitudes, and expectations of the community in which she is being raised.[102]

In order to determine whether any particular nontherapeutic alteration of a child's body is ethically and perhaps also legally acceptable, therefore, it is not enough to invoke a vague conception of "serious harm" (such that, for any action X, an interested party could plausibly argue that it is "not harmful enough" to warrant state interference), nor to refer to the "wide latitude" that is typically granted to parents. Instead, it is necessary to triangulate between analogous cases to determine where the limits should lie.

CONCLUSION

As Shaw has argued, a near-exclusive focus in the medical literature on potential biases stemming from financial conflicts of interest "has tended to obscure the fact that other biasing factors can seriously compromise an author's impartiality and objectivity."[103] In the present context, we have argued that one such potentially biasing factor is whether one has been circumcised oneself, or has circumcised his or her son.[104] Because circumcision is irreversible, there is likely to be a strong motive among such persons to reach the conclusion that it is desirable, on balance, to be circumcised. For if it is not desirable on balance, there are few, if any, options for "undoing" what has already been done.

Moreover, having a personal or political stake in the circumcision of male infants, whether on religious or other grounds, could play a biasing role.[105] While individual AAP Task Force members may feel free to lobby for legal or other protections for nontherapeutic circumcision as private citizens, they should not allow such political ends to enter into their evaluations of the science. Moreover, a concerted effort should be made to balance out whatever political, moral, or other normative viewpoints there are among committee members, by appointing not only proponents of circumcision, but also critics. More generally, whenever professional medical or ethical opinion is polarized, qualified representatives of both poles should be included in the relevant scientific and policy discussions.

NOTES

1. AAP, "Circumcision Policy Statement," *Pediatrics* 130, no. 3 (2012): 585-86; AAP, "Male Circumcision (Technical Report)," *Pediatrics* 130, no. 3 (2012): e756-85, e757.

2. E. Shapiro, "American Academy of Pediatrics Policy Statements on Circumcision and Urinary Tract Infection," *Reviews in Urology* 1, no. 3 (1999): 154-56; S.E. Waldeck, "Using Male Circumcision to Understand Social Norms as Multipliers," *University of Cincinnati Law Review* 72 (2003): 455-526.

3. See, e.g., KNMG, "Nontherapeutic Circumcision of Male Minors," *Royal Dutch Medical Association-KNMG* (2010), *https://www.circumstitions.com/Docs/KNMG-policy.pdf*; RACP, "Circumcision of Infant Males," *Royal Australasian College of Physicians* (2010) (including a summary of position statements from other medical bodies in the appendix), *https://www.racp.edu.au/docs/default-source/advocacy_library/circumcision-of-infant-males.pdf*; see also more recently, Canadian Paediatric Society, "Newborn Male Circumcision," *Paediatrics & Child Health* 20, no. 6 (2015): 311-320; and see C. England, "Doctors in Denmark Want to Stop Circumcision for Under-18s," *Independent*, 7 December 2016.

4. Various critiques in addition to those listed in table 1 were also raised: see the references collected in B.D. Earp, "Do the Benefits of Male Circumcision Outweigh the Risks? A Critique of the Proposed CDC Guidelines," *Frontiers in Pediatrics* 3, no. 18 (2015): 1-6. Note that re-

sponses and counter-responses to some of these critiques are available at the relevant journal websites.

5. M. Frisch et al., "Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision," *Pediatrics* 131, no. 4 (2013): 796-800, 796.

6. AAP, "Male Circumcision (Technical Report)," see note 1 above.

7. Frisch et al., "Cultural Bias," see note 5 above, p. 776.

8. N. Bostrom and T. Ord, "The Reversal Test: Eliminating Status Quo Bias in Applied Ethics," *Ethics* 116, no. 4 (2006): 656-79.

9. RACP, "Circumcision of Infant Males," see note 3 above.

10. I. Sneppen and J. Thorup, "Foreskin Morbidity in Uncircumcised Males," *Pediatrics* 137, no. 5 (2016): e20154340; see also M. Frisch and B.D. Earp, "Circumcision of Male Infants and Children as a Public Health Measure in Developed Countries: A Critical Assessment of Recent Evidence," *Global Public Health*, in press.

11. B.J. Morris, S.A. Bailis, and T.E. Wiswell, "Circumcision Rates in the United States: Rising or Falling? What Effect Might the New Affirmative Pediatric Policy Statement Have?" *Mayo Clinic Proceedings* 89, no. 5 (2014): 677-86, 678. But see I. Jenkins, "Bias and Male Circumcision," *Mayo Clinic Proceedings* 89, no. 5 (2014): 677-86.

12. AAP, "Male Circumcision (Technical Report)," e772, see note 1 above. "The true incidence of complications after newborn circumcision is unknown, in part due to differing definitions of 'complication' and differing standards for determining the timing of when a complication has occurred (i.e., early or late). Adding to the confusion is the comingling of 'early' complications, such as bleeding or infection, with 'late' complications such as adhesions and meatal stenosis. Also, complication rates after an in-hospital procedure with trained personnel may be far different from those of the developing world and/or by untrained ritual providers."

13. See, e.g., G.J. Boyle et al., "Male Circumcision: Pain, Trauma, and Psychosexual Sequelae," *Journal of Health Psychology* 7, no. 3 (2002): 329-43; T. Hammond and A. Carmack, "Long-Term Adverse Outcomes from Neonatal Circumcision Reported in a Survey of 1,008 Men: An Overview of Health and Human Rights Implications," *International Journal of Human Rights* 21, no. 2 (2017): 189-218.

14. F. Schwaller and M. Fitzgerald, "The Consequences of Pain in Early Life: Injury-Induced Plasticity in Developing Pain Pathways," *European Journal of Neuroscience* 39, no. 3 (2014): 344-52; AAP, "Prevention and Management of Procedural Pain in the Neonate: An Update," *Pediatrics* 137, no. 2 (2016): e20154271; G. Page, "Are There Long-Term Consequences of Pain in Newborn or Very Young Infants?" *Journal of Perinatal Education* 13, no. 3 (2004): 10-17; A.N. Schore, "All Our Sons: The Developmental Neurobiology and Neuroendocrinology," *Infant Mental Health Journal* 38, no. 1 (2017): 15-52; M. Frisch and J. Simonsen, "Ritual Circumcision and Risk of Autism Spectrum Disorder in 0- to 9-Year-Old Boys: National Cohort Study in Denmark," *Journal of the Royal Society of Medicine* 108, no. 7 (2015): 266-79; M. Frisch and J. Simonsen, "Circumcision-Autism Link Needs Thorough Evaluation: Response to Morris and Wiswell," *Journal of the Royal Society of Medicine* 108, no. 8 (2015): 297-98.

15. P.J. Ball, "A Survey of Subjective Foreskin Sensation in 600 Intact Men," in *Bodily Integrity and the Politics of Circumcision* (New York: Springer, 2006), 177-88; R. Darby and L. Cox, "Objections of a Sentimental Character: The Subjective Dimensions of Foreskin Loss," *Matatu-Journal for African Culture and Society* 37, no. 1 (2009): 145-68; S. Johnsdotter, "Discourses on Sexual Pleasure after Genital Modifications: The Fallacy of Genital Determinism (a Response to J. Steven Svoboda)," *Global Discourse* 3, no. 2 (2013): 256-65; J. Richters, "Bodies, Pleasure and Displeasure," *Culture, Health & Sexuality* 11, no. 3 (2009): 225-36; B.D. Earp, "Infant Circumcision and Adult Penile Sensitivity: Implications for Sexual Experience," *Trends in Urology & Men's Health* 7, no. 4 (2016): 17-21; B.D. Earp, "Sex and Circumcision," *American Journal of Bioethics* 15, no. 2 (2015): 43-45.

16. L. Brotto et al., "Psychological and Interpersonal Dimensions of Sexual Function and Dysfunction," *Journal of Sexual Medicine* 13, no. 4 (2016): 538-71.

17. A. McMath, "Infant Male Circumcision and the Autonomy of the Child: Two Ethical Questions," *Journal of Medical Ethics* 41, no. 8 (2015): 687-90; H. Maslen et al., "Brain Stimulation for Treatment and Enhancement in Children: An Ethical Analysis," *Frontiers in Human Neuroscience* 8, no. 953 (2014): 1-5.

18. A.L. Freedman, "The Circumcision Debate: Beyond Benefits and Risks," *Pediatrics* 137, no. 5 (2016): e20160594.

19. See discussion in R.S. Van Howe, "The American Academy of Pediatrics and Female Genital Cutting: When National Organizations Are Guided by Personal Agendas," *Ethics & Medicine* 27, no. 3 (2011): 165-74.

20. McMath, "Infant Male Circumcision and the Autonomy of the Child," see note 17 above, p. 689.

21. Ibid.

22. See generally, D.M. Kahan, "Ideology, Motivated Reasoning, and Cognitive Reflection: An Experimental Study," *Judgment and Decision Making* 8, no. 4 (2013): 407-21; J.J. Koehler, "The Influence of Prior Beliefs on Scientific Judgments of Evidence Quality," *Organizational Behavior and Human Decision Processes* 56, no. 1 (1993): 28-55.

23. Hammond and Carmack, "Long-Term Adverse Outcomes," see note 13 above; Ball, "A Survey of Subjective Foreskin Sensation," see note 15 above; B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56.

24. R. Darby, "Risks, Benefits, Complications and Harms: Neglected Factors in the Current Debate on Non-Therapeutic Circumcision," *Kennedy Institute of Ethics Journal* 25, no. 1 (2015): 1-34.

25. J. Bossio, C. Pukall, and K. Bartley, "You Either Have It or You Don't: The Impact of Male Circumcision

Status on Sexual Partners," *Canadian Journal of Human Sexuality* 24, no. 2 (2015): 104-19, 104.

26. For a more recent discussion, see M. Jansen, "Still Locked: A Reply to Wodak, Ziegler and Morris," *Journal of Paediatrics and Child Health* 53, no. 1 (2017): 93-4.

27. *Status quo bias*—i.e., in favor of continuing the practice of circumcision—would also apply in this case, although the international critics did not raise this issue. Another potential source of bias is what has been called *intervention bias*, namely, the tendency of doctors to favor taking action, including surgical action, when nonintervention is equally justified or more justified on strictly medical grounds: A.J. Foy and E.J. Filippone, "The Case for Intervention Bias in the Practice of Medicine," *Yale Journal of Biology and Medicine* 86, no. 2 (2013): 271-80. *Publication bias* may also play a role—the tendency of journals to favor publication of studies that appear to show a positive effect of the intervention in question, in this case circumcision: P.J. Easterbrook et al., "Publication Bias in Clinical Research," *Lancet* 337, no. 8746 (1991): 867-72; B.D. Earp, "The need for reporting negative results—a 90 year update," editorial, *Journal of Clinical and Translational Research* 3, no. 52 (2017): 1-4; B.D. Earp and P. Wilkinson, "The Publication Symmetry Test—A Simple Editorial Heuristic to Combat Publication Bias," *Journal of Clinical and Translational Research*, in press. Finally, *peer review bias* has also been mentioned as a possible factor: R.S. Van Howe, "Peer-Review Bias Regarding Circumcision in American Medical Publishing," in *Male and Female Circumcision* (New York: Springer US, 1999), 357-78.

28. Frisch et al., "Cultural Bias," see note 5 above, p. 796.

29. Ibid.

30. Canadian Paediatric Society, "Newborn Male Circumcision," see note 3 above.

31. RACP, "Circumcision of Infant Males," see note 3 above; see also K. Pringle, "Circumcision Health Risks and Benefits—Experts Respond," *Science Media Center*, 4 April 2014; D. Forbes, "Circumcision and the Best Interests of the Child," *Journal of Paediatrics and Child Health* 51, no. 3 (2015): 263-5; A.F. Na, T. Sharman, and J.M. Hutson, "Circumcision: Is It Worth It For 21st-Century Australian Boys?" *Journal of Paediatrics and Child Health* 51, no. 6 (2015): 580-3.

32. W. Hartmann, "Expert Statement: Dr Med. Wolfram Hartmann, President of 'Berufsverband Der Kinder-Und Jugendärzte' for the Hearing on the 26th of November 2012 Concerning the Drafting of a Federal Government Bill," 2012, *http://www.intactamerica.org/german_pediatrics_statement.*

33. As paraphrased in England, "Doctors in Denmark," see note 3 above. Please note that the British Medical Association is currently revising its guidelines; it is not known what position it will take.

34. AAP, "Cultural Bias and Circumcision: The AAP Task Force on Circumcision Responds," *Pediatrics* 131, no. 4 (2013): 801-4, 801.

35. Canadian Academy of Health Sciences/Académie Canadianne Des Sciences de La Santé, "Noni MacDonald," 5 April 2017, *http://cahs-acss.ca/noni-macdonald/.*

36. AAP, "Cultural Bias and Circumcision," see note 34 above, p. 801.

37. B.J. Morris et al., "Estimation of Country-Specific and Global Prevalence of Male Circumcision," *Population Health Metrics* 14, no. 4 (2016): 1-3; E. Wallerstein, "Circumcision: The Uniquely American Medical Enigma," *Urologic Clinics of North America* 12, no. 1 (1985): 123-32.

38. W.G. Wallace, "An Undeniable Need for Change: The Case for Redefining Human Penis Types: Intact, Circumcised, and Uncircumcised (All Three Forms Exist and All Are Different)," *Clinical Anatomy* 28, no. 5 (2015): 563-4; R.V. Hill, "Altered Anatomy Demands Dedicated Terminology: A Response to Wallace (2015)," *Clinical Anatomy* 28, no. 8 (2015): 960-1; W.G. Wallace, "An Undeniable Need for Recognition: What Do You Call a Man Who Has Undergone Foreskin Restoration? A Response to Hill (2015)," *Clinical Anatomy* 28, no. 8 (2015): 962-3.

39. It should be noted that in many cultures in which ritual female genital cutting is common and normative, girls with intact vulvae are also referred to (in English) as "uncircumcised," in many cases as an explicit pejorative. O. Bamgbose, "Women and the Law in Africa: Legal and Cultural Approaches to Sexual Matters in Africa: The Cry of the Adolescent Girl," *University of Miami International and Comparative Law Review* 10 (2001): 127-241; B. Shell-Duncan and Y. Hernlund, *Female "Circumcision" in Africa: Culture, Controversy, and Change* (Boulder, Colo.: Lynne Rienner, 2000).

40. Morris et al., "Estimation of Country-Specific and Global Prevalence of Male Circumcision," see note 37 above.

41. Na, Shaman, and Hutson, "Circumcision," see note 31 above.

42. B.D. Earp, "The AAP Report on Circumcision: Bad Science + Bad Ethics = Bad Medicine," *Practical Ethics*, 29 August 2012, *http://blog.practicalethics.ox.ac.uk/2012/08/the-aap-report-on-circumcision-bad-science-bad-ethics-bad-medicine/.*

43. Wallerstein, "Circumcision: The Uniquely American Medical Enigma," see note 37 above.

44. L.B. Glick, "Defying the Enlightenment: Jewish Ethnicity and Ethnic Circumcision," in *Genital Cutting: Protecting Children from Medical, Cultural, and Religious Infringements* (New York: Springer, 2013), 285-96; R.A. Shweder, "Shouting at the Hebrews: Imperial Liberalism versus Liberal Pluralism and the Practice of Male Circumcision," *Law, Culture and the Humanities* 5, no. 2 (2009): 247-65.

45. F.M. Hodges, "A Short History of the Institutionalization of Involuntary Sexual Mutilation in the United States," in *Sexual Mutilations* (New York: Springer, 1997), 17-40; D.L. Gollaher, *Circumcision: A History of the World's Most Controversial Surgery* (New York: Basic Books, 2000); D.L. Gollaher, "From Ritual to Science: The Medical Transformation of Circumcision in America," *Journal of Social History* 28, no. 1 (1994): 5-36; Waldeck, "Using Male Circumcision to Understand Social Norms as Multipliers," see note 2 above.

46. D.M. Kahan, "Cultural Cognition as a Conception of the Cultural Theory of Risk," in *Handbook of Risk Theory*, ed. S. Roeser et al. (Dordrecht: Springer Netherlands, 2012), 725-59, 728.

47. M. Douglas, *Risk Acceptability According to the Social Sciences* (New York: Russel Sage, 1985), 60.

48. M. Douglas and A.B. Wildavsky, *Risk and Culture: An Essay on the Selection of Technical and Environmental Dangers* (Berkeley, Calif.: University of California Press, 1982), 8, 85.

49. Waldeck, "Using Male Circumcision to Understand Social Norms as Multipliers," see note 2 above.

50. For a detailed explanation of the dimensions along which the two procedures are analogous, see B.D. Earp, "Female Genital Mutilation and Male Circumcision: Toward an Autonomy-Based Ethical Framework," *Medicolegal and Bioethics* 5, no. 1 (2015): 89-104. See also, B.D. Earp, "Does Female Genital Mutilation Have Health Benefits? The Problem with Medicalizing Morality," *Quillette Magazine,* 15 August 2017.

51. For an in-depth discussion, see B.D. Earp, "Between Moral Relativism and Moral Hypocrisy: Reframing the Debate on 'FGM,'" *Kennedy Institute of Ethics Journal* 26, no. 2 (2016): 105-44.

52. WHO, "Eliminating Female Genital Mutilation: An Interagency Statement," 2008, *apps.who.int/iris/handle/10665/43839.*

53. D.S. Davis, "Male and Female Genital Alteration: A Collision Course with the Law," *Health Matrix* 11 (2001): 487-570; K.S. Arora and A.J. Jacobs, "Female Genital Alteration: A Compromise Solution," *Journal of Medical Ethics* 42, no. 3 (2016): 148-54; A. Shahvisi, "Why UK Doctors Should Be Troubled by Female Genital Mutilation Legislation," *Clinical Ethics* 12, no. 2 (2016): 102-8; A.K. Rashid, S.S. Patil, and A.S. Valimalar, "The Practice of Female Genital Mutilation among the Rural Malays in North Malaysia," *Internet Journal of Third World Medicine* 9, no. 1 (2010): 1-8; S. Taha, "A Tiny Cut: Female Circumcision in South East Asia," *Islamic Monthly*, 12 March 2013; R. Steinfeld and B.D. Earp, "How Different Are Female, Male and Intersex Genital Cutting?" *Conversation*, 15 May 2017, *http://theconversation.com/how-different-are-female-male-and-intersex-genital-cutting-77569.*

54. AAP, "Cultural Bias and Circumcision," see note34 above, p. 803.

55. AAP, "Male Circumcision (Technical Report)," e759, see note 1 above: ". . . there are social, cultural, religious, and familial benefits and harms to be considered as well. It is reasonable to take these nonmedical benefits and harms for an individual into consideration when making a decision about circumcision."

56. BMA, "The Law and Ethics of Male Circumcision: Guidance for Doctors," *Journal of Medical Ethics* 30, no. 3 (2004): 259-63, 261.

57. Ibid.

58. Earp, "Female Genital Mutilation and Male Circumcision," see note 50 above.

59. In this regard, the female genitalia are, if anything, relatively more hospitable to bacteria, yeasts, and other potential sources of infection or disease, than are the male genitalia due to the presence of the foreskin. E.J. Dielubanza and A.J. Schaeffer, "Urinary Tract Infections in Women," *Medical Clinics of North America* 95, no. 1 (2011): 27-41. However, we expect that few people in Western medicine would be tempted to leverage this observation into a research program looking at the prophylactic health benefits of removing folds of tissue from the pediatric vulva.

60. A.F. Chung, J.M. Woodruff, and J.L. Lewis, Jr. "Malignant Melanoma of the Vulva: A Report of 44 Cases," *Obstetrics & Gynecology* 45, no. 6 (1975): 638-46.

61. Thus, is conceivable that removing one testicle from each male newborn would reduce his risk of developing testicular cancer later in life without necessarily impairing normal development or fertility. It would also likely reduce the population-level incidence of testicular cancer and associated healthcare costs. Similarly, removing one breast bud from each infant girl would conceivably reduce her risk of developing breast cancer later in life—and so on. Again, however, few would see these possibilities as supporting a valid argument in favor of prophylactic testicle/breast bud removal from infant boys or girls.

62. Frisch and Earp, "Circumcision of Male Infants and Children as a Public Health Measure in Developed Countries," see note 10 above; E. Ungar-Sargon, "On the Impermissibility of Infant Male Circumcision: A Response to Mazor (2013)," *Journal of Medical Ethics* 41, no. 2 (2015): 186-90.

63. The one exception to this may be in cases of recurrent, pathologic phimosis due to balanitis xerotica obliterans (lichen sclerosis et atrophicus), which is rare: A.M.K. Rickwood, "Medical Indications for Circumcision," *BJU International* 83, no. S1 (1999): 45-51. Most cases of true phimosis can be treated in less invasive ways than circumcision, such as by the application of a steroid cream: A. Orsola et al., "Conservative Treatment of Phimosis in Children Using a Topical Steroid," *Urology* 56, no. 2 (2000): 307-10.

64. A. Adams and E. Moyer, "Sex Is Never the Same: Men's Perspectives on Refusing Circumcision from an In-Depth Qualitative Study in Kwaluseni, Swaziland," *Global Public Health* 10, no. 5-6 (2015): 721-38; Hammond and Carmack, "Long-Term Adverse Outcomes from Neonatal Circumcision," see note 13 above; T. Hammond, "A Preliminary Poll of Men Circumcised in Infancy or Childhood," *BJU International* 83, no. S1 (1999): 85-92. Re: tonsillectomies, see B. Goodman, "New Guidelines on When Kids Need Tonsillectomies," *WebMD*, 2011, *http://www.webmd.com/oral-health/news/20110102/new-guidelines-on-when-kids-need-tonsillectomies.*

65. B.D. Earp, "In Defence of Genital Autonomy for Children," *Journal of Medical Ethics* 42, no. 3 (2016): 158-63.

66. S. Holm, "Irreversible Bodily Interventions in Children," *Journal of Medical Ethics* 30, no. 3 (2004): 237.

67. J. R. Taylor, A.P. Lockwood, and A.J. Taylor, "The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision," *British Journal of Urology* 77, no. 2 (1996):

291-5.

68. P. Werker, A. Terng, and M. Kon, "The Prepuce Free Flap: Dissection Feasibility Study and Clinical Application of a Super-Thin New Flap," *Plastic & Reconstructive Surgery* 102, no. 4 (1998): 1075-82; G. Kigozi et al., "Foreskin Surface Area and HIV Acquisition in Rakai, Uganda (Size Matters)," *AIDS* 23, no. 16 (2009): 2209-13.

69. J.A. Bossio, C. Pukall, and S. Steele, "Examining Penile Sensitivity in Neonatally Circumcised and Intact Men Using Quantitative Sensory Testing," *Journal of Urology* 195, no. 6 (June 2016): 1848-53; M.. Sorrells et al., "Fine-Touch Pressure Thresholds in the Adult Penis," *BJU International* 99, no. 4 (April 2007): 864-69; Earp, "Infant Circumcision and Adult Penile Sensitivity, see note 15 above.

70. D. Harrison, "Rethinking Circumcision and Sexuality in the United States," *Sexualities* 5, no. 3 (2002): 300-16; Earp, "Sex and Circumcision," see note 15 above.

71. Freedman, "The Circumcision Debate," see note 18 above, p. e20160594.

72. T. Merwin, "Fleshing out Change on Circumcision," *Jewish Week*, 9 September 2012, *http://jewishweek.timesofisrael.com/fleshing-out-change-on-circumcision/*.

73. Kahan, "Ideology, Motivated Reasoning, and Cognitive Reflection," see note 22 above, p. 408.

74. Ibid.

75. Koehler, "The Influence of Prior Beliefs on Scientific Judgments of Evidence Quality," see note 22 above, p. 28.

76. Ibid., 39.

77. The emphasis is on "in principle." It is not clear whether Freedman's statement from the interview, despite superficial appearances, has any direct relevance for the debate concerning potential bias among the AAP Task Force. As noted, it is possible that a commitment to circumcision on religious grounds could incline someone, whether consciously or unconsciously, to give relatively more weight to evidence suggesting that the procedure is medically beneficial. However, (a) the existence of such an inclination cannot simply be inferred from a single case, and (b) even if it could be inferred, this would not entail a particular policy conclusion.

78. A.J. Muller, "To Cut or Not to Cut? Personal Factors Influence Primary Care Physicians' Position on Elective Newborn Circumcision," *Journal of Men's Health* 7, no. 3 (2010): 227-32, 227.

79. Z. Kunda, "The Case for Motivated Reasoning," *Psychological Bulletin* 108, no. 3 (1990): 480-98.

80. An alternative explanation reverses causation. This explanation says that a doctor's dispassionate reading of the medical literature causes him to make a decision about the risk/benefit ratio of newborn circumcision, and this decision, in turn, is what causes him to circumcise (or not circumcise) his own son. This could very well explain, at least in principle, the observed association between those two variables. However, it could not explain the other observed association, namely the one between one's *own* circumcision status and one's evaluation of the literature. At least, it could not explain this association if one was circumcised in infancy or early childhood, as most of the doctors in this survey presumably were. This is because reverse causation in such a case would not be possible (one cannot retroactively circumcise oneself in infancy based on one's current, dispassionate reading of the medical literature).

81. L. Festinger, *A Theory of Cognitive Dissonance* (Stanford, Calif.: Stanford University Press, 1962); E. Harmon-Jones and C. Harmon-Jones, "Cognitive Dissonance Theory after 50 Years of Development," *Zeitschrift Für Sozialpsychologie* 38, no. 1 (2007): 7-16.

82. Waldeck, "Using Male Circumcision to Understand Social Norms as Multipliers," see note 2 above, p. 495.

83. We are reluctant to speculate about the circumcision statuses of the male AAP Task Force members or their European counterparts. However, if one considers the very high rate of neonatal circumcision in the United States until recently, and the very low rate of circumcision in Europe both historically and presently, the possibility of greater personal bias (in the sense just outlined) among the former cannot be discounted entirely. A related consideration can be illustrated by way of an analogy. Imagine a committee charged with preparing a technical report on the benefits and risks of labiaplasty for adolescent girls who have been diagnosed with "labial hypertrophy" (long labia). Now imagine an early draft of this report that does not include a detailed description of the anatomy and functions of the labia minora, that downplays the limitations of studies purporting to show that labiaplasty poses only a trivial risk to women's sexual enjoyment (or fails to mention such limitations altogether), and that implicitly assigns the female genital labia themselves a value of "zero" in its benefit-risk analysis (see table 1). It is not unreasonable to think that a female committee member with surgically unmodified genitalia, compared to one whose labia were removed in childhood, or who never had labia due to being male, would be significantly more likely to notice such oversights and propose that they be corrected before final publication. This is another sense, then, in which personal experience may factor into policy discussions.

84. AAP, "Cultural Bias and Circumcision," see note34 above, p. 801.

85. AAP, "Male Circumcision (Technical Report)," see note 1 above, p. e758.

86. Morris, Bailis, and Wiswell, "Circumcision Rates in the United States," see note 11 above.

87. Freedman, "The Circumcision Debate," see note 18 above.

88. R. Merkel and H. Putzke, "After Cologne: Male Circumcision and the Law. Parental Right, Religious Liberty or Criminal Assault?" *Journal of Medical Ethics* 39, no. 7 (2013): 444-9.

89. B.D. Earp, "Mental Shortcuts," *Hastings Center Report* 46, no. 2 (2016): inside front cover; B.D. Earp and D. Trafimow, "Replication, Falsification, and the Crisis of Confidence in Social Psychology," *Frontiers in Psychology* 6, no. 621 (2015): 1-11.

90. See B.D. Earp, "'Legitimate Rape,' Moral Coher-

ence, and Degrees of Sexual Harm," *Think* 14, no. 41 (2015): 9-20; see also E. Vogelstein, "Professional Hubris and Its Consequences: Why Organizations of Health-Care Professions Should Not Adopt Ethically Controversial Positions," *Bioethics* 30, no. 4 (2016): 234-43. Ironically given the arguments in the present article, Vogelstein explicitly exempts the AAP 2012 circumcision policy from his proposed prohibition on healthcare organizations adopting controversial positions. See R.S. Van Howe, "Response to Vogelstein: How the 2012 AAP Task Force on Circumcision Went Wrong," **[name of publication? in press.]**

91. R. Collier, "Ugly, Messy and Nasty Debate Surrounds Circumcision," *Canadian Medical Association Journal* 184, no. 1 (2012): E25-6, doi:10.1503/cmaj.109-4017; B.D. Earp, "Addressing Polarisation in Science," *Journal of Medical Ethics* 41, no. 9 (2015): 782-4.

92. Van Howe, "The American Academy of Pediatrics and Female Genital Cutting," see note 19 above.

93. D. Diekema, "Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention," *Theoretical Medicine and Bioethics* 25, no. 4 (2004): 243-64.

94. M. Benatar and D. Benatar, "Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision," *American Journal of Bioethics* 3, no. 2 (2003): 35-48; J. Mazor, "The Child's Interests and the Case for the Permissibility of Male Infant Circumcision," *Journal of Medical Ethics* 39, no. 7 (2013): 421-28; J. Savulescu, "Male Circumcision and the Enhancement Debate: Harm Reduction, Not Prohibition," *Journal of Medical Ethics* 39, no. 7 (2013): 416-7.

95. M. Fox and M. Thomson, "Short Changed? The Law and Ethics of Male Circumcision," in *Children's Health and Children's Rights* (Leiden, The Netherlands: Brill, 2006), 161-82; D.L. DeLaet, "Framing Male Circumcision as a Human Rights Issue? Contributions to the Debate over the Universality of Human Rights," *Journal of Human Rights* 8, no. 4 (2009): 405-26; D.L. DeLaet, "Genital Autonomy, Children's Rights, and Competing Rights Claims in International Human Rights Law," *International Journal of Children's Rights* 20, no. 4 (2012): 554-83; G.J. Boyle et al., "Circumcision of Healthy Boys: Criminal Assault?" *Journal of Law and Medicine* 7, no. 1 (2000): 301-10; R. Merkel and H. Putzke, "After Cologne: Male Circumcision and the Law," see note 88 above; K.-K. Ford, "'First, Do No Harm': The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants," *Yale Law & Policy Review* 19, no. 2 (2001): 469-88; B.D. Earp, J. Hendry, and M. Thomson, "Reason and Paradox in Medical and Family Law: Shaping Children's Bodies," *Medical Law Review*, in press; B.D. Earp and R. Steinfeld, "Gender and Genital Cutting: A New Paradigm," in *Gifted Women, Fragile Men*, ed. T. G. Barbat, Euromind Monographs 2 (Brussels, Belgium: ALDE Group-EU Parliament, 2017); J.S. Svoboda, P.W. Adler, and R.S. Van Howe, "Circumcision Is Unethical and Unlawful," *Journal of Law, Medicine & Ethics* 44, no. 2 (2016): 263-82; J.S. Svoboda, "Promoting Genital Autonomy by Exploring Commonalities between Male, Female, Intersex, and Cosmetic Female Genital Cutting," *Global Discourse* 3, no. 2 (2013): 237-55; M. Dustin, "Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies," *European Journal of Women's Studies* 17, no. 1 (2010): 7-23.

96. J.S. Svoboda and R.S. Van Howe, "Out of Step: Fatal Flaws in the Latest AAP Policy Report on Neonatal Circumcision," *Journal of Medical Ethics* 39, no. 7 (2013): 434-4. 435.

97. AAP, "Male Circumcision (Technical Report)," see note 1 above, p. e759.

98. Ibid.

99. For a closely related view concerning female children's genitals specifically, see A. Rahman and N. Toubia, *Female Genital Mutilation: A Practical Guide to Worldwide Laws & Policies* (London and New York: Zed Books, 2000). These authors state, "The cutting of healthy genital organs for non-medical reasons is at its essence a basic violation of girls' and women's right to physical integrity. This is true regardless of the degree of cutting or the extent of the complications that may or may not ensue."

100. J. Chegwidden, "Response: Tasmanian Law Reform Institute Issues Paper No. 14: Non-Therapeutic Male Circumcision," 2009, *http://www.utas.edu.au/_data/assets/pdf_file/0003/28370/CircumcisionIssuesPaperA4toPrint.pdf*.

101. Ibid.

102. Davis, "Male and Female Genital Alteration," see note 53 above.

103. D.M. Shaw, "Beyond Conflicts of Interest: Disclosing Medical Biases," *Journal of the American Medical Association* 312, no. 7 (2014): 697-8. This is not to say that financial conflicts of interest are not relevant. As a reviewer for this paper points out, the fact that circumcision generates sometimes substantial incomes for American doctors in the context of a for-profit medical system should not be discounted. This monetary aspect plausibly does play a role in perpetuating circumcision in the United States. As Christopher Price states, "Circumcision is a very complex issue [about which it has been said that] 'Mothers demand it, doctors profit by it, and babies cannot complain about it.' It is estimated that, with more than one million circumcisions a year at a cost on the order of $200 each, doctors in the United States earn in excess of $200 million *per annum*, from circumcisions. Such a major financial incentive to continue routine neonatal circumcision helps cloud the legal and ethical issues inherent in this activity." C. Price, "Male Non-Therapeutic Circumcision: Legal and Ethical Issues," in *Male and Female Circumcision* (New York: Springer US, 1999), 425-54. With respect to the AAP Task Force in particular, we note that, while no financial (or other) conflicts of interest were disclosed in the original AAP documents, a financial conflict of interest was in fact included in the AAP response to the European critics, as follows: "FINANCIAL DISCLOSURE: Dr. Carlo is a Director of Mednax; the other authors have indicated they have no financial relationships relevant to this article to disclose." This disclosure is hard to interpret, as no details are given as to the nature of the financial conflict of interest; it is also of concern that the

conflict—whatever it is—was not mentioned in the original policy statement or technical report. AAP, "Cultural Bias and Circumcision," see note 34 above, p. 801.

104. Shaw has argued from this premise that committee members should be required to disclose, as a potential conflict of interest, whether they are circumcised or have circumcised their son (Shaw, "Beyond Conflicts of Interest," see note 103 above). However, we will not pursue that argument here.

105. R.S. Van Howe, "The American Academy of Pediatrics and Female Genital Cutting," see note 19 above.