

CIRCUMCISION, SEXUAL EXPERIENCE, AND HARM

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ABSTRACT

Surgically modifying the genitals of children – female, male, and intersex – has drawn increased scrutiny in recent years. In Western societies, it is illegal to modify the healthy genitals of female children in any way or to any extent in the absence of a strict medical indication. By contrast, modifying the healthy genitals of male children and intersex children is currently permitted. In this journal in 2015, Stephen R. Munzer discussed a controversial German court case from 2012 (and its aftermath) that called into question the legal status of nontherapeutic male circumcision (NTC), particularly as it is carried out in infancy or early childhood. Whether NTC is legal before an age of consent depends partly upon abstract principles relating to the best interpretation of the relevant laws, and partly upon empirical and conceptual questions concerning the degree to which, and ways in which, such circumcision can reasonably be understood as a harm. In this article, we explore some of these latter questions in light of Professor Munzer's analysis, paying special attention to the subjective, personal, and individually and culturally variable dimensions of judgments about benefit versus harm. We also highlight some of the inconsistencies in the current legal treatment of male versus female forms of nontherapeutic childhood genital alteration, and suggest that problematically gendered assumptions about the sexual body may play a role in bringing about and sustaining such inconsistencies.

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1. INTRODUCTION

In a recent article in this journal, Stephen R. Munzer provided a nuanced and fair-minded discussion of the ongoing moral, legal, and medical controversy surrounding the nontherapeutic circumcision (“NTC”) of male infants and children.¹ His focus was on the Cologne ruling of 7 May 2012, which held that it is a criminal offense under the German Basic Law (Grundgesetz) to circumcise a male minor unless it is medically indicated² (a decision that was subsequently nullified by the passage of a special law by the German legislature).³ In his analysis of the ruling and its political aftermath, Professor Munzer emphasized the sharply contrasting perspectives that have come to characterize this at times “uncivil” debate.⁴ In this article, we shall highlight some of the key issues raised by Munzer that in our judgment deserve further attention. We focus in particular on the sexual implications of NTC and on the subjective elements of judgments about harm.

1.1. Risk and Personal Preference

Much of the controversy surrounding NTC concerns the extent to which, and ways in which, it may reasonably be understood as a harm. Although we will touch on some of the ongoing scientific disputes about the positive and negative physical consequences of NTC (chiefly claimed health

¹ Stephen R. Munzer, *Secularization, Anti-minority Sentiment, and Cultural Norms in the German Circumcision Controversy*, 37 U. PA. J. INT'L L. 503 (2015). For introductions to the controversy by the present authors, see generally Brian D. Earp & Robert Darby, *Does Science Support Infant Circumcision?* THE SKEPTIC (2014), available at https://www.academia.edu/9872471/Does_science_support_infant_circumcision; Brian D. Earp, *The Ethics of Infant Male Circumcision*, 39(7) J. MED. ETHICS 418 (2013).

² No. 151 Ns 169/11, Landgericht Köln [LG Köln] [Regional Court of Cologne] May 7, 2012, NEUE JURISTISCHE WOCHENSCHRIFT [NJW], 2128. As Jan F. Orth explains, “Regional Courts (*Landgerichte*) in Germany have chambers for criminal and civil law cases, both as court of first instance and as court of appeals. In this case, the chamber acted as a court of appeals.” Jan F. Orth, *Explaining the Cologne Circumcision Decision*, 77 J. CRIM. L. 497, 497 (2013).

³ For discussion, see generally Diana Aurenque & Urban Wiesing, *German Law on Circumcision and Its Debate: How an Ethical and Legal Issue Turned Political*, 29 BIOETHICS 203, 203–10 (2015); Reinhard Merkel & Holm Putzke, *After Cologne: Male Circumcision and the Law: Parental Right, Religious Liberty or Criminal Assault?* 39(7) J. MED. ETHICS 444, 444–49 (2013).

⁴ See Roger Collier, *Ugly, Messy and Nasty Debate Surrounds Circumcision*, 184(1) C.M.A.J. E25–E26, E25 (2012) (discussing polarized attitudes and the resulting “uncivil debate” surrounding male circumcision).

benefits versus surgical complications), these will not be the focus of our discussion. Instead, we shall argue that “new medical evidence on the risks and benefits of circumcision” is unlikely to provide compelling grounds for “an empirical refutation”⁵ of either of the principle stances on NTC: namely, that the procedure is on balance harmful as opposed to beneficial.

Why do we think that new medical evidence is unlikely to settle such disagreement? First, it is apparent that the scientific literature in this area is itself highly politicized,⁶ showing signs of polarization⁷ as well as personal, ideological, and cultural biases⁸ among many of those responsible for

⁵ Munzer, *supra* n.1, at 532.

⁶ See, e.g., Peter Aggleton, “Just a Snip”? A Social History of Male Circumcision, 29 REPROD. HEALTH MATTERS 15, 15 (2007) (questioning “the value neutrality of an act so profound in its social significance and so rich in meaning” and highlighting “how male circumcision – like its counterpart female genital mutilation – is nearly always a strongly political act, enacted upon others by those with power”); Sara Johnsdotter, *Discourses on Sexual Pleasure After Genital Modifications: the Fallacy of Genital Determinism (a Response to J. Steven Svoboda)*, 3(2) GLOB. DISC. 256, 256 (2013) (demonstrating that “medical statements about effects [of circumcision] on sexual pleasure are associated with politics”).

⁷ See, e.g., Kirsten Bell, *HIV Prevention: Making Male Circumcision the ‘Right’ Tool for the Job*, 10(5-6) GLOB. PUBLIC HEALTH 552, 552 (2015) (stressing “the need to expand the parameters of the debate beyond the current polarised landscape, which presents us with a problematic either/or scenario regarding the efficacy of male circumcision”); Brian D. Earp, *Addressing Polarisation in Science*, 41(9) J. MED. ETHICS 782, 782-83 (2015) (using the literature on male circumcision as an example of polarization in science).

⁸ See, e.g., Jennifer A. Bossio, et al., *A Review of the Current State of the Male Circumcision Literature*, 11(12) J. SEX. MED. 2847, 2848 (2014) (stating that “[t]he literature documenting the risks and benefits associated with neonatal circumcision is often influenced by author biases”); Jennifer A. Bossio, et al., *Response to: The Literature Supports Policies Promoting Neonatal Male Circumcision in N. America*, 12(5) J. SEX. MED. 1306, 1306 (2015) (noting the “high risk of bias” in an oft-cited review article “introduced by the authors’ well documented, unconditional support of the practice of circumcision”); Morten Frisch et al., *Cultural Bias in the AAP’s 2012 Technical Report and Policy Statement on Male Circumcision*, 131(4) PEDIATR. 796, 796 (2013) (stating that “cultural bias reflecting the normality of nontherapeutic male circumcision in the United States seems obvious,” which may explain why the conclusions expressed in the American Academy of Pediatrics’ 2012 statement on circumcision “are different from those reached by physicians in other parts of the Western world, including Europe, Canada, and Australia”); Ronald Goldman, *Circumcision Policy: A Psychosocial Perspective*, 9(9) PAEDIATR. & CHILD HEALTH 630, 630 (2004) (speculating that “conflicting opinions and conclusions in the medical literature ... together with the tenacity with which advocates and critics of circumcision hold on to their viewpoints, suggest that deep, unrecognized or implicit psychosocial factors are involved”); Andries J. Muller, *To Cut Or Not To Cut? Personal Factors Influence Primary Care Physicians’ Position on Elective Newborn Circumcision*, 7 J. MEN’S HEALTH 227, 227 (2010) (reporting the results of a survey of 572 doctors, finding that “[a]lthough most respondents stated that they based their decisions on medical evidence, 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”); Brian D. Earp & David M. Shaw, *Cultural Bias in American Medicine: The Case of Infant Male Circumcision*, J. PEDIATR. ETHICS (in press) (for a general discussion).

producing and interpreting the relevant research and turning it into policy.⁹ This can, at times, make it difficult, if not impossible, to determine what “the evidence” really suggests. But suppose that were not the case, and there were instead an agreed-upon set of “objective” facts concerning the likelihood of various physical and non-physical consequences of NTC, under whatever specified conditions. Still, one could not settle the question of how each benefit or risk should be characterized, much less weighted, in terms of subjective factors including the affected male’s preferences and values. To illustrate this idea, take the concept of risk. Philosopher Scott Campbell argues,

one of the components of risk is harm. This is the level of badness or loss associated with the occurrence of x. Harm does not just include physical injury but any sort of circumstance that P would prefer not to be the case. If there is nothing bad about x at all then P is not at risk from x. This entails that our attitudes and preferences partly determine risk, because our attitudes and preferences determine what counts as a harm.¹⁰

⁹ Such biases arguably point in both directions. See, e.g., Jennifer A. Bossio, et al., *Re: Examining Penile Sensitivity in Neonatally Circumcised and Intact Men Using Quantitative Sensory Testing*, 195 J. UROL. 1848, 1852-53 (2016) (stating that their findings should not be interpreted as supporting “either the pro or anti-circumcision ‘camp’” and that “[o]ne does not have to search far for [personal] biases in the circumcision literature, such as frequent references to non-peer-reviewed articles and author involvement in anti or pro-circumcision advocacy groups”). See also AAP, *Cultural Bias and Circumcision: The AAP Task Force on Circumcision Responds*, 131(4) PEDIATR. 801, 801 (2013) (stating that their critics “hail from Europe, where the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis [and there] is a clear bias against circumcision”). In response to this contention, however, see Brian D. Earp, *The AAP Report on Circumcision*, PRACTICAL ETHICS (2012), available at https://www.academia.edu/15617255/The_AAP_report_on_circumcision_Bad_science_bad_ethics_bad_medicine (pointing out that being “biased” against medically unnecessary surgeries performed on nonconsenting minors is usually regarded as the default position in Western medicine, regardless of a doctor’s country of origin).

¹⁰ Here P refers to a person and x to an action or occurrence. The quote is from Scott Campbell, *Risk and the Subjectivity of Preference*, 9 J. RISK RES. 225, 226-27 (2006). Campbell then emphasizes the objective nature of certain harms, once the subjective preferences are known: “It is true that risk is subjective in the sense that it depends upon our preferences ... risk is not independent of minds and cultures.” But once one’s preferences are known, “then whether there exists a risk, and how much of a risk there is, is a matter of objective fact.” Suppose that action A could lead to x, where x is something contrary to your preferences, and therefore a harm to you. It follows from this proposition that “it is a fact about the world that in doing A, you risk x. ... It would be misleading to say that such a fact is purely subjective. Given that person P regards x as a harm and that A could lead to x, it is then an objective fact about the world that P runs the risk of x in doing A.” *Id.*, at 227-28.

Note that something could be bad for a person even if he does not prefer that the circumstances were different: for example, his preferences could be tied to a gross misunderstanding about the state of the world.¹¹ But assuming he is reasonably well-informed, and that his preferences fall within some rationally defensible spectrum, his own assessment of whether x poses a risk to him – and, if it does, the nature and degree of the risk – must be factored into the equation.¹² As Campbell states, in many cases, we “cannot determine whether or not x is a risk” without first taking stock of people’s preferences.¹³

But preferences vary between groups and individuals. In the case of NTC, sources of variance include people’s tolerance for certain kinds of risk compared to others (and related attitudes concerning available risk-management strategies), judgments about the real-world importance of alleged benefits or risks, and assessments of their personal relevance given one’s habits and circumstances. Preferences may also vary over time as people are exposed to different perspectives, form new impressions, or process additional information.

In short, there is a fundamentally unstable, personal dimension to assessments of benefit versus risk (which we take to mean “prospect of benefit” versus “risk of harm” for the purposes of this analysis).¹⁴ This subjective element is especially pertinent to childhood NTC since it involves

¹¹ Some risk theorists are objectivists about harm, at least in certain cases. Campbell notes that “it may not always be the case that harm is just a matter of people’s own preferences. For example, suppose P wishes to commit an act of self-mutilation. Is there no harm to P in carrying out such an action just because it is in accordance with P’s own wishes?” Some moral philosophers and others say no. “They would claim that P’s self-mutilation is a harm for P, regardless of whether or not he (or anyone else) realizes it” (Campbell, *supra* n.10, at 229). That Campbell chooses “mutilation” to make his point is telling; indeed, the laceration or removal of non-diseased, functional bodily tissue – which is what we assume he means by “mutilation” in this context – is the very sort of thing that many people do regard as in-and-of-itself a harm. We will not, however defend this view in the present essay. Instead, we shall simply try to show that it is reasonable for a man to regard someone else’s having cut off his foreskin when he was an infant or young child as a harm (i.e., something contrary to his considered preferences).

¹² We are using the masculine pronoun in this paragraph because the topic of discussion is male circumcision; however, the argument applies regardless of sex or gender.

¹³ Campbell, *supra* n.10, at 227-228.

¹⁴ See Robert Darby, *Risks, Benefits, Complications and Harms: Neglected Factors in the Current Debate on Non-Therapeutic Circumcision*, 25(1) KENNEDY INSTITUTE OF ETHICS J. 1(2015) (emphasizing that the term “risk” in biomedical ethics is usually taken to mean risk of any type of harm, physical or non-physical, and not just the risk of surgical complications, as implicitly assumed in the 2012 circumcision policy of the American Academy of Pediatrics).

the involuntary surgical alteration of a psychosexually significant part of the body—the penis. Needless to say, individual attitudes concerning the aesthetics of the penis, whether surgically modified or natural, as well as the sensual and symbolic significance of the organ, vary considerably both within and between cultures. Moreover, the state of one's genitals, circumcised or intact, can inspire strong emotions relating to one's sexuality, self-image, and self-esteem.¹⁵ It is for these reasons that we shall emphasize the sexual implications of NTC in our discussion.

1.2. Science, Sex, and Subjectivity

In discussing these implications, we adopt a skeptical attitude toward the prospect of assessing them scientifically, much less applying them universally.¹⁶ In this regard, we are sympathetic to the view of Juliet Richters, who notes that “[a]rguments about circumcision reveal something of the limitations of evidence-based medicine. They can tell us how many circumcisions are necessary to prevent one case of penile cancer (about 1000),

¹⁵ As physician Thomas Ritter suggests: “Males in particular, because of their convex genital makeup, visually confront, and probably assess, their penises many times a day. Daily the male awakens with an erection. The penis must be touched when washing, dressing, and directing the urinary stream,” and when conducting other aspects of his daily routine. “A man usually regards his penis as an extremely valued possession, and in its frequent perusal, cannot fail to associate with it emotions, reminiscences, and possible fantasies.” Thomas J. Ritter, *Foreword to ROSEMARY ROMBERG, CIRCUMCISION: THE PAINFUL DILEMMA*, vii, vii-ix (Bergin and Garvey, 1985).

¹⁶ Please note that such purported assessments often are applied universally in both the empirical and policy literatures. See Bossio, et al., *Review of Male Circumcision Literature*, *supra* n.8, at 2847-64. As these authors note, there are “important problems with using men who undergo circumcision as adults to draw conclusions about the impact of the procedure on sexual functioning” generally. In North America, for example, most circumcisions occur in neonates, and the effects of undergoing circumcision at this age compared to adulthood “are unknown with regard to factors such as pain perception, penile sensitivity, and sexual functioning.” Moreover, many of the participants in the studies the authors review “consisted of nonrandom samples of men who had undergone circumcision to correct medical or sexual issues involving their genitals.” But in such self-selected samples, “self-reported outcomes are likely to be heavily biased by the men’s own decisions to have the procedure.” It is therefore problematic that when “policy statements about neonatal circumcision take sexual functioning into account, they primarily cite articles with the methodological shortcomings” just discussed: “the populations that compose the current research in the area of circumcision and sexual functioning are not comparable to the typical healthy, neonatally circumcised male in North America.” *Id.*, at 2853.

but they cannot [adequately] engage with the subjective experiences of the sexual body."¹⁷

And yet such experiences are crucial for making intelligible judgments of benefit versus harm, while at the same time being highly individualized: they may be quite different from person to person even if the "objective" outcomes of circumcision are held constant for the sake of analysis. As Sara Johnsdotter argues, "[w]hile genitalia usually are central to sexual activity, and can be seen as a prerequisite for sexual intercourse, it is a misapprehension to see the state of them (cut or uncut) as determinative of the individual's experience of the sexual encounter."¹⁸

Below, we will provide evidence that many men, including a substantial number of men from majority-circumcising cultures or sub-cultures, regard themselves as being sexually or otherwise harmed by circumcision. This perception of harm often exists even in the absence of surgical complications or other commonly acknowledged "medical" risks of circumcision:¹⁹ the men feel harmed simply by virtue of having had their foreskins removed, especially without their consent.²⁰ This response is due to two main factors: first, the positive value the men assign to the notion or embodied state of genital intactness or wholeness, as well as to the foreskin itself (a structure lost to circumcision by design); and second, the negative value they assign to various outcomes of circumcision that are intrinsic to the procedure. These outcomes include the denuded appearance of the penis (or the appearance of its scar tissue), changes in external tactile properties of the

¹⁷ Juliet Richters, *Bodies, Pleasure and Displeasure*, 11(3) CULT. HEALTH SEX. 225, 229 (2009). Note that the figure on cancer provided by Richters is one of the lowest available estimates; others range as high as 322,000 (see the discussion of penile cancer *infra*).

¹⁸ Johnsdotter, *supra* n.6, at 264.

¹⁹ This perception of harm in the absence of medical problems has led some commentators to conclude that such judgments are misguided or out of proportion. For example, Ronald A. Lindsay has recently stated that "agonizing over the loss of a foreskin is an unwarranted, excessive reaction." Ronald A. Lindsay, *Male Circumcision and Self Determination*, HUFFINGTON POST (Dec. 13, 2016), available at http://www.huffingtonpost.com/ronald-a-lindsay/male-circumcision-and-self-determination_b_13600924.html. In contrast, we shall try to show that such feelings are not necessarily unwarranted or excessive, in part by drawing analogies to other cases.

²⁰ For evidence and extensive discussion, see generally Tim Hammond & Adrienne Carmack, *Long-term Adverse Outcomes from Neonatal Circumcision Reported in a Survey of 1,008 men: An Overview of Health and Human Rights Implications*, INT'L. J. HUM. RTS. (in press).

head of the penis that are brought about by circumcision, the foreclosure of the ability to experience sex with surgically unmodified genitalia (i.e., to engage in sexual activities that require manipulation of the foreskin), and the loss of personal choice concerning a very “private” part of the body.²¹

By contrast, other men regard themselves as being sexually (or otherwise) enhanced by virtue of having been circumcised, due to a different set of attitudes and values. For example, where circumcision is culturally normative, the foreskin might be presumed to be of limited or no intrinsic or instrumental value, or even of negative value, such that its loss to circumcision would be less likely to be construed as in-and-of-itself a harm.²²

²¹ It is sometimes argued, correctly, that infants and young children do not have free choice with respect to many important aspects of their lives. But it is also true that there are certain restrictions that societies may place on the actions parents may permissibly take or authorize with respect to their children—particularly when it comes to permanent modifications of the child’s body. For example, in some jurisdictions, parents may not authorize the tattooing of a child’s body, even when the child requests it and the parents believe that it would be in the child’s best interests. As barrister James Chegwiddden notes, “the common law is very cautious before treating children’s consent as justifying any non-therapeutic body alteration.” In the decision of *Burrell v Harmer* [1967] Crim LR 169 (UK), for instance, “a tattoo artist was convicted of assault following his tattooing of two boys aged 12 and 13, despite their consent. The court observed that if a child [was] ‘unable to appreciate the nature of an act, apparent consent to it was no consent at all.’ It held that such was the case with tattooing, since children are likely not to foresee the long-term consequences.” James Chegwiddden, *Response: Tasmanian Law Reform Institute Issues Paper No. 14: Non-therapeutic Male Circumcision* 1, 17-18 (n.d. [2009]). As Chegwiddden goes on to note, the specific grounds given in the ensuing Parliamentary debates for a ban on tattooing before the age of 18 “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 damage to the tattooed person’s social integration and sometimes, to their feelings of self-worth;
- The embarrassment felt by those tattooed who later regret it;
- The unhygienic conditions in which some tattooing is performed.

Circumcision has not yet come under the same scrutiny as tattooing. But the logic behind the latter’s banning is undeniably relevant to the former.” *Id.* at 18. In addition, in Western societies, parents may not legally cut into, much less remove, any part of a female child’s genitalia when it is deemed medically unnecessary to do so, including forms of such cutting or removal of tissue that are less physically invasive than the most common forms of male circumcision (see later discussion). Consequently, in order to determine whether any particular nontherapeutic alteration of a child’s body is acceptable, it is necessary to triangulate between analogous cases to determine where the limits lie. By contrast, simply pointing out that infants and young children do not have the ability to make free choices, and that certain of their future options are regularly foreclosed upon as a part of normal (and even reasonable) parenting, is insufficient to draw justified conclusions about the permissibility of any particular action taken toward a child.

²² See *infra*, Section 3.2.

But whatever the case, individual differences in circumcision-related body-image appraisals can affect one's sexual experiences in significant ways. Combined with differences in subjective weightings of the various other alleged benefits and risks of NTC, such appraisals pose a challenge for this debate. Specifically, they pose a challenge to any legal analysis that presumes the possibility of an "empirical refutation" of an asserted ratio of benefit to harm.

To frame this challenge, we begin by discussing the role of harm judgments generally in legal reasoning, with an emphasis on their "open textured" nature.²³ This nature goes a long way toward explaining the contradictory conclusions that are often drawn about the harmfulness of NTC. Then, to explore the sexual dimensions of this potential harmfulness, we describe some of the specific ways in which circumcision changes the penis, emphasizing the range of possible surgical, anatomical, and other outcomes. Following that, we share several personal accounts from men who have had differing responses to such penile alterations.

We will also discuss some of the benefits, both medical and non-medical, that have been attributed to circumcision. To this end, we explore how men may reasonably reach different conclusions about the importance or even relevance of those benefits, given alternative means of achieving them. Along the way, we reflect on the problem of uncertainty regarding whether a boy who is circumcised in infancy or early childhood will grow up to view himself as having been enhanced by circumcision, as opposed to diminished by it or even mutilated. In this regard, we emphasize the very intimate nature of the genitalia, as well as the temporal and geographic instability of the cultural, social, and other norms that typically influence such personal evaluations. Given such unstable conditions, we conclude that, in most cases, the balance of considerations weighs in favor of avoiding NTC in infancy or early childhood. In this way, each individual can perform his own risk-benefit analysis at an age of understanding, factoring in his personal preferences and values.

²³ See *infra*, Section 2.1.

Finally, we draw attention to the current legal disparity in protections afforded to male versus female children when it comes to nontherapeutic genital alterations. Although we do not draw any hard and fast conclusions about how these disparities should be addressed, we do maintain that the *status quo* is untenable.

2. THE QUESTION OF HARM

Is circumcision, at least on balance, harmful? In addressing this question, Professor Munzer discusses the work of Dr. Bijan Fateh-Moghadam, who was critical of the Cologne decision. In Dr. Fateh-Moghadam's view, the "risk-benefit ratio of circumcision is acceptable," and therefore "parental consent to circumcision lies within the scope of the parents' discretion."²⁴ Of course, judgments about the acceptability of this ratio are likely to differ between reasonable people, and the claimed ratio itself may change with the shifting tides of scientific opinion. Nevertheless, according to Munzer, "[b]e the test acceptability or some other standard, Fateh-Moghadam's argument could be vulnerable to an empirical refutation."²⁵

The idea that the acceptability of circumcision rests on a refutable empirical contention has significant historical precedent. In a 1890s treatise on the cultural, religious, and medical aspects of circumcision, the German Jewish physician Abraham Glassberg advocated circumcision of infants as a health precaution, but also conceded that if circumcision were shown to be harmful it would be necessary for the state to intervene.²⁶ Other defenders of cultural/religious circumcision have similarly proposed that, since circumcision was not at all harmful, not harmful on balance, or not harmful

²⁴ As summarized by Munzer, *supra* n.1, at 531.

²⁵ *Id.* at 532.

²⁶ See LEONARD GLICK, MARKED IN YOUR FLESH: CIRCUMCISION FROM ANCIENT JUDAEA TO MODERN AMERICA 134-36 (2005).

enough to warrant interference with parental prerogatives or traditional customs, it should remain unrestricted.²⁷

The question of harm, then, has become central to the debate over the ethical and legal permissibility of circumcision. While critics of the practice often argue that it is harmful by its very nature—seeing the non-consensual loss of functional tissue as a sufficient condition for harm—or harmful on balance by virtue of its average consequences, defenders often suggest that the procedure does not cause or constitute harm except in the case of surgical mishaps. Some supporters go even further and claim that it is highly beneficial,²⁸ at least socially or spiritually if not necessarily physically.²⁹ Despite this disagreement, however, both sides appear to believe that there is one right answer to the question: either circumcision is harmful or it is not harmful, and—if one sets aside claims about intrinsic harm—“the evidence” will show us which is correct.

But there are difficulties with this way of framing the issue. First, as we have noted, “the evidence” is itself highly politicized and strenuously contested. Second, there are no universally agreed-upon benchmarks for defining harm or setting a harm threshold beyond which state interference

²⁷ See, e.g., Michael Benatar & David Benatar, *Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision*, 3(2) AM. J. BIOETH. 35 (2003) (arguing that since the benefits and harms of circumcision are balanced in their judgment, it is reasonable for parents to make the decision); Joseph Mazor, *The Child's Interests and the Case for the Permissibility of Male Infant Circumcision*, 39(7) J. MED. ETHICS 421 (2013) (suggesting that the balance of benefits and risks is close enough to permit parental choice, while conceding that if circumcision is not being carried out to fulfill a perceived religious obligation, the balance of interests most likely weighs against the procedure); AAP, *Circumcision Policy Statement*, 130 PEDIATR. 585 (2012) (asserting that the benefits of circumcision outweigh the risks and that parents should therefore be able to decide).

²⁸ See, e.g., Brian J. Morris, *Why Circumcision is a Biomedical Imperative for the 21st century*, 29 BIOESSAYS 1147, 1147 (2007) (claiming that NTC “represents a surgical ‘vaccine’ against a wide variety of infections, adverse medical conditions and potentially fatal diseases over [the boy’s] lifetime” providing “enormous public health benefits”). Professor Morris is probably the most vocal contemporary proponent of circumcision on health grounds; his publications are also generally regarded as among the most controversial. See, e.g., Barry Lyons, *Male Infant Circumcision as a “HIV Vaccine,”* 6 PUBLIC HEALTH ETH. 90, 91 (2013) (criticizing the vaccine analogy and noting that “no western representative medical organization” agrees with Morris’s extreme views).

²⁹ The latter claim functions as an escape valve: even if circumcision did entail harms, they would be outweighed by the sundry benefits. See, e.g., Allan J. Jacobs & Kavita S. Arora, *Ritual Male Infant Circumcision and Human Rights*, 15(2) AM. J. BIOETH. 30 (2015) (making the claim that any harms that might be associated with NTC are compensated for or overbalanced by various medical and non-medical benefits).

would be justified. Third, any weighing of particular harms and benefits—even if their existence were undisputed and their likelihood precisely estimated—would result in different conclusions depending on one's starting assumptions, preferences, and values. Finally, as we explain in the following section, the very concept of "harm" lends itself to wide-ranging interpretations as to its meaning and proper scope of application.

2.1. Harm as an Open Textured Concept

That contradictory assertions have been made about the harmfulness of circumcision, often seemingly in good faith by proponents and critics alike, should come as no surprise. According to one widely accepted view, harm is an "open textured concept,"³⁰ a term introduced by the legal philosopher H. L. A. Hart. As Kwame Anthony Appiah has suggested, such concepts may be at play when "two people who both know what [the words they are using] mean can reasonably disagree about whether they apply in particular cases."³¹ Hart argues that legal decisions depend upon the application of rules, which in turn depend on the interpretation of terms whose range of applicability is uncertain and often influenced by the values and interests of the parties to the discussion. He uses the simple example of a law that prohibits vehicles from entering a public park – which immediately raises the question of what counts as a vehicle. Does it include bicycles, skateboards, golf buggies, baby strollers, or children's pedal cars? The law cannot specify all the possible objects to be covered by the rule, so it is left to the courts to determine whether skateboards or golf buggies, for example, are vehicles and hence whether their operators are breaking the law by entering the park.

Interpretations of open texture terms can almost always be challenged, and lengthy legal appeals have arisen from disputes over the ambit of terms such as vehicle, structure, fair wages, reasonable price, and safe working conditions. Indeed, some expressions that bear more directly on the present issue of contested interventions into children's bodies – such as the oft-

³⁰ H. L. A. HART, *THE CONCEPT OF LAW* 124-36 (3d ed. 2012) (1961).

³¹ KWAME ANTHONY APPIAH, *COSMOPOLITANISM: ETHICS IN A WORLD OF STRANGERS* 58 (2007).

invoked “best interests” standard – are about as open textured as possible, and they have given rise to diverse interpretations, depending on, *inter alia*, the cultural presuppositions of the parties to the debate.

This influence of culture can be seen most vividly in the related case of ritualized female genital cutting, as discussed by Munzer.³² This practice, or rather set of practices, is primarily seen by Western observers as being unambiguously harmful, “repugnant,” and “intolerable.”³³ But as Robert S. Van Howe has pointed out, “there are practitioners, especially in cultures where female circumcision is common, who fervently believe that [even the] more invasive forms of female circumcision ... do not pose risks of physical or psychological harm.”³⁴ This difference in perspective could be taken to suggest that culturally variant background assumptions – perhaps bolstered by conscious or unconscious “motivated cognitions”³⁵ aimed at reducing

³² Note that the World Health Organization uses the term “FGM” for Female Genital Mutilation, which is also the term employed by Munzer. But, among scholars of ritual genital cutting practices, this term has fallen out of favor for several reasons including its lack of value-neutrality. For discussions, see generally Dena S. Davis, *Male and Female Genital Alteration: A Collision Course With the Law*, 11 HEALTH MATRIX 487 (2001); Fuambai S. Ahmadu, *Why the Term Female Genital Mutilation Is Ethnocentric, Racist and Sexist – Let’s Get Rid of It!*, HYSTERIA (2016), available at <http://www.hystericalfeminisms.com/why-the-term-female-genital-mutilation-fgm-is-ethnocentric-racist-and-sexist-lets-get-rid-of-it/> (last visited Sept. 24, 2016). Increasingly, “FGC” for “Female Genital Cutting” or “FGA” for Female Genital Alteration(s) are the preferred terms. “Female circumcision” is sometimes employed as well.

³³ Munzer, *supra* n.1., at 561. For recent scholarship challenging this perspective as overly simplistic, see generally Public Policy Advisory Network on Female Genital Surgeries in Africa, *Seven Things to Know About Female Genital Surgeries in Africa*, 42(6) HASTINGS CENTER REP. 19 (2012); Richard A. Shweder, *The Goose and the Gander: The Genital Wars*, 3(2) GLOB. DISC. 348 (2013); Richard A. Shweder, *What About “Female Genital Mutilation”? And Why Understanding Culture Matters in the First Place*, 129(4) DAEDALUS 209 (2000); Brian D. Earp, *Between Moral Relativism and Moral Hypocrisy: Reframing the Debate on “FGM,”* 26(2) KENNEDY INSTITUTE OF ETHICS J. 105 (2016); L. Amede Obiora, *Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign Against Female Circumcision*, 47 CASE W. RES. L. REV. 275 (1996); GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD: DISPUTING US POLEMICS (Stanley M. James & Claire C. Robertson eds., 2002).

³⁴ Robert S. Van Howe, *The American Academy of Pediatrics and Female Genital Cutting: When National Organizations Are Guided by Personal Agendas*, 27(3) ETHICS & MED. 165, 167 (2011).

³⁵ One form of motivated reasoning is what Dan Kahan refers to as “cultural cognition:” namely, “the tendency of individuals to conform their perceptions of risk and other policy-consequential facts to their cultural worldviews.” Dan M. Kahan, *The Supreme Court 2010 Term - Foreword: Neutral Principles, Motivated Cognition, and Some Problems for Constitutional Law*, 125 HARV. L. REV. 1, 23 (2011). For related discussions, see generally Adel S. Z. Abadeer, *Cognitive Dissonance and Gender Discrimination* in NORMS AND GENDER DISCRIMINATION IN THE ARAB WORLD 115 (2015); Cory J. Clark et al., *Moral Coherence Processes: Constructing Culpability and Consequences*, 6 CURRENT OPINION IN PSYCHOLOGY 123 (2015); Brian D. Earp, ‘Legitimate Rape,’ *Moral Coherence, and Degrees of Sexual Harm*, 14(41) THINK 9 (2015).

cognitive dissonance—have the potential to stretch one's perceptions or interpretations of harm to a significant degree.³⁶ Moreover, when the purported social and cultural benefits of female circumcision are factored into the equation—including, in some groups, perceived aesthetic enhancement,³⁷ beliefs about improved cleanliness, and greater acceptance by one's peers and elders³⁸—“practitioners could easily convince themselves that any harm is more than offset by the many perceived benefits.”³⁹

Dictionary definitions will not resolve such disagreements. The Shorter Oxford English Dictionary, for example, defines harm as “hurt, injury, damage, mischief.”⁴⁰ Most people across a range of cultural settings would agree these things are bad, and often bad enough to warrant legal sanction. But the question of whether these terms are applicable to—or accurate descriptions of—any particular practice, such as nontherapeutic male or female genital cutting, requires deeper reflection, and, ultimately, heavily value-laden judgments.

³⁶ In a classic study from 1964, Speisman and colleagues showed participants a film of what they call “primitive adolescent ‘subincision’ rites” (a relatively extreme form of ritualized male genital cutting), but manipulated how the film was framed by playing three different soundtracks (designed to influence participants’ mindsets while watching the films) and comparing stress responses to a silent control condition. “The findings supported the importance of the process of cognitive appraisal [in] producing stress reactions, permitting the conclusion that the same visual stimulus varies in the amount of stress produced depending upon the nature of the cognitive appraisal the person makes.” Joseph C. Speisman et al., *Experimental Reduction of Stress Based on Ego-defense Theory*, 68(4) J. ABNORM. & SOC. PSYCHOL. 367, 367 (1964).

³⁷ See, e.g., Lenore Manderson, *Local Rites and Body Politics: Tensions Between Cultural Diversity and Human Rights*, 6(2) INT'L FEMINIST J. POL. 285 (2004); Fuambai S. Ahmadu & Richard A. Shweder, *Disputing the Myth of the Sexual Dysfunction of Circumcised Women: An Interview with Fuambai S. Ahmadu by Richard A. Shweder*, 25(6) ANTHROPOL. TODAY 14 (2009).

³⁸ Bettina Shell-Duncan, et al., *Dynamics of Change in the Practice of Female Genital Cutting in Senegambia: Testing Predictions of Social Convention Theory*, 73(8) SOC. SCI. MED. 1275 (2011). These authors present original data suggesting that, in Senegal and the Gambia at least, “being circumcised serves as a signal to other circumcised women that a girl or woman has been trained to respect the authority of her circumcised elders and is worthy of inclusion in their social network. In this manner, FGC facilitates the accumulation of social capital by younger women and of power and prestige by elder women.” *Id.* at 1275.

³⁹ Van Howe, *supra* n.34, at 167. For further discussion, see generally J. Steven Svoboda, *Promoting Genital Autonomy by Exploring Commonalities Between Male, Female, Intersex, and Cosmetic Female Genital Cutting*, 3(2) GLOB. DISC. 237 (2013); British Medical Association, *The Law and Ethics of Male Circumcision: Guidance for Doctors*, 30(3) J. MED. ETHICS 259 (2004).

⁴⁰ NEW SHORTER OXFORD ENGLISH DICTIONARY 1191 (Oxford: Clarendon Press, 1993).

2.2. A Legal Framework

In a legal context, there are several plausible frameworks for guiding such judgments, one of which comes from the work of Joel Feinberg. In his analysis of the moral limits of criminal law, Feinberg (whose influential “open future”⁴¹ principle is also discussed by Munzer) defines harm as a “setback to interests.” Interests, in turn, are glossed as ordinary desiderata shared by most people: “[t]he interests in one’s own physical health and vigour, the integrity and normal functioning of one’s body, the absence of absorbing pain and suffering or grotesque disfigurement ... the absence of groundless anxieties and resentments, the capacity to engage normally in social intercourse and to enjoy and maintain friendships.”⁴²

Feinberg explains that despite their everyday nature, these interests are “the very most important interests a person has, and cry out for protection, for without their fulfillment a person is lost. ... These minimal goods can be called a person’s welfare interests. When they are blocked or damaged, a person is very seriously harmed.”⁴³ Because these interests are so important, their violation falls properly within the domain of criminal law. Significantly, he adds that “[i]mpairment of function ... is the most common form of a setback to welfare interests, and perhaps the mode characteristic of the most serious harms to persons.”⁴⁴

Functions are impaired “[w]hen they are weakened and lose their effectiveness. A broken arm is an impaired arm, one which has (temporarily) lost its capacity to serve a person’s needs effectively, and in virtue of that impairment its possessor’s welfare interest is harmed.”⁴⁵ A person who deliberately breaks another person’s arm will appropriately be prosecuted for causing him harm, even though the injury (the impairment) is temporary and

⁴¹ For critical discussions, see generally Robert Darby, *The Child’s Right to an Open Future: Is the Principle Applicable to Non-Therapeutic Circumcision?* 39 J. MED. ETHICS 463 (2013); Eldar Sarajlic, *Can Culture Justify Infant Circumcision?* 29(4) RES PUBLICA 327 (2014).

⁴² JOEL FEINBERG, HARM TO OTHERS 36-37 (1984) (emphasis added).

⁴³ *Id.* at 37.

⁴⁴ *Id.*

⁴⁵ *Id.* at 53.

the arm is expected to heal. If, therefore, NTC results in any impairment of function, even if only temporarily, it may be legitimate—according to this line of thought—for the law to regulate, restrict, or even prohibit it in certain circumstances.⁴⁶ We will return to this point in Section 3.3.

Here, too, one will find subjective, individually variable judgments about what *counts* as a functional impairment, as well as about how and by whom such impairments should be assessed. But such judgments cannot be entirely free-floating: to be credible, they must be firmly tethered to an informed understanding of what is actually implied by the practice in question. Since much of the legal literature treats NTC as a vague abstraction,⁴⁷ with minimal or no description of surgery itself or the part of the penis it is designed to remove, we shall take some time to elucidate these matters in the following section. Once we have a grasp of what NTC involves and how the penis is altered by it in the typical case, we will be in a better position to

⁴⁶ In determining whether an action is sufficiently harmful to warrant legal sanction, it is noteworthy that one of the leading cases in this area has set the threshold rather low. This is the “Spanner” case (Rex v. Brown et al., 1993), in which the British appeals court found that although the activities in question involved adults, were consensual, and resulted in no permanent physical damage, such sado-masochist encounters were unlawful because they resulted in “actual bodily harm” and “wounding.” In the words of Lord Templeman, “[t]he appellants belonged to a group of sado-masochistic homosexuals who ... willingly participated in the commission of acts of violence against each other, including genital torture, for the sexual pleasure which it engendered in the giving and receiving of pain. The passive partner or victim in each case consented to the acts being committed and suffered no permanent injury.” R v Brown [1993] 2 All ER 75. For our purposes, the key point from this case is that the harms (here glossed as injuries) inflicted on the passive participants were temporary – whipping, beating, hot wax, some scratching and minor laceration of the skin. All participants recovered quickly, without the need for any medical attention. The injuries were, in fact, both less severe and less permanent than those entailed by infant or early childhood NTC, which, in addition to lacking the consensual character of the aforementioned activities, permanently removes functional, non-diseased bodily tissue, and not infrequently requires subsequent medical attention to deal with bleeding, infection, pain, and other complications. Thus, while an individual’s own implicit understanding of the term “harm” (as well as its proper scope of applicability) may certainly vary between groups and individuals, there is some Western legal precedent for construing bodily injuries that are less extensive than male circumcision as being in-and-of-themselves harmful. Importantly, this is the case notwithstanding that various countervailing benefits are often also claimed for the actions causing the injuries (e.g., sadomasochistic pleasure). It is therefore curious that Templeman chose to comment in passing that ritual (male) circumcision—along with ear-piercing and violent sports—were lawful activities, without explaining the logical basis for these exceptions. (Note that this is an *obiter dictum*, having no bearing on the issue decided in the case, and is therefore not legally binding; the court was deciding on the lawfulness of consensual sadomasochism, not ritual circumcision).

⁴⁷ For a criticism of this tendency, see, e.g., David P. Lang, *Circumcision, Sexual Dysfunction, and the Child’s Best Interests: Why the Anatomical Details Matter* 39(7) J. MED. ETHICS 429 (2013).

understand the sharply differing attitudes that some men have about whether they have been harmed by the procedure.

3. WHAT DOES NTC INVOLVE AND HOW DOES IT CHANGE THE PENIS?

For the purposes of this analysis, NTC is defined as the deliberate removal of part or all of the penile prepuce (foreskin) in a healthy individual for whom there is no immediate medical indication for the procedure. As the pathologists Christopher Cold and John Taylor state:

The prepuce is an integral, normal part of the external genitalia, that forms the anatomical covering of the glans penis ... The outer epithelium has the protective function of internalising the glans [as well as the] urethral meatus (in the male) and the inner preputial epithelium, thus decreasing external irritation or contamination. The prepuce is a specialized, junctional mucocutaneous tissue which marks the boundary between mucosa and skin; it is similar to the eyelids, labia minora, anus and lips. The male prepuce also [typically] provides adequate mucosa and skin to cover the entire penis during erection. The unique innervation of the prepuce establishes its function as an erogenous tissue.⁴⁸

The foreskin thus has two layers—the inner and outer epithelia—which, when unfolded, comprise about 30-50 square centimeters of highly sensitive tissue in the average adult organ (roughly the surface area of a credit card and about half the moveable skin system of the penis).⁴⁹ It is of course much smaller in infancy or early childhood. While removing this genital structure at such an age may appear to be simple or straightforward, it is in fact an intricate procedure that produces a range of physical and cosmetic outcomes. This variability, even for circumcisions that are “properly”

⁴⁸ Christopher J. Cold & John R. Taylor, *The Prepuce*, 83(S1) BJU INT'L. 34, 34 (1999).

⁴⁹ Godfrey Kigozi et al., *Foreskin Surface Area and HIV Acquisition in Rakai, Uganda (Size Matters)*, 23(16) AIDS 2209 (2009); Paul Werker et al., *The Prepuce Free Flap: Dissection Feasibility Study and Clinical Application of a Super-Thin New Flap*, 102 PLAST. RECONSTR. SURG. 1075 (1998); Claude C. Malic et al., *Resuscitation Burn Card – a Useful Tool for Burn Injury Assessment*, 33(2) BURNS 195 (2007); John R. Taylor et al., *The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision*, 77(2) BRIT. J. UROL. 291 (1996).

performed, is important to keep in mind when attempting to draw any general conclusions about the potential harms of the procedure *per se*.

3.1. *The Problem of Variability*

The variability just mentioned arises from two main sources: the body part circumcision is designed to remove—the foreskin—and the method employed to remove it. To take the second point first, “[c]ircumcision methods can be classified into one of three types or combinations thereof: dorsal slit, shield and clamp, and excision.”⁵⁰ Whichever method is used, practitioners must contend with the fact that the foreskin is not a discrete entity, like a finger or gall bladder, but rather a sheath of tissue wrapped around and integrated with the larger structure of which it is a part (i.e., the penis). Moreover, in infants and young children, the inside of the foreskin is usually firmly adherent to the head of the penis, since “[t]he fused mucosa of the glans penis and the inner lining of the prepuce separate [only] gradually over years, as a

⁵⁰ Abdullahi Abdulwahab-Ahmed & Ismaila A. Mungadi, *Techniques of Male Circumcision*, 5(1) J. SURG. TECHNIQUE & CASE REP. 1, 2 (2013). Among “shield and clamp” style devices, the Gomco clamp is one of the most widely used (for video of a circumcision using this device, see <http://newborns.stanford.edu/Gomco.html>). If the person undergoing the circumcision is an infant, he is typically first placed into an apparatus called a “circumstraint” to which his arms and legs are strapped; in a religious setting, the child’s limbs may simply be held down by a family member. Once the child is immobilized and a local anesthetic (if any) has been administered, a straight forceps is advanced between the glans and foreskin along the dorsal midline to the depth of the coronal sulcus. The forceps is then clamped along this line on the inside and outside of the foreskin. A slit is cut with a scalpel along the side of the forceps. The foreskin is then forcibly detached from the glans using a blunt probe, after which it is retracted toward the base of the penis. With the Gomco method, a metal bell is now placed over the newly exposed glans, after which the foreskin is pulled back up over the bell. A metal plate is placed over the bell, so that the prepuce becomes situated between the plate and the bell. A tensioning bar is then “hooked under a T-shaped piece on the top of the bell and screwed down tight to the metal plate; this traps the foreskin in position.” At this point, a “scalpel is run around the upper surface of the plate to remove the prepuce after adequate strangulation.” Abdulwahab-Ahmed & Mungadi, *Techniques of Male Circumcision*, at 2. The Gomco method, as with other common methods, thus proceeds by several discrete steps, each of which has the potential to go awry and so must be executed with care. As Aaron J. Krill and colleagues explain: “Complications from a Gomco circumcision are mainly related to technical factors. It is important to assure that the metal bell completely covers the glans, otherwise insufficient skin will be removed and accidental incision into the glans is possible.” In addition, “overly aggressive retraction of the skin through the platform can lead to excessive skin removal and subsequent corrective surgery; conversely, insufficient drawing up of the skin will lead to an incomplete circumcision, which may also require corrective surgery.” Finally, if the screw is not tightened sufficiently, this may result in “inadequate compression of the skin and subsequent bleeding.” Aaron J. Krill et al., *Complications of Circumcision*, 11 SCI. WORLD J., 2458, 2459 (2011).

spontaneous biological process.”⁵¹ Consequently, NTC at this age requires “tearing the common prepuce/glands penis mucosa apart ... with the concomitant risk of glanular excoriation and injury.”⁵² This step is not required in adult circumcision.

Depending on the specific technique or combination of techniques employed, the instrument or instruments used, and the skill of the practitioner, different quantities and types of tissue may be removed by circumcision⁵³ such that the effects of the procedure—including any complications⁵⁴—are not uniform.⁵⁵ With respect to complications, estimates vary widely in the medical literature, ranging from an overall complication rate for neonatal NTC of a fraction of a per cent to a rate as high as 20% for meatal stenosis alone.⁵⁶ Such

⁵¹ Cold & Taylor, *supra* n.48, at 35.

⁵² *Id.*

⁵³ For example, the frenulum, the highly sensitive tissue that connects the foreskin to the rest of the penis, may or may not be removed, depending upon the “style” of circumcision. See J. S. Paick et al., *Penile Sensitivity in Men with Premature Ejaculation.*, 10 INT'L J. IMPOTENCE RES. 247, 248-49 (1998) (showing that the frenulum is highly sensitive).

⁵⁴ Medical risks associated with circumcision include, but are not limited to: excessive bleeding, infection, inflammation, fistula formation, development of skin bridges, meatal stenosis (a narrowing of the urethral opening which can cause problems with urination), partial or complete penile amputation or other injury to the penis (in addition to the intended excision of the foreskin), and death. Krill et al., *supra* n.50, at 2459-66. Death is usually described as a rare complication of NTC, especially when it is performed in a modern clinical setting by a well-trained provider, although a lack of adequate record-keeping in the United States and some other countries where the surgery is common precludes the establishment of reliable annual figures. Alexandre T. Rotta, Personal Communication, Apr. 11, 2016 (Dr. Rotta holds the Chair in Pediatric Critical Care and Emergency Medicine and is Chief of the Division of Pediatric Critical Care, Rainbow Babies & Children's Hospital, University Hospitals of Cleveland).

⁵⁵ To reflect this lack of uniformity, J. Steven Svoboda and Robert Darby have proposed a typology of male circumcision to complement the classification of female genital cutting devised by the World Health Organization. The 7-point scale is based principally on the quantity of foreskin tissue removed, and ranges from mild lacerations without loss of tissue to partial or complete denudation of the penis. Robert Darby & J. Steven Svoboda, *A Rose by Any Other Name: Rethinking the Differences/Similarities Between Male and Female Genital Cutting*, 31(3) MED. ANTHROPOLOG. Q. 301(2007); J. Steven Svoboda & Robert Darby, *A Rose by Any Other Name: Symmetry and Asymmetry in Male and Female Genital Cutting* in FEARFUL SYMMETRIES: ESSAYS AND TESTIMONIES AROUND EXCISION AND CIRCUMCISION (Chantal Zabus ed., 2008).

⁵⁶ For references and discussion, see Morten Frisch & Brian D. Earp, *Circumcision of Male Infants and Children as a Public Health Measure in Developed Countries: A Critical Assessment of Recent Evidence*, GLOBAL PUB. HEALTH (in press), available online ahead of print at <http://dx.doi.org/10.1080/17441692.2016.1184292>. For a recent large-scale nationwide cohort study providing evidence that circumcision is associated with a marked increase in the risk of meatal stenosis and other urethral stricture disease, see Morten Frisch & Jacob Simonsen, *Cultural Background, Non-Therapeutic Circumcision And The Risk Of Meatal Stenosis And Other Urethral Stricture Disease: Two Nationwide Register-Based Cohort Studies In Denmark 1977-2013*, THE SURGEON (in press), available online ahead of print at [http://www.thesurgeon.net/article/S1479-666X\(16\)30179-2/fulltext](http://www.thesurgeon.net/article/S1479-666X(16)30179-2/fulltext).

wide variation in professional estimates, in combination with ongoing disputes over the appropriate diagnostic criteria for some adverse events⁵⁷ and systematic barriers to complete reporting of even overt complications (including a lack of adequate long-term follow-up),⁵⁸ suggests that a definitive conclusion about the “medical” risks of NTC cannot at this time responsibly be drawn.⁵⁹

Disparities arising from surgical factors are only part of the story. Such disparities are compounded by sometimes substantial individual differences in penile, including foreskin, anatomy.⁶⁰ These differences range from variations in the size and shape of the penis *in toto*, to the length, thickness, and surface area of the foreskin itself to the precise organization of the foreskin’s innervation and vasculature, its elasticity and mobility, the number and distribution of nerve endings it contains, and the degree and quality of

⁵⁷ See, e.g., AAP, *Circumcision Policy Statement*, *supra* n.27, at e772 (stating: “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.” Adding to the problem is the “comingling of ‘early’ complications, such as bleeding or infection, with ‘late’ complications such as adhesions and meatal stenosis” and the fact that “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”).

⁵⁸ For a discussion, see generally, Bossio et al., *Review of Male Circumcision Literature*, *supra* n.8, at 2847-64. See also Brian D. Earp, *The Need to Control for Socially Desirable Responding in Studies on the Sexual Effects of Male Circumcision*, 10(9) PLOS ONE 1 (2015) (recommending that future research on the sexual effects of circumcision be improved by employing much longer-term follow-up periods); Brian D. Earp, *Infant Circumcision and Adult Penile Sensitivity: Implications for Sexual Experience*, 7(4) TRENDS UROL. MEN’S HEALTH 17 (2016) (noting that generalizations about the effects of NTC on sexual outcome variables cannot be made beyond the limits entailed by the sample characteristics).

⁵⁹ One inevitable adverse consequence, however, is pain, both during the operation and the healing period. Because general anesthesia is contra-indicated in infants under six months of age, it is difficult, if not impossible, to provide fully effective pain control. Moreover, the local anesthetics that are used for neonatal circumcision require multiple injections either into the base or around the circumference of the penis; such injections are themselves painful as assessed by objective (i.e., behavioral) measures. Behrouz Banieghbal, *Optimal Time for Neonatal Circumcision: An Observation-Based Study*, 5(5) J. PEDIATR. UROL. 359 (2009). As Bellieni et al. noted after a survey of the literature, “there is no such thing as a pain-free circumcision.” Carlo V. Bellieni et al., *Analgesia for Infants’ Circumcision*, 39(38) IT. J. PEDIATR. n.p. (2013), available at <http://www.ijponline.net/content/39/1/38>. By contrast, in adult circumcision, general anesthesia can safely be used; the patient can also effectively manage his own discomfort as he heals.

⁶⁰ For example, in a study of 965 men, Kigozi et al. obtained measurements of foreskin surface area ranging from approximately 7 – 100 cm². Kigozi et al., *supra* n.49.

sensation transmitted by those nerve endings in response to different types of stimulation.⁶¹

To illustrate just one aspect of this variability, consider an individual whose foreskin plays a significant role in the generation or facilitation of pleasurable sensations during sexual intercourse, foreplay, or masturbation.⁶² Compared to someone whose foreskin plays a less significant role, or even a negative role (perhaps due to anatomical or other anomalies), this person has more to lose, so to speak, by being circumcised – even if the “surgical” aspects of the procedure in both cases are identical.

To summarize, a typical circumcision is not “just a snip”⁶³ as is often asserted, but is rather a delicate surgical procedure consisting of several discrete steps, each of which carries risks.⁶⁴ These risks vary in their nature, likelihood, and magnitude as a function of numerous interacting variables – including the skill of the practitioner, the instruments used, the amount of tissue removed, and so on – many of which have not been adequately studied. Moreover, when they do occur, adverse events are likely to have an outsized impact on the affected individual due to the special significance of the organ

⁶¹ When NTC is performed on an infant or young child, the anatomical complexity is compressed into a small space. Since there is no determinate location where the foreskin “ends” and where the rest of the penis “begins,” and since the organ will typically increase in size by more than 200% as the child develops (see Dr. Alan Greene, *Penis Size* (last updated Jan. 1, 2015), <http://www.drgreene.com/qa-articles/penis-size/>), there is a considerable amount of guesswork in terms of where to cut or apply the circumcision device. Therefore, there is an increased risk at this age, compared to NTC performed in later adolescence or adulthood, of removing more tissue than was intended or desired, which may result in insufficient slack in the remaining penile skin to accommodate a full erection later in life. This can lead to pain and discomfort during sex or masturbation, promote curvature of the penis, or contribute to other unwanted outcomes. See John van Duyn & William S. Warr, *Excessive Penile Skin Loss from Circumcision*, 51 J. MED. ASS'N GA. 394 (1962); Jorgen Thorup et al., *Complication Rate After Circumcision in a Paediatric Surgical Setting Should Not Be Neglected*, 60 DAN. MED. J. A4681 (2013). These adverse outcomes, however, might not become apparent until after puberty, when the organ has reached its full size and the individual becomes sexually active. As a result, they may never be recorded as a complication of the initial procedure, nor recognized by the individual as being due to the loss of his foreskin (as he has no other frame of reference).

⁶² Or would play such a role, assuming it is not removed in infancy or childhood.

⁶³ Aggleton, *supra* n.6, at 15-21.

⁶⁴ While it is likely impossible to reach agreement on what an acceptable level of circumcision complications would look like, two principles should arguably govern any such efforts: (1) that the threshold of acceptability for cosmetic or nontherapeutic surgery should be higher than for therapeutic procedures; and (2) that the threshold for children and others incapable of providing valid consent should be higher still.

in question: it is not only the likelihood of a given risk that is important, but also its magnitude or importance were it actually to take place. That said, different men relate to their bodies differently, and the personal impact of specific outcomes associated with circumcision cannot be known in advance. Such uncertainty is especially apparent in the case of the one outcome of NTC that is (almost) guaranteed to occur, since it is the intended effect of the procedure: the loss of the foreskin itself.

3.2. Differing Attitudes Concerning Foreskin Loss

In the academic literature, as well as in popular discussion, the loss of the foreskin is rarely treated as an adverse consequence of circumcision. Yet whether one regards this loss as a harm will depend almost entirely on the value one assigns to the foreskin or to the notion of genital intactness.

The view that the foreskin has little value appears to be more common in cultural settings such as the United States, where, in contrast to most other industrialized nations, neonatal circumcision rates remain relatively high.⁶⁵ In such a context, popular knowledge about the surgically unmodified penis is likely to be comparatively lacking, such that the anatomy and functions of the foreskin might not be as robustly understood even by medical professionals. The majority of these medical professionals are either themselves neonatally circumcised males or non-circumcised females; in either case, they are relatively unlikely to have had significant personal experience with surgically unmodified male genitalia.⁶⁶

⁶⁵ Brian J. Morris et al., *Estimation of Country-Specific and Global Prevalence of Male Circumcision*, 14(1) POP. HEALTH METR. 1 (2016) (estimating the percentage of circumcised US males to be 71.2%; for comparison, the estimate for the UK is 20.7%; for Germany, 10.9%; for the Netherlands, 5.7%); Edward Wallerstein, *Circumcision: The Uniquely American Medical Enigma*, 12(1) UROL. CLIN'S. N. AM. 123, 123 (1985) (stating "[t]he continuing practice of routine neonatal nonreligious circumcision represents an enigma, particularly in the United States. About 80 percent of the world's population do *not* practice circumcision, nor have they ever done so. Among the non-circumcising nations are Holland, Belgium, France, Germany, Switzerland, Austria, Scandinavia, the USSR, China, and Japan").

⁶⁶ "Because circumcision is so common in the United States, the natural history of preputial development has been lost, and one must depend on observations made in countries in which circumcision usually is not practiced." MHAIRI MACDONALD ET AL., *AVERY'S NEONATOLOGY: PATHOPHYSIOLOGY AND MANAGEMENT OF THE NEWBORN* 1088 (Philadelphia: Lippincott Williams

For comparison, in contexts where ritualized female genital cutting is more normative, the anatomy, functions, and associated sensory implications of the surgically unmodified female genitalia are similarly thought to be inadequately understood.⁶⁷ In such settings, “uncircumcised” women are commonly stigmatized as having genitalia that are unsightly or difficult to clean.⁶⁸ Even the external clitoris—typically a highly valued body part among those who possess one—may be viewed in these settings as something that is ugly, unfeminine, or simply “extra,” and hence as unnecessary for normal sexual functioning.⁶⁹ These observations indicate that there is a strong role for cultural conditioning in shaping one’s assumptions about the importance of a given genital structure for intimate activity and sexual enjoyment.⁷⁰

Such cultural conditioning is subject to change, however, and stigmatizing attitudes may not remain stable. As people are exposed to and learn about different cultural assumptions and practices regarding cut versus uncut genitalia—whether through travel, reading, or surfing the Internet—they may come to regard the majority practice of their own group as being harmful or otherwise problematic, and consequently re-assess the value of their own genital status. For example, Sara Johnsdotter and Birgitta Essén have recently documented evidence of “cultural change after migration” with

& Wilkins, 6th ed.). For evidence showing that many US medical textbooks do not accurately describe the anatomy of the intact penis, see, e.g., Gary L. Harryman, *An Analysis of the Accuracy of the Presentation of the Human Penis in Anatomical Source Materials* in FLESH AND BLOOD 17 (Denniston et al. eds., 2004).

⁶⁷ Sami A. Abu-Sahlieh, *To Mutilate in the Name of Jehovah or Allah: Legitimization of Male and Female Circumcision*, 13(7-8) MED. & L. 575 (1993) (discussing various misconceptions about the vulva and the clitoris among many groups that practice forms of ritualized female genital cutting).

⁶⁸ For examples and discussion, see generally Manderson, *supra* n.37, at 285-307.

⁶⁹ Lucretia Catania et al., *Pleasure and Orgasm in Women with Female Genital Mutilation/Cutting (FGM/C)*, 4(6) J. SEX. MED. 1666, 1673 (2007) (referring to circumcised women who “achieve orgasm by stimulating the vagina and consider the clitoris as something extra”). For further in-depth discussion, see Brian D. Earp, *In Defence of Genital Autonomy for Children*, 41(3) J. MED. ETHICS 158, 158-63 and the online Appendix (2016).

⁷⁰ The argument here is *a fortiori*. If even the widely accepted value of the external clitoris, at least in Western societies, is downplayed or disregarded by women who have little personal experience of the tissue, then how much more likely is it that the potential value of the penile foreskin might be downplayed or disregarded by men who have never experienced sex with one intact?

respect to female genital cutting practices among Somali immigrants to Sweden:

... migration gives rise to cultural reflection: All the motives for [female] circumcision in Somalia are turned [inside] out in exiled life in Sweden. What was once largely seen as 'normal' and 'natural' about ... cut and sewn genitalia was questioned in Sweden, when the women were met with shocked reactions among healthcare providers in maternal care and delivery rooms. A thitherto strong conviction that circumcision of girls was required by religion was questioned when Somalis met Arab Muslims, who do not circumcise their daughters ... The fear that their daughters would be rejected at marriage if uncircumcised disappeared in the light of the immense Somali diaspora in the West, where Somali men can be expected to accept and even appreciate uncircumcised wives. In addition, the risk of stigmatization and ostracism disappeared when living in an environment where most girls are not circumcised.⁷¹

Similar stories are told by some circumcised men, whose realization that not everyone's penis has been cut like theirs—or that circumcision is in fact a minority practice in most Western countries outside of the United States—may prompt a difficult reevaluation of the normalcy of going through life without a foreskin. As one such man recounted to the psychologist Ronald Goldman:

The shock and surprise of my life came when I was in junior high school, and I was in the showers after gym ... I wondered what was wrong with those penises that looked different than mine ... I soon realized I had part of me removed. I felt incomplete and very frustrated when I realized that I could never be like I was when I was born—intact. That frustration is with me to this day. Throughout life I have regretted my circumcision. Daily I wish I were whole.⁷²

⁷¹ Sara Johnsdotter & Birgitta Essén, *Cultural Change after Migration: Circumcision of Girls in Western Migrant Communities*, 32 BEST PRACT. RES. CLIN. OBSTET. GYNAECOL. 15, *4 (2016) [page 4 of the online advanced publication available at <http://www.sciencedirect.com/science/article/pii/S1521693415001959>].

⁷² Gregory J. Boyle et al., *Male Circumcision: Pain, Trauma and Psychosexual Sequelae*, 7(3) J. HEALTH PSYCHOL. 329, 329-43 (2002).

Such feelings are not uncommon, as the anthropologist Eric Silverman noted more than a decade ago:

opposition to FC [female circumcision] is well known ... Less obvious to anthropologists is an equally vociferous, diverse movement that opposes the routine medical and ritual circumcision of infant boys in the West. The number ... of these activist groups [is] staggering ... these groups are serious, and it would be incorrect to dismiss them as the fringe. They are fast moving to the center of legal, medical, and moral discourse. And they are both very angry and very aggressive.⁷³

Strikingly, Silverman seems reluctant to consider, much less conclude, that any negative feelings experienced by circumcised men might be a reasonable reaction to having had part of their genitals removed without their consent—or indeed that such feelings might have anything whatsoever to do with the loss of the foreskin:

I propose that for many opponents of the procedure, MC (male circumcision) is a potent symbol of anxieties that are not linked directly to the penis. Rather, the lost foreskin symbolizes a series of modern losses arising from historically specific anxieties. These anxieties concern the lost effectiveness of the political, economic, and judicial process; pluralism; violence; contested notions of masculinity, motherhood, sexuality, and gender; the medicalization of birth; vulnerability before technological advances ... and the hypercapitalist commodification of the body.⁷⁴

While anxieties relating to such abstract concerns as “pluralism,” “violence,” or “motherhood” may very well have something to do with the way in which some or even many circumcised men feel about their altered penises (although we struggle to see the precise connection), it seems plausible that a more direct explanation is being overlooked. Specifically, insofar as the foreskin itself, or the surgically unmodified penis more generally, has properties it is reasonable to regard as valuable—sexually, aesthetically, or otherwise—then a man’s experiencing the involuntary removal of that tissue

⁷³ Eric K. Silverman, *Anthropology and Circumcision*, ANN. REV. ANTHROPOL. 419, 434 (2004) (internal references omitted).

⁷⁴ *Id.* at 436 (internal references omitted).

as an intrinsic harm should be viewed as a sensible reaction. Consider the following “Dear Abby” exchange, which shows a similar pattern of judgment to that of Silverman:

Dear Abby: I am a young man who is currently in college. When I was an infant, I was circumcised, and I feel violated that my parents decided to circumcise me without my consent. When the doctor performed the surgery, he took too much off, which causes me pain. When I was in grade school, I was sexually assaulted by an older classmate, but I feel much more violated from the circumcision because it took a part of me that I can never get back. ... My parents know how I feel and are sorry, but I still have negative feelings toward them because I can't get the procedure undone.

– *Cut Short in California.*

Dear C. S.: ... The place to start would be your student health center to determine exactly what is causing your pain and if there is help for it. ... In addition, I urge you to talk to a licensed mental health professional to help you work through your anger because it may be misdirected and a result of the sexual assault you experienced in grade school.”⁷⁵

In this exchange, Dear Abby (Jeanne Phillips) appears to appreciate that the physical pain associated with a circumcision that removed “too much” tissue is a serious concern that deserves some remedy. But the idea that the non-consensual loss of the foreskin itself might be valid grounds for anger or resentment does not appear to strike her as plausible. Instead, she proposes that the man’s feelings might be “misdirected” from some other problem, for which he should seek the services of a mental health professional.

Recall that the foreskin is a touch-sensitive, motile sleeve of tissue that comprises dozens of square centimeters in the average adult organ.⁷⁶ Recent research relying on objective measures indicates that this tissue is the most sensitive part of the penis to light touch, while also being significantly more

⁷⁵ Jean Phillips, *Dear Abby: Decision to Circumcise Causes Festering Anger*, DETROIT NEWS (Mar. 21, 2016), available at <http://www.detroitnews.com/story/life/advice/2016/03/21/dear-abby-advice/81994520/>.

⁷⁶ Cold & Taylor, *supra* n.48, at 34-44; Kigozi et al., *supra* n.49, at 2209; Werker et al., *supra* n.49, at 1075-82.

sensitive than the head of the penis to mild sensations of warmth.⁷⁷ Even if this tissue had no erotogenic properties whatsoever, which is generally understood not to be the case, one need only to imagine the involuntary removal of a comparable amount of non-diseased tissue from another part of the body – or perhaps from the genitals of a female child in the form of neonatal labiaplasty – to appreciate why some people might validly experience such removal as distressing.⁷⁸ The common failure to appreciate this distress in the Western discourse is itself a curious phenomenon, and it has led some anthropologists and sociologists to take a deeper look at the cultural constructions of male and female sexuality.

3.3. Differing Cultural Constructions of Male vs. Female Sexuality

Reading through the medical literature, one is liable to form the impression that the mere capacity to maintain an erection, ejaculate, impregnate one's female partner, or experience some degree of pleasurable sensation during sex, exhaust the scientific imagination on male sexuality. In other words, if these or other similar basic capacities are retained, many commentators are prepared to conclude that circumcision has negligible, if any, adverse effects on male "sexual function."⁷⁹ As the anthropologist Kirsten Bell has said of her North American college students:

Over the course of our discussions ... one thing became clear: students did not think that carving up male genitalia had any damaging effects on male sexuality as long as the penis remained largely intact. My students reasoned that as long as the man retained the ability to ejaculate, his sexuality was unimpaired. They were so ready to assert that female sexuality has been totally annihilated by genital surgery of any kind and so reluctant to proclaim that anything short of full frontal

⁷⁷ Bossio et al., *Penile Sensitivity*, *supra* n.9, at 1848-53. *But see* Earp, *Infant Circumcision and Adult Penile Sensitivity*, *supra* n.58, at 17-21 (pointing out some of the ways in which Bossio et al. mischaracterized the findings from their own study).

⁷⁸ For an in-depth discussion, *see* Earp, *In Defence of Genital Autonomy*, *supra* n.69, at 158-63.

⁷⁹ Indeed, Munzer himself seems to endorse (or at least recognize) such a view when he writes, "[t]he sexual functioning of ... men is, let us suppose, largely unaffected by removal of all or part of the prepuce." Munzer, *supra* n.1, at 560.

castration will affect a man's sexuality in the same way, it seemed clear that something very interesting was being revealed. Importantly, their insistence seemed to have less to do with these practices themselves and more to do with underlying assumptions about the nature of female and male sexuality, assumptions echoed in the dominant discourses on genital cutting.⁸⁰

A common assumption in this discourse, according to Marie Fox and Michael Thomson, is that "male sexual pleasure is not an issue provided the penis is adequate for penetration, thus privileging one popular understanding of male sexual function and pleasure." And yet "the sensitivity protected by the foreskin, the erogenous nature of the foreskin itself, and sexual practices relying on an intact penis—such as docking⁸¹—are all erased in these characterisations."⁸²

According to this perspective—and now invoking Feinberg's conception of harm, discussed *supra*—it could be argued that circumcision necessarily impairs function because, whatever else it does, it impairs (indeed, eliminates) all sexual acts or functions that require manipulation of the foreskin itself.⁸³ These acts include a range of masturbatory styles that involve

⁸⁰ Kirsten Bell, *Genital Cutting and Western Discourses on Sexuality*, 19(2) MED. ANTHROPOLOG. Q. 125, 127 (2005).

⁸¹ "Docking" is a form of sex common among some men who have sex with men (MSM). As Harrison states: "The general idea ... involves one man extending his foreskin in such a manner that it forms an orifice that is then penetrated by another (presumably erect) object. To put the point very bluntly, circumcision prohibits men from ever being on the 'giving' end of such a relationship, closing off a potential form of pleasure that some find to be very satisfying." Parents who authorize the circumcision of their sons, therefore, are "unwittingly circumscribing certain types of sexual behavior for their sons, and are thus limiting exploration of other sexual possibilities of the penis. Circumcision diverts male sexuality down a particular path, disallowing for certain erotic potentials." Daniel M. Harrison, *Rethinking Circumcision and Sexuality in the United States*, 5(3) SEXUALITIES 300, 310-11 (2002). On a related note, in a recent study of 196 Canadians, gay men "indicated a strong preference toward intact penises for all sexual activities assessed and held more positive beliefs about intact penises." Jennifer A. Bossio, et al., *You Either Have It or You Don't: The Impact of Male Circumcision Status on Sexual Partners*, 24(2) CAN. J. HUM. SEX. 104, 104 (2015). For further discussion, see Morten Frisch & Brian D. Earp, *Problems in the Qualitative Synthesis Paper on Sexual Outcomes Following Non-Medical Male Circumcision by Shabanzadeh et al.*, 63(7) DAN. MED. J. A5245 (2016) (noting that studies concluding that circumcision makes little or no difference to sexual experience are problematically heteronormative because they exclude by definition popular practices among MSM that require the presence of a foreskin).

⁸² Michael Fox & Marie Thomson, *Foreskin is a Feminist Issue*, 24(60) AUS. FEMINIST STUD. 195, 200 (2009).

⁸³ See Brian D. Earp, *Sex and Circumcision*, 15(2) AM. J. BIOETH. 43 (2015).

gliding the foreskin back and forth over the head of the penis⁸⁴ as well as some forms of oral sex that similarly involve interplay with the foreskin. Of course, whether the inability to have one's foreskin orally or manually manipulated interferes with one's sexual enjoyment is not something that can be "objectively" determined: it depends on one's sexual preferences. For a point of comparison, consider that the female genital labia can also be "tugged, stretched, sucked on, and otherwise fondled during sexual interaction ... for those for whom such activities are an important part of their sexual experience, the loss of labia," like the loss of the foreskin in men with analogous sexual preferences, would indeed represent a setback to their interests.⁸⁵

Another necessary consequence of circumcision is a loss of sensation. At minimum, all sensation that would have been experienced "in" the excised tissue itself is eliminated by the procedure; there may also be an additional loss of sensation in the penile glans in some men due to its rubbing against clothing and other elements without the protective covering of the foreskin over the course of many years.⁸⁶ As Harrison states, "[s]ince circumcised men have no feeling in their foreskin (in fact, no foreskin at all), the only form of stimulation comes in the form of pressure on the head and the shaft of the penis, and in the orgasm itself."⁸⁷

⁸⁴ In response to a request for "any comments on feelings related to the foreskin during intercourse or masturbation," family practitioner Peter J. Ball notes that the "penis rolling in and out of its skin tube during intercourse was echoed by the answers to this question. Some fifty percent of intact men [in the survey] intimated here that, for them, the foreskin was essential for the enjoyment of sex whether for masturbation or intercourse." Peter J. Ball, *A Survey of Subjective Foreskin Sensation in 600 Intact Men* in *BODILY INTEGRITY AND THE POLITICS OF CIRCUMCISION* 177-88 (Denniston et al. eds., 2006).

⁸⁵ Earp, *In Defence of Genital Autonomy*, *supra* n.69, at 29 of the Online Appendix.

⁸⁶ For a recent study suggesting decreased glans sensitivity in circumcised compared to non-circumcised men, see Lisa Örtqvist et al., *Sexuality and Fertility in Men with Hypospadias; Improved Outcome*, *ANDROLOGY* (in press), available online ahead of print at <http://onlinelibrary.wiley.com/doi/10.1111/andr.12309/full>. While the main purpose of the study was to assess sexuality and fertility in men with hypospadias, as the title suggests, circumcised and non-circumcised men were used as controls. For further evidence of this view, see Morris L. Sorrells et al., *Fine-Touch Pressure Thresholds in the Adult Penis*, 99(4) *BJU INT'L.* 864, 864 (2007) (finding that "[t]he glans of the circumcised penis is less sensitive to fine touch than the glans of the uncircumcised penis. ... Circumcision ablates the most sensitive parts of the penis"). Note that various critiques and counter-critiques of this study are available at the journal's website.

⁸⁷ Harrison, *supra* n.81, at 310.

Again, the question of whether this loss of sensation should be counted as a harm is not something with a universal answer: one and the same sensory decrement may be experienced differently by different men, depending on, among other things, their baseline sensitivity. Some men, for example, may believe that they are “too sensitive” and may struggle with what they or their partner(s) regard as premature ejaculation,⁸⁸ whereas other men may not feel “sensitive enough” and may struggle instead with a lack of sensation overall and possibly erectile dysfunction, especially as they get older.⁸⁹ Other individual differences can easily be imagined.

Given so much room for variation, it should come as no surprise that studies and surveys in this area produce conflicting results.⁹⁰ Some have concluded that adult circumcision was associated with reduced sexual functionality and/or enjoyment in some men,⁹¹ while others have concluded

⁸⁸ For critical discussions of the issue of premature ejaculation, see Ylva Söderfeldt et al., *Distress, Disease, Desire: Perspectives on the Medicalisation of Premature Ejaculation*, J. MED. ETHICS (in press), available online ahead of print at <http://jme.bmj.com/content/early/2017/03/23/medethics-2015-103248> (questioning restrictive sexual norms that feed into the notion of premature ejaculation to the exclusion of other modes of sexual expression); Brian D. Earp & Julian Savulescu, *Love Drugs: Why Scientists Should Study the Effects of Pharmaceuticals on Human Romantic Relationships*, TECH. IN SOCIETY (in press), available online ahead of print at <http://www.sciencedirect.com/science/article/pii/S0160791X1630118X> (noting that a relative shortening or lengthening of the average time it takes for a man to ejaculate is not objectively better or worse than the alternative: it depends on the needs and preferences of those engaged in the sexual encounter).

⁸⁹ Earp, *Infant Circumcision and Adult Penile Sensitivity*, *supra* n.58, at 20.

⁹⁰ Until the early twentieth century, it was simply assumed that the foreskin was a primary source of sexual sensation in the male and that those who underwent circumcision lost much of the pleasure of sexual activity. See ROBERT DARBY, *A SURGICAL TEMPTATION: THE DEMONIZATION OF THE FORESKIN AND THE RISE OF CIRCUMCISION IN BRITAIN* (2005), especially Chapter 2. For a collection of quotations from medical and sex advice texts, see *Circumcision, The Foreskin and Sexuality: The Verdict of the Centuries*, CIRCUMCISION INFORMATION AUSTRALIA, available at <http://www.circinfo.org/quote.html> (last accessed Dec. 4, 2016). This assumption was certainly held by Victorian doctors who introduced circumcision as a means of controlling juvenile and adolescent sexuality, particularly to discourage masturbation. As late as the 1940s, American obstetricians were recommending circumcision for this reason. See, e.g., Alan F. Guttmacher, *Should the Baby Be Circumcised?*, PARENTS MAG. No. 16 (Sept. 1941), cited in Robert Darby, *Targeting Patients Who Cannot Object? Re-Examining the Case for Non-Therapeutic Infant Circumcision*, SAGE OPEN (April-June 2016), available at <http://journals.sagepub.com/doi/full/10.1177/2158244016649219>. It was not until the 1990s that anatomical studies established the dense innervation and associated vascularity of the foreskin, supporting the traditional understanding that the foreskin was a principal sensory platform of the penis. See Cold & Taylor, *supra* n.48, at 34-44.

⁹¹ See, e.g., Daisik Kim & Myung Geol Pang, *The Effect of Male Circumcision on Sexuality*, 99(3) BJU INT'L 619, 619 (2007) (finding that “[m]asturbatory pleasure decreased after circumcision in 48% of the respondents, while 8% reported increased pleasure. Masturbatory difficulty increased after circumcision in 63% of the respondents but was easier in 37%.” Approximately 6%

that such circumcision made little or no difference, or even enhanced sexual function or experience.⁹² None of these studies allows one to draw meaningful conclusions about the effects of neonatal or early childhood circumcision, however,⁹³ since they rely on self-reports from men who have an active interest in the surgery's outcome, and all suffer from methodological limitations.⁹⁴ In

"answered that their sex lives improved, while 20% reported a worse sex life after circumcision").

⁹² See, e.g., John N. Krieger et al., *Adult Male Circumcision: Effects on Sexual Function and Sexual Satisfaction in Kisumu, Kenya*, 5(11) J. SEX. MED. 2610, 2610 (2008) (stating that "[a]dult male circumcision was not associated with sexual dysfunction. Circumcised men reported increased penile sensitivity and enhanced ease of reaching orgasm"). For a controversial review and summary, see Brian J. Morris and John N. Krieger, *Does Male Circumcision Affect Sexual Function, Sensitivity, or Satisfaction? A Systematic Review*, 10(11) J. SEX. MED. 2644, 2644 (2013) (stating that "the highest-quality studies suggest that medical male circumcision has no adverse effect on sexual function, sensitivity, sexual sensation, or satisfaction"). For critical commentaries on this paper see, e.g., Gregory J. Boyle, *Does Male Circumcision Adversely Affect Sexual Sensation, Function, or Satisfaction? Critical Comment on Morris and Krieger (2013)*, 5 ADVANCES SEX. MED. 7, 7 (2015) (arguing that "by selectively citing Morris' own non-peer-reviewed letters and opinion pieces purporting to show flaws in studies reporting evidence of negative effects of circumcision, and by failing adequately to account for replies to these letters by the authors of the original research (and others), Morris and Krieger give an incomplete and misleading account of the available literature"); Bossio et al., *Response to: The Literature Supports Policies Promoting Neonatal Male Circumcision*, *supra* n.8, at 1306-07 (stating that "according to the SIGN criteria that Morris and Krieger utilize, would their entire review in question not warrant a rating of 'low quality' based on the 'high risk of bias' introduced by the authors' well documented, unconditional support of the practice of circumcision?"). For author replies, see the journal websites. For further discussion of the literature on the sexual effects of male circumcision, see generally Brian D. Earp, *Female Genital Mutilation and Male Circumcision: Toward an Autonomy-Based Ethical Framework*, 5(1) MEDICOLEGAL BIOETH. 89, Box 1 (2015).

⁹³ For large-scale studies including analyses of the sexual effects of early circumcision (as opposed to adult circumcision exclusively), see, e.g., Morten Frisch et al., *Male Circumcision and Sexual Function in Men and Women: A Survey-Based, Cross-Sectional Study in Denmark*, 40(5) INT'L. J. EPIDEMIOL. 1367, 1367 (2011) (finding that "circumcision was associated with frequent orgasm difficulties in Danish men and with a range of frequent sexual difficulties in women, notably orgasm difficulties, dyspareunia and a sense of incomplete sexual needs fulfillment"); Guy A. Bronselaer et al., *Male Circumcision Decreases Penile Sensitivity as Measured in a Large Cohort*, 111(5) BJU INT'L. 820, 820 (2013) (reporting that "[f]or the glans penis, circumcised men reported decreased sexual pleasure and lower orgasm intensity. They also stated more effort was required to achieve orgasm, and a higher percentage of them experienced unusual sensations" including "burning, prickling, itching, or tingling and numbness of the glans penis"). Critiques and counter-critiques of both studies can be found at the journal websites.

⁹⁴ See, e.g., Morten Frisch, *Author's Response to: Brian Morris et al., Does Sexual Function Survey in Denmark Offer Any Support for Male Circumcision Having an Adverse Effect?*, 41 INT'L. J. EPIDEMIOL. 312, 313 (2012) (noting that the questionnaires used in the study by Krieger et al. – *supra* n. 92 – were not well-designed: "several questions were too vague to capture possible differences between circumcised and not-yet circumcised participants." For example, there was a "lack of a clear distinction between intercourse and masturbation-related sexual problems and no distinction between premature ejaculation and trouble or inability to reach orgasm." Thus, "non-differential misclassification of sexual outcomes in these African trials probably favoured the null hypothesis of no difference, whether an association was truly present or not"). See also Earp, *Need to Control for Socially Desirable Responding*, *supra* n.58; Bossio et al., *Review of Male Circumcision Literature*, *supra* n.8.

any event, men do not experience sex as embodied statistical averages: the generalized conclusions that are often drawn from these studies reflect group means associated with particular samples of men (along whatever assessed dimension), and not necessarily the experience of any individual man, much less all men.⁹⁵

Nevertheless, many men who were circumcised as infants do insist that they have been sexually harmed as a result of the procedure and strongly resent what was done to them without their consent. As noted earlier, often this absence of consent is as serious a cause of psychosexual distress as any overtly “physical” effects of the procedure.⁹⁶ Consider this statement from Leo Milgrom addressed to the Chief Rabbi of Denmark:

What must I do if I want my foreskin back? I never wanted a strange man to touch me [on] my private parts. I would NEVER ON MY LIFE allow anyone to cut off a piece of my penis. ... Imagine if our neighbors - for religious reasons - had the habit of cutting [the] earlobes, the outer joint of their little finger, or the nipples of their babies. Just like that, off with them. We would never allow that to happen. Nevertheless we accept something even worse: the cutting into and cutting off [of] parts of children's private and intimate sexual organs.⁹⁷

Eran Sadeh, an Israeli citizen, offered a similar perspective the same year, in a speech he gave in Berlin in response to the Cologne ruling:

I was born 43 years ago in Tel Aviv, a healthy baby with a perfect body. [Eight] days after I was born one man held my tiny legs down while another man cut a part of my penis off with a knife. I was in pain, I screamed, I bled. It's over. But the

⁹⁵ Earp, *Infant Circumcision and Adult Penile Sensitivity*, *supra* n.58, at 20 (stating that “the current tendency to draw broad conclusions about the effects of neonatal circumcision on adult sexuality from group ‘averages’, thereby obscuring the responses of individual participants, is problematic. No one engages in sexual activity as an embodied statistical average; instead, each person’s sexual experience is unique”).

⁹⁶ For examples and discussion, see generally John Warren et al., *Circumcision of Children*, 312 *BMJ* 377 (1996); Tim Hammond, *A Preliminary Poll of Men Circumcised in Infancy or Childhood*, 83(S1) *BJU INT'L* 85 (1999); Robert Darby & Laurence Cox, *Objections of a Sentimental Character: The Subjective Dimensions of Foreskin Loss* in *FEARFUL SYMMETRIES: ESSAYS AND TESTIMONIES AROUND EXCISION AND CIRCUMCISION* (Chantal Zabus ed., 2008).

⁹⁷ Leo Milgrom, *Kan du give mig min forhud tilbage?* POLITIKEN (2013), available at <http://politiken.dk/debat/kroniken/premium/ECE1701377/kan-du-give-mig-min-forhud-tilbage/> [translation by Leo Milgrom].

part that was cut off from my penis is forever gone. ... circumcision is nothing but a euphemism for forcibly amputating a healthy body part of a helpless child, causing irreversible bodily damage and pain and putting the child at risk. All this in the name of religion and tradition. ... This will not do in a country that protects children's human rights, especially the right to bodily integrity and the right to equal protection by the law.⁹⁸

Lindsay Watson, in his introduction to fifty personal accounts from circumcised men, many of whom consider themselves to have been harmed by a "successful" circumcision (one without serious medical complications or other unintended outcomes), reports that feelings of violation, grief, anger, resentment, shame, and humiliation are prominent.⁹⁹ Similar findings were reported by Hammond in 1999, and again in 2017.¹⁰⁰ None of these sources is based on a random sampling, and the feelings expressed may not be representative of the general population. Nevertheless, enough complaints have been raised to think that the proportion of men who do regard themselves as being harmed by circumcision is sufficient to warrant further attention.

Precise numbers are hard to come by, but a 2015 YouGov poll concluded that 10% of circumcised American men wish that they had not been circumcised.¹⁰¹ In addition, a more recent, demographically diverse survey of 999 American men found that 13.6% wished that they had not been circumcised, with nearly a quarter of that sub-group reporting that they would "seriously consider" changing their circumcision status if it were possible—i.e., through a process of "foreskin restoration."¹⁰² Consistent with this finding,

⁹⁸ Eran Sadeh, "I was shocked," transcript and video available at <https://justasnip.wordpress.com/2013/06/26/i-was-shocked/#more-914>.

⁹⁹ LINDSAY WATSON, UNSPEAKABLE MUTILATIONS: CIRCUMCISED MEN SPEAK OUT (Ashburton, NZ: CreateSpace 2014). Also available as an Amazon e-book at http://www.amazon.com/Unspeakable-Mutilations-Circumcised-Men-Speak-ebook/dp/B00L5FPF2C/ref=pd_ybh_1.

¹⁰⁰ Hammond, *supra* n.96, at 85-92; Hammond & Carmack, *supra* n.20.

¹⁰¹ Available at <https://today.yougov.com/news/2015/02/03/younger-americans-circumcision/>.

¹⁰² The survey was conducted in late 2016 by researchers from Quinnipiac University and Yale University, including one of the present authors (Earp). The data are being written up and will soon be submitted for publication; in the meantime, they can be obtained by sending an email to brian.earp@yale.edu. Of the 999 total survey respondents, 771 reported being circumcised and answered the question, "Did you or do you ever wish that you were the opposite circumcision status?" Of the 771, 105 (13.6%) responded "Yes," 660 (85.6%) responded "No,"

there are many thousands of devices¹⁰³ currently being sold to men throughout the English-speaking world to assist with such “restoration.” This is an arduous process that results, if successful, in a pseudo-prepuce consisting of modified penile shaft skin that lacks the original nerve tissue.¹⁰⁴ From this fact, it is reasonable to conclude that such men are highly unsatisfied with their circumcised state.¹⁰⁵

Given that such efforts could be seen as a relatively extreme expression of dissatisfaction, there are likely to be “manifold more men who are seriously resentful about having been circumcised, but who do not go to such lengths to try to rectify their situation (or who may simply feel uncomfortable talking about such personal matters in public).”¹⁰⁶ Indeed, it is

and the rest ($n = 6$) responded “Prefer not to answer.” Of those who answered “Yes” (minus $n = 4$ who skipped the follow-up question), 25 (24.8%) reported that they would “seriously consider” changing their circumcision status if it were possible, i.e., through a foreskin restoration process. The remaining survey respondents included 182 men who reported not being circumcised, 35 men who reported not being sure of their circumcision status, and 11 who preferred not to report their circumcision status. Among non-circumcised men, 29 (15.9%) responded “Yes” to the above question, 151 (83%) responded “No,” and the rest ($n = 2$) responded “Prefer not to answer.” Given that NTC remains the prevailing cultural custom in the United States, it is notable that almost as many circumcised men (as a percentage of the total) have wished that they were not circumcised, as non-circumcised men have wished that they were circumcised (13.6% compared to 15.9%). Yet as we argue in Section 4.1., only men in the latter group have an adequate remedy available to them if they desire to change their status: that is, one can undertake circumcision in adulthood if one has not already been circumcised, but one cannot “undo” a circumcision after it has been done.

¹⁰³ See Earp, *Between Moral Relativism and Moral Hypocrisy*, *supra* n.33, at E9 of the Online Appendix (providing evidence based on sales records of the relevant devices obtained from the manufacturer).

¹⁰⁴ This refers to the use of weights, tapes, elastic straps, and other instruments to stretch any remaining tissue from the penile shaft up over the head of the penis. To do so requires the wearing of a contraption under one’s clothing for multiple hours each day over the course of several months or years. For discussion, see generally Roger Collier, *Whole Again: The Practice of Foreskin Restoration*, 183 C.M.A.J. 2092 (2011); G. Corey Carlisle, *The Experience of Foreskin Restoration: A Case Study*, 35 J. PSYCHOL. & CHRISTIANITY 83 (2016); D. Schultheiss et al., *Uncircumcision: A Historical Review of Preputial Restoration*, 101 PLAST. RECONSTR.SURG. 1990 (1998).

¹⁰⁵ Watson, *supra* n.99.

¹⁰⁶ Earp, *Sex and Circumcision*, *supra* n.83, at 44. It is often asserted that “men don’t complain” about being circumcised, so why should there be a movement against the practice? This assertion is problematic for two reasons. First, a great many men do complain, publicly, as noted by Silverman (see also <https://www.mendocomplain.com>). And second, a man’s failure to publicly complain about his circumcision is not necessarily good evidence that he does not feel harmed. There are numerous barriers that may face a man even if he does feel harmed and desires to register a complaint: (1) pressure to conform; (2) fear that he will not be taken seriously or treated with compassion; (3) concern that his masculinity or sexual status/ability will be questioned; and (4) a lack of mainstream platforms willing to give such men a voice. See, e.g., Boyle et al., *Male Circumcision: Pain, Trauma and Psychosexual Sequelae*, *supra* n. 72, at 336-37

improbable that there would be a vigorous, community-based anti-circumcision movement such as the one discussed by Silverman, *supra*, unless a significant number of men – and women – were convinced that circumcision was harmful.

4. WHAT ABOUT BENEFITS? THE OTHER SIDE OF THE COIN

We have so far been discussing some of the reasons why different men might reasonably reach different conclusions about whether they have been harmed by circumcision. A similar analysis applies to the question of benefits. Briefly, in addition to the social benefits that are often claimed for circumcision—such as a decreased risk of being teased by one's peers or ostracized by one's religious community (risks that could also be reduced by changing the relevant social norms, as is commonly suggested in the case of female circumcision)—evidence has accumulated that NTC may confer certain health-based benefits as well. The most significant of these is a reduction in the risk of contracting urinary tract infections (UTIs) in early childhood as well as some sexually-transmitted infections (STIs) after sexual debut.¹⁰⁷

Some experts dispute these benefits, pointing to confounding factors in the original studies,¹⁰⁸ but we shall simply take them for granted in our

(discussing some of the reasons why men may be reluctant to disclose the feeling that they have been harmed by circumcision).

¹⁰⁷ Another commonly cited benefit of circumcision is reduced risk of penile cancer. However, as the American Academy of Pediatrics notes, based on available evidence, it would take between 909 and 322,000 circumcisions to prevent a single case of penile cancer. AAP, *Male Circumcision*, 130 PEDIATR. e756 (originally published online Aug. 27, 2012).

¹⁰⁸ See, e.g., Robert S. Van Howe, *Effect of Confounding in the Association Between Circumcision Status and Urinary Tract Infection*, 51(1) J. INFECT. 59, 59 (2005) (stating that “[p]reviously reported differences in the rate of urinary tract infection by circumcision status could be entirely due to sampling and selection bias. Until clinical studies adequately control for sources of bias, circumcision should not be recommended as a preventive for urinary tract infection”); Robert S. Van Howe, *Sexually Transmitted Infections and Male Circumcision: A Systematic Review and Meta-analysis*, ISRN UROL. 1, 1 (2013), available at <https://www.hindawi.com/journals/isrn/2013/109846/> (stating that “[i]n studies of general populations, there is no clear or consistent positive impact of circumcision on the risk of individual sexually transmitted infections.” Consequently, “the prevention of sexually transmitted infections cannot rationally be interpreted as a benefit of circumcision, and any policy of circumcision for the general population to prevent sexually transmitted infections is not supported by the evidence in the medical literature”). For critiques and replies, see the journal websites.

analysis. For context, it should be noted that none of the pediatric or other medical bodies that have issued formal¹⁰⁹ policies on routine neonatal circumcision consider these health benefits to exceed the risks, regardless of the metric used.¹¹⁰ The sole exception to this is the American Academy of Pediatrics (AAP), whose 2012 policy – due to expire this year – states that the medical benefits of circumcision “outweigh” the risk of surgical complications.¹¹¹ However, this claim was later softened after considerable international criticism¹¹² in an editorial by AAP Circumcision Task Force

¹⁰⁹ A 2014 draft recommendation by the US Centers for Disease Control and Prevention echoes the findings of the American Academy of Pediatrics, but has not yet been revised in light of peer-review nor released in its final form. For further discussion, see Frisch & Earp, *Critical Assessment of Recent Evidence*, supra n.56; Brian D. Earp, *Do the Benefits of Male Circumcision Outweigh the Risks? A Critique of the Proposed CDC Guidelines*, 3 FRONT. PEDIATR. 18 (2015). For one of the invited peer-reviews of the CDC draft, see Robert S. Van Howe, *A CDC-Requested, Evidence-Based Critique of the Centers for Disease Control and Prevention 2014 Draft on Male Circumcision: How Ideology and Selective Science Lead to Superficial, Culturally-Biased Recommendations by the CDC* (2015), available at https://www.researchgate.net/profile/Robert_Van_Howe.

¹¹⁰ See, e.g., Royal Dutch Medical Association, *Non-Therapeutic Circumcision of Male Minors* 1, 4 (2010), available at <http://www.circumstitutions.com/Docs/KNMG-policy.pdf> (stating “[t]here is no convincing evidence that circumcision is useful or necessary in terms of prevention or hygiene ... [in] light of the complications which can arise during or after circumcision [it] is not justifiable except on medical/therapeutic grounds.” Stating also that “[i]nsofar as there are medical benefits, such as a possibly reduced risk of HIV infection, it is reasonable to put off circumcision until the age at which such a risk is relevant and the boy himself can decide about the intervention, or can opt for any available alternatives”); Royal Australasian College of Physicians (RACP), *Circumcision of Infant Males* 1, 5 (2010), available at <https://www.racp.edu.au/docs/default-source/advocacy-library/circumcision-of-infant-males.pdf> (stating that “[a]fter reviewing the currently available evidence, the RACP believes 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”); Canadian Paediatric Society, Fetus and Newborn Committee, *Newborn Male Circumcision*, 20 PAEDIATR. CHILD HEALTH 311, 313 (2015) (stating that “the medical risk:benefit ratio of routine newborn male circumcision is closely balanced when current research is reviewed”). See also British Medical Association, *The Law and Ethics of Male Circumcision: Guidance for Doctors*, 30(3) J. MED. ETHICS 259, 260 (2004) (noting that “[t]here is a spectrum of views within the BMA’s membership about whether non-therapeutic male circumcision is a beneficial, neutral, or harmful procedure or whether it is superfluous, and whether it should ever be done on a child who is not capable of deciding for himself.” Stating also that “[t]he medical harms or benefits have not been unequivocally proved except to the extent that there are clear risks of harm if the procedure is done inexpertly”).

¹¹¹ AAP, *Circumcision Policy Statement*, supra n.27.

¹¹² See generally, Frisch et al., *Cultural Bias in the AAP’s 2012 Technical Report*, supra n.8; J. Steven Svoboda & Robert S. Van Howe, *Out of Step: Fatal Flaws in the Latest AAP Policy Report on Neonatal Circumcision*, 39(7) J. MED. ETHICS 434 (2013); Wolfram Hartmann, *Expert Statement: Dr. Med. Wolfram Hartmann, President of “Berufsverband der Kinder- und Jugendärzte” [German Pediatric Society] for the Hearing on the 26th of November 2012 Concerning the Drafting of a Federal Government Bill*, BERUFSVERBAND DER KINDER- UND JUGENDÄRZTE (BVKJ) (2012) [German original available from http://www.kinderaerzte-im-netz.de/bvkj/kinpopup/psfile/pdf/70/121126_Ste50aa5e211e6a6.pdf; English translation available from <http://www.intactamerica.org/>

member Dr. Andrew Freedman. Freedman stated that, in addition to having “insufficient information about the actual incidence and burden of nonacute complications,” the AAP’s 2012 assessment of benefit versus risk also suffered due to the “lack of a universally accepted metric to accurately measure or balance the risks and benefits.”¹¹³ Even more significantly, he went on to concede that

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 non-medical reasons. There can be no doubt that religion, culture, aesthetic preference, familial identity, and personal experience all factor into their decision.¹¹⁴

german_pediatrics_statement]; Zachary T. Androus, *Critiquing Circumcision: In Search of a New Paradigm for Conceptualizing Genital Modification*, 3 GLOB. DISC. 266 (2013); Brian D. Earp, *The AAP Report on Circumcision*, *supra* n.9; Lyons, *Male Infant Circumcision as a “HIV Vaccine,” supra* n.28. Critiques and counter-critiques to some of these papers are available at the journal websites.

¹¹³ Given this absence or uncertainty of net benefit, it is relevant that several legal cases have determined that unnecessary surgery is in itself a harm, sometimes so serious that substantial damages have been awarded to plaintiffs who experienced no adverse effects from the treatment. In a US case, *Tortorella v. Castro* (2006), a doctor misread an MRI scan and removed healthy tissue. In holding him liable for damages, the California appeals court stated, “it seems self-evident that unnecessary surgery is injurious and causes harm to a patient. Even if a surgery is executed flawlessly, if the surgery were unnecessary, the surgery in and of itself constitutes harm.” The court stated further, “the patient needlessly has gone under the knife and has been subject to pain and suffering.” See *Tortorella v. Castro*, 43 Cal. Rptr. 3d 853, 855-56, 860, 862 (Cal. Dist. Ct. App. 2006). See also *Dilieto v. Cnty. Obstetrics & Gynecology Grp.*, 297 Conn. 105 (2010) (physician liable for unnecessary removal of patient’s reproductive organs); *Murphy v. Blau*, 2010 WL 745056 (Conn. 2010) (doctor deemed negligent in performing unnecessary surgery and failing to communicate the risks to the patient) (cited in Peter Adler, *Is Circumcision Legal?*, XVI(3) RICH. J. L. & PUB. INT. 439, 469 (2013)). In an Australian case, unnecessary dental work in itself was held to be a “trespass to the person,” even though no additional harm resulted, and substantial damages (more than \$1 million) were awarded to the patient. *Dean v Phung* [2012] NSWCA 223 (25 July 2012), available at <http://www.austlii.edu.au/au/cases/nsw/NSWCA/2012/223.html>. See also [Unnecessary Extractions of Teeth constitutes Bodily Harm, Even If an Ignorant Patient Asks for It], 68(14) ZAHNARTZTL MITTZ. 769 (1978), available at <http://www.ncbi.nlm.nih.gov/pubmed/277023>. Most recently, a French man won a case against the surgeon who circumcised him as a consenting adult, then aged 26, after a diagnosis of phimosis. The court found that the surgeon had neglected to inform him about the risks and consequences of the surgery and failed to advise him of less harmful alternative therapies. Since the recommendation to circumcise was made “arbitrarily,” the patient was awarded almost € 32,000 in compensation: € 5000 for moral damage resulting from the lack of information; € 3000 for physical and mental suffering; € 250 for temporary functional deficit and € 3,560 for permanent functional deficit; and € 20,000 for sexual harm because of “a partial loss of the ability to access pleasure.” See *Circoncision: un Chirurgien Français Lourdemment Condamné*, DROIT AU CORPS: POUR L’ABANDON DES MUTILATIONS SEXUELLES (June 24, 2016), available at <http://www.droitaucorps.com/jugement-circoncision-france-2016>.

¹¹⁴ Andrew L. Freedman, *The Circumcision Debate: Beyond Benefits and Risks*, 137 PEDIATR. 1 (2016).

4.1. *Weighing Benefits Against Risks: What Values Should One Assign
(and Who Should Assign Them)?*

It is uncontroversial that non-medical factors may reasonably factor into a person's decision about circumcision. What does inspire controversy, as Professor Munzer notes in his article, is the assumption implicit in Dr. Freedman's analysis that this person should be someone other than the individual who would be personally affected by the surgery were it to take place.¹¹⁵ This assumption is also at play in the following discussion of a "trade-off" analysis of circumcision performed by Dimitri Christakis and colleagues:

Parents' subjective weighing of the benefits of prevention and the harm of complications is fundamental to this decision-making process. Accordingly, we did not assign relative weights to the outcomes. Further, we believe that attempts to designate utilities for these outcomes – whether they be based on expert panels or community surveys – would be misguided. The weighing process in this decision should remain individualized and subjective, taking fully into account the parents' general degree of aversion to risk, and in particular whether the risk arises from either omitted or committed actions. Parents might well have greater feelings of guilt associated with adverse events arising from circumcision [i.e., a committed action], such as needing a penile wound repaired, than from a different adverse and somewhat preventable event [stemming from an omitted action], such as a [treatable] UTI occurring in uncircumcised boys. This aversion to committed action risk and its associated feelings may counter-balance or outweigh any potential benefits.¹¹⁶

In this passage, Christakis et al. are evaluating neonatal circumcision, specifically, so their invocation of the parents' subjective weightings is appropriate. But it is also important to consider the subjective weightings of the person who, to use their example, might need to have a penile wound repaired as a result of a surgical complication. This is a person for whom the

¹¹⁵ Brian D. Earp, *Male Circumcision: Who Should Decide?*, e-letter in 37(5) PEDIATR. (2016). Please note that minor portions of this section have been adapted from this letter.

¹¹⁶ Dimitri A. Christakis et al., *A Trade-off Analysis of Routine Newborn Circumcision*. 105(Supp. 2) PEDIATR. 246, 248 (2000).

stakes of the decision are arguably much higher, and for whom they are certainly much more personal. Needless to say, this person might reasonably conclude that such a risk—no matter how slight—is intolerable to him, given the nature of the organ in question. As Julian Savulescu has recently argued:

The tendency today is to roll over and 'scientifically' everything. Evidence will tell us what to do, people believe. But what [is required is an] ethical judgment about *weighing* risk and benefit. In Australia the speed limit is 100 km/h; in Germany, it is unlimited. Which is right? It depends on how you weigh convenience, pleasure, economic growth versus health. The safest speed to drive at is (almost) zero.¹¹⁷

Savulescu is right to emphasize the importance of weighing benefits against risks, in light of trade-offs and alternative options, and the intrinsically value-laden nature of this enterprise. To see how this insight applies to the specific health benefits that have been attributed to circumcision, let us first take the example of UTIs. According to the AAP, it would take about 100 circumcisions to prevent 1 UTI.¹¹⁸ Given that boys have an approximately 1% absolute risk of getting a urinary tract infection in the first year of life,¹¹⁹ regardless of circumcision status, and given that these infections can be treated effectively with oral antibiotics, as they are for girls, it seems fair to ask how much weight one should assign to this particular benefit.

A similar question applies to the claimed risk-reductions for STIs. Before one can make a determination about the importance of this benefit, one must consider a number of factors: (1) children are not at risk of contracting sexually transmitted infections before they become sexually active; (2) the absolute risk of the most serious of these infections is low in developed countries; (3) there are other, more effective modes of prevention that do not involve surgery and its attendant risks; (4) bacterial STIs, if they do occur, can

¹¹⁷ Julian Savulescu, *Bioethics: Why Philosophy is Essential for Progress*, 41(1) J. MED. ETHICS 28, 30 (2015) (emphasis added).

¹¹⁸ AAP, *Male Circumcision*, *supra* n.107. See also Davinder Singh-Grewal, et al., *Circumcision for the Prevention of Urinary Tract Infection in Boys: A Systematic Review of Randomised Trials and Observational Studies*, 90(8) ARCH. DIS. CHILD. 853 (2005).

¹¹⁹ *Id.*

typically be cured with antibiotics; and (5) viral STIs can now be prevented in some cases by vaccination, or otherwise managed with medications.¹²⁰

Given these (and other) considerations, what is the relative weight or value that one should assign to a claimed risk-reduction for STIs? Is it worth the risk already mentioned – that of a “botched” circumcision? Is it worth the loss of the foreskin itself? Is it worth the risk of removing too much skin – as we saw in the “Dear Abby” exchange – which may lead to painful erections later in life? Is it worth the risk, no matter how slight, of death?¹²¹

The answers to these questions cannot be objectively determined. Instead, they will depend upon the value an individual places on having intact rather than modified genitalia, how willing he is to engage in safer sex practices (which is advised regardless of one’s circumcision status, and in addition to which the marginal benefit of circumcision is negligible),¹²² and

¹²⁰ With respect to (1), proponents of circumcision often point out that some males become sexually active before an age at which they would be legally allowed to consent to circumcision (presumed to be 18). There are two ways to respond to this: first, the age of consent for circumcision could be lowered, perhaps to 15 or 16, if that really is the main issue; but second, this is mostly a red herring. As Van Howe notes, “[a]ccording to the CDC’s own numbers, the risk of HIV infection under the age of 15 years is very low. How many 15 year olds are having unprotected sex with female partners who are HIV-infected?” Van Howe, *CDC-Requested Critique*, *supra* n.109, at 15. With respect (2), also concerning HIV, see Sarah Bundick, *Promoting Infant Male Circumcision to Reduce Transmission of HIV: A Flawed Policy for the US*, HARV. HEALTH & HUM. RIGHTS J. BLOG. (2009, Aug. 31), available at <http://www.hhrjournal.org/2009/08/promoting-infant-male-circumcision-to-reduce-transmission-of-hiv-a-flawed-policy-for-the-us/> (pointing out that “[t]aken together, the data [as applied to the relevant populations] suggest that the number of HIV infections that could be prevented in the US by promoting infant male circumcision is likely to be only in the hundreds per year – a tiny fraction of the estimated 50,000 new HIV infections”). See also CDC, *HIV in the United States: At a Glance* (2016), available at <https://www.cdc.gov/hiv/statistics/overview/ata glance.html> (providing figures consistent with Bundick’s analysis, in that new HIV infections are rare, and the most affected sub-groups would derive no benefit from circumcision, since they are primarily MSM, for whom there is no compelling evidence of a protective effect – see the review by Templeton et al. *infra* n.128). With respect to (3), we allude to condom-use and other safe sex strategies, which should be practiced whether or not one is circumcised, and which a man might rationally prefer over losing his foreskin (and then engaging in such strategies anyway, thereby virtually eliminating the marginal benefit for circumcision). With respect to (4) and (5), for an accessible overview, see National Institutes of Health, *Treatments for Specific Types of Sexually Transmitted Diseases and Sexually Transmitted Infections (STDs/STIs)* (2017), available at <https://www.nichd.nih.gov/health/topics/stds/conditioninfo/Pages/specific.aspx> (last accessed Jan. 14, 2017).

¹²¹ For a recent example, see Lizzie Dearden, *Newborn Bleeds to Death after Doctor ‘Persuades’ Parents to Have Him Circumcised in Canada*, THE INDEPENDENT (Oct. 27, 2015), available at <http://www.independent.co.uk/life-style/health-and-families/health-news/newborn-bleeds-to-death-after-doctor-persuades-parents-to-have-him-circumcised-in-canada-a6710061.html>.

¹²² See, e.g., Akim McMath, *Infant Male Circumcision and the Autonomy of the Child: Two Ethical Questions*, 41(8) J. MED. ETHICS 687 (2015).

how much risk he is comfortable taking on when submitting to a surgical intervention on a part of the body that is both physically and symbolically sensitive.¹²³ None of this, however, can be known with certainty while the individual is still an infant; he can only report on his values when he is older and fully informed.¹²⁴

That an individual's values can only be known when he is mentally mature, however, does not automatically lead to the conclusion that circumcision should be delayed. In fact, so long as the alternative is not strictly prohibited, a parental decision to refrain from circumcision in infancy is – as Munzer notes – still a decision, and one with which the child may later disagree. Again, this line of reasoning assumes that his parents were legally entitled to make such a choice in the first place; if they were not, the grown child could not rationally fault them for having left his genitals intact when he was an infant. Of course, this points to one possible solution to the collective action problems regarding teasing or other potential social harms,¹²⁵ as well as to the more general problem of uncertainty regarding the child's best interests (i.e., a legal prohibition that would apply across the board, thereby eliminating the grounds for teasing or uncertainty); but we shall not pursue that argument further.

In the meantime, 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 (and run the risk of the child experiencing surgical

¹²³ The foregoing paragraphs are loosely adapted from Frisch & Earp, *Critical Assessment of Recent Evidence*, *supra* n.56.

¹²⁴ As Munzer notes, it is possible that in infancy "there is now no fact of the matter concerning the future time at which a circumcised child attains majority in regard to his welcoming or regretting his circumcision" since "this possibility turns on the thorny philosophical problem of whether propositions about future contingents have a truth-value." See Munzer, *supra* n.1, at 533.

¹²⁵ For a discussion of analogous collective action problems in the case of female genital cutting, see, e.g., Gerry Mackie, *Ending Footbinding and Infibulation: A Convention Account*, 61 AM. SOCIOLOGICAL REV. 999 (1996). For a short description of why social/structural solutions are needed in such cases, rather than a reliance on unilateral efforts by individuals, see, e.g., Jim A. C. Everett et al., *A Tragedy of the (Academic) Commons: Interpreting the Replication Crisis in Psychology as a Social Dilemma for Early-career Researchers*, 6 FRONT. PSYCHOL. 1 (2015).

complications, resentment, and so on), while parents who refrain from early surgery close off the option for the affected male to undergo the surgery *during infancy or early childhood*.¹²⁶

That much cannot be disputed. But are these cases symmetrical? As Adrienne Carmack et al. note, "it is possible that the affected male whose parents opt against early surgery to allow him to make his own decision in the future may later decide in favor of surgery,"¹²⁷ and so he may. However, nontherapeutic circumcisions are rarely sought by adults with intact genitals, even in cultures in which circumcision is common and normative.¹²⁸ Therefore,

¹²⁶ Adrienne Carmack et al., *Should Surgery for Hypospadias Be Performed Before An Age of Consent?*, 53 J. SEX RES. 1047, 1057 (2016) (emphasis added). Please note that while this analysis concerns surgery for hypospadias – a different penile surgery that is often carried out in infancy or early childhood – the same principles apply to NTC. Hence the use of this quote here.

¹²⁷ *Id.*

¹²⁸ Definitive figures on this issue are elusive, but analysis of rebates for circumcision procedures provided by the Australian government health insurance system, Medicare, suggests that approximately 3.8% of non-circumcised boys aged 15 in 2005 will have been circumcised by their 65th birthday – an annual rate of 0.076%. These figures were calculated by John Cozjin from data kept by the Health Insurance Commission (<http://www.health.gov.au/medicarestats>); see <http://www.circinfo.org/statistics.html>. In the US, a study by Chongyi Wei and colleagues found that even if they believed that circumcision provided significant protection against HIV, very few of the adult men they sampled would elect it for themselves. Chongyi Wei et al., *What Is the Potential Impact of Adult Circumcision on the HIV Epidemic Among Men Who Have Sex with Men in San Francisco?* 37 SEX TRANSM. DIS. 1 (2010). Proponents of circumcision sometimes cite this study to imply that such men must be irrational, or simply too afraid to undergo a surgery that they know is in their objective best interests. This claim is then harnessed into a paternalistic assertion that circumcision should take place in infancy. But there is an alternative explanation: perhaps such men simply regard their foreskins as valuable enough that they would prefer to keep their genitals intact, even if this meant a slight increase in the absolute risk of contracting HIV. Or perhaps the men understand that they are being asked a hypothetical question with a false premise: there is no compelling evidence that circumcision reduces the risk of HIV transmission among MSM. See, e.g., David J. Templeton et al., *Male Circumcision to Reduce the Risk of HIV and Sexually Transmitted Infections Among Men who Have Sex with Men.*, 23 CURR. OPIN. INFECT. DIS. 45, 45 (2010) (stating that "[t]he evidence that circumcision reduces HIV and other STIs among MSM is weak and inconsistent [although] MSM who predominantly take the insertive role in anal intercourse may be at a lower risk of HIV infection." While some MSM "may be willing to undergo adult circumcision, should it be proven to reduce HIV acquisition risk, there is substantial potential that behavioural disinhibition could offset any benefits achieved by a circumcision intervention"). Indeed, the available data only suggest a reduction in risk from females to males during heterosexual intercourse; the trial looking at male to female transmission, by contrast, had to be stopped early due to futility – i.e., more infections occurring in the female partners of circumcised, compared to non-circumcised, men. Maria J. Wawer et al., *Circumcision in HIV-infected Men and its Effect on HIV Transmission to Female Partners in Rakai, Uganda: A Randomised Controlled Trial*, 374 LANCET 229, 229 (2009) (finding that "17 (18%) women in the intervention [circumcision] group and eight (12%) women in the control [no circumcision] group acquired HIV during follow-up ... Circumcision of HIV-infected men did not reduce HIV transmission to female partners over 24 months; longer-term

this point may be mostly academic. Nevertheless, if a non-circumcised adult is considering NTC, for whatever reason, he can perform his own risk-benefit analysis of the surgery, taking into account the fullness of his circumstances. If he then chooses NTC, 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 such a case, as supporters of NTC often point out, there is an indeterminate likelihood that he would wish the surgery had already taken place, perhaps in infancy, so that he does 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.¹²⁹ 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 no one takes 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 less risky at this age” – all of which are regularly invoked in defense of NTC – would be considered offensive. Rather, the expectation is that girls should be able to make such personal decisions for themselves when they are older and can understand what is at stake.

In any event, the adult with unmodified genitals – who now prefers that they be altered – has an option available with which to satisfy the preference.¹³⁰ By contrast, the man whose early circumcision was not desired,

effects could not be assessed. Condom use after male circumcision is essential for HIV prevention”).

¹²⁹ We do not mean to imply that such “cosmetic” genital surgeries are unproblematic, simply because they are performed on adults. Nor do we maintain that the decision to pursue them is free from invidious social pressures stemming from, *inter alia*, distorted notions of what is “normal” and/or restricted views about what is “beautiful.” We do suggest, however, that if a nontherapeutic genital surgery is to be performed, whether in response to unjust social pressures or anything else, it would be better if the proximate decision to undergo the surgery were made by the person whose genitals will be affected by it, all else being equal. For a related analysis, see Brian D. Earp, *Hymen “Restoration” in Cultures of Oppression: How Can Physicians Promote Individual Patient Welfare Without Becoming Complicit in the Perpetuation of Unjust Social Norms?*, 40 J. MED. ETHICS 431 (2014).

¹³⁰ Indeed, she or he can provide specific input as to the “style” of labiaplasty/circumcision that is desired (concerning how much tissue and of what kind to remove), and can also manage her/his pain control needs throughout the healing process. Neither of these features would apply in infancy.

and is now a cause of significant distress, has no comparable remedy. He may attempt artificial foreskin “restoration,” as described earlier – 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: he can never recover the tissue or the nerve endings that were lost. 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.

4.2. *The Question of Timing*

Let us pursue this issue of timing further. As Akim McMath observes: “People disagree over what constitutes a harm and what constitutes a benefit” when it comes to circumcision. This disagreement is especially likely for non-medical harms and benefits, which allow even more room for subjective judgments than the ones we have so far considered. For example, “[s]ome people believe circumcision benefits the child by bringing him closer to God, while others disagree. In light of such disagreement, some commentators conclude that the parents should decide.” But this does conclusion does not follow: “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, McMath concludes, “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.”¹³¹

Against this view, as Munzer notes, it is sometimes argued that circumcision – among practicing Jews at least – must be performed on the 8th day after birth to meet religious requirements (i.e., to fulfill a perceived divine covenant), and therefore cannot be postponed. This argument does carry considerable force, especially in light of the strong moral and legal protections that are typically afforded to religious practices in Western countries.

¹³¹ McMath, *supra* n.122, at 689.

However, it must be acknowledged that such protection does not currently extend to any form of nontherapeutic female genital cutting, no matter how slight, and no matter how sincere her parents' conviction that such cutting is religiously required.¹³² Moreover, as Eldar Sarajlic notes, the argument rests on certain metaphysical assumptions that one might regard as highly questionable. For example,

it presumes the existence of a divine entity that commands the performance of circumcision. While the question about the existence of such an entity is a matter of personal persuasion, the mere presumption can hardly warrant authorizing an invasive intervention into the body of another human being, even if in cases of parents and their children. Without a definite proof that such an intervention would bring metaphysical benefits (provided these are defined more precisely) to the child, circumcision cannot be justified [on best interest grounds].¹³³

Furthermore, the claim about metaphysical salvation "presumes that the child will necessarily share their parents' metaphysical beliefs once it is

¹³² As Kavita S. Arora and Allan J. Jacobs point out, it is often claimed that female genital cutting is not truly a religious practice, because it is not mentioned in the Koran, the central scripture of Islam. But this view is highly simplistic and misleading. As they note, "legal protection of a religious practice is not [normally] contingent either on the orthodoxy of the practice or on a consensus within a religious tradition accepting the practice." Furthermore, "outsiders to a religious tradition cannot infer the practices of a religious system from a literal reading of its canonical texts. It is no more possible to define Islam within the four corners of the Quran than to define Christianity (which includes traditions ranging from Presbyterian to Pentecostal to Greek Orthodoxy) solely from a reading of the Bible." Rather, "the content of religious belief and practice are guided by interpretive texts and traditions. Thus, many Muslim scholars classify FGA as "Sunnah" or practice established by the prophet Muhammad. Though not prescribed explicitly in the Quran, the practice thus is religiously virtuous." Kavita S. Arora & Allan J. Jacobs, *Female Genital Alteration: A Compromise Solution*, 42 J. MED. ETHICS 148, 151 (2016). For further extensive discussion, see Dena S. Davis, *Male and Female Genital Alteration*, *supra* n.32; Brian D. Earp, Jennifer Hendry, and Michael Thomson, *Reason and Paradox in Medical and Family Law: Shaping Children's Bodies*, MED. L. REV. (in press) (noting that even if religious practices could be conceptually cordoned off from "merely" cultural ones, the latter would not necessarily be any less deserving of respect). See also Alex Myers, *Neonatal Male Circumcision, If Not Already Commonplace, Would Be Plainly Unacceptable by Modern Ethical Standards*, 15 AM. J. BIOETH. 54, 55 (2015) (noting that "in Sunni Islam, the dominant branch of Islam, two of the four schools of jurisprudence, Shafi'i and Hanbali, consider Type 1 female circumcision to be obligatory, while the other two schools, Maliki and Hanafi, recommend the practice." And going on to argue that "[t]he scriptural support for this is no weaker than that for male circumcision—both are derived from the secondary source of Islamic law known as the Hadith ... Thus, if we defer to religious justifications, we shall find that in many cases, the circumcision of female as well as male children could be permitted on this basis").

¹³³ Sarajlic, *supra* n. 41, no page numbers provided.

grown up.”¹³⁴ But research shows that children are increasingly abandoning their parents’ religion or otherwise changing their core beliefs as they get older.¹³⁵ In multi-religious, multi-ethnic, multi-cultural societies, children are regularly exposed to different belief systems and ways of life, and they often find as they mature that worldviews other than the one with which they were raised are more compelling. Permanently altering a child’s body in accordance with just one defeasible metaphysical belief system – one which there is a non-trivial likelihood the child will later reject – is therefore problematic.

Another common argument against delaying NTC is that the surgery is “less risky” in infancy, such that deferring the decision to an age-of-consent would be undesirable from a medical perspective. If so, this would count as an ethically-relevant asymmetry pointing in the opposite direction to the one concerning available remedies for resentful adults. But this argument, too, is not straightforward. In the first place, it may be the case that any number of nontherapeutic bodily interventions are less risky in infancy compared to later in life: removing the earlobes, for example, may carry fewer surgical risks in the neonatal period than in adulthood, although we are not aware of any data on this question.¹³⁶ The same may be true of ritualized tooth extractions, or of the facial scarification procedures practiced by some groups.¹³⁷ The initial question, however, is whether such interventions are permissible at all, given the prevailing moral and legal norms of the wider society in which the child is being raised. If they are not, then the question of preferred timing on the basis of relative risk profiles does not arise.

Second, it is not clear that infant circumcision, compared to adult

¹³⁴ *Id.*

¹³⁵ According to a recent summary of a Pew Research study, focusing just on the United States, “[w]hile the US public in general is becoming less religious, the nation’s youngest adults are by many measures much less religious than everyone else.” Indeed, “one of the most striking findings in the recently released Religious Landscape Study is that Millennials (young adults born between 1981 and 1996) are much less likely than older Americans to pray or attend church regularly or to consider religion an important part of their lives.” David Masci, *Why Millennials are Less Religious than Older Americans*, PEW RESEARCH CENTER (Jan. 8, 2016), available at <http://www.pewresearch.org/fact-tank/2016/01/08/qa-why-millennials-are-less-religious-than-older-americans/>.

¹³⁶ As such removal would be considered assault.

¹³⁷ Again, we are not aware of any data on this subject.

circumcision, does in fact carry less surgical risk. The claim that it does, oft-repeated by NTC proponents, is based largely upon retrospective comparisons of non-concurrent studies with results drawn from dissimilar populations, using dissimilar methods and criteria for identifying complications.¹³⁸ Thus, these comparisons do not adequately control for the skill of the practitioner, the specific technique employed, the setting of the surgery, and the methods of data collection, among other factors.¹³⁹

But even if we simply grant that there is an increase in the relative risk of complications between the surgery performed in childhood versus adulthood, it is the difference in absolute risk that is most ethically relevant. Even proponents of circumcision contend that the absolute likelihood of clinically important, difficult-to-resolve surgical complications associated with circumcision is “low,” irrespective of the age at which the procedure is performed.¹⁴⁰ Given such a low baseline risk according to the proponents’ view, the existence of a relative risk reduction in the incidence of adverse events in infancy compared to adulthood is unlikely to be morally decisive: a small risk divided by any amount is still a small risk.¹⁴¹

¹³⁸ See, e.g., Brian J. Morris et al., *A ‘Snip’ in Time: What is the Best Age to Circumcise?*, 12(1) BMC PEDIATR. n.p. (2012). For further discussion, see J. Steven Svoboda, & Robert S. Van Howe, *Circumcision: A Bioethical Challenge*, J. MED. ETHICS (2014) e-letter, available at <http://www.arclaw.org/sites/default/files/svoboda-van-howe-circumcision-a-bioethical-challenge.pdf>.

¹³⁹ There is also an “epistemic asymmetry” between men circumcised in infancy and men circumcised as adults in terms of their ability to recognize, and report on, any adverse outcomes. Men circumcised as adults have a conscious baseline against which they can assess any undesired consequences, whereas men circumcised as infants have no other frame of reference.

¹⁴⁰ See, e.g., Brian J. Morris & Edward .C. Green, *Circumcision, Male* in THE WILEY BLACKWELL ENCYCLOPEDIA OF HEALTH, ILLNESS, BEHAVIOR, AND SOCIETY 253-56 (W. Cockerham, R. Dingwall & S. R. Quah, eds., 2014). Note, however, that even a low risk of such complications, when multiplied by the millions of circumcisions that are performed each year, will nevertheless result in what many people regard as an unacceptably large number of men who must go through life with penile deformities or other significant problems that they otherwise would not have to face. Against this view, it could be argued that many common things in life carry risk: swimming, playing sports, and so on. However, these activities are typically undertaken with the age-appropriate consent of the child, who has at least some understanding of what is likely implied by his or her participation. Procedures carried out on a child’s genitals without a strict medical indication, we suggest, pose a different kind of risk, and one that might reasonably be judged to be less acceptable than the risks to which a child may expose himself by participating in sports or similar activities.

¹⁴¹ As Sarah Williams notes, “[t]he size of the initial absolute risk is what’s really important here. If the initial risk is very small, even a huge increase may not make much absolute difference.” Sarah Williams, *Absolute Versus Relative Risk – Making Sense of Media Stories*, CANCER RESEARCH UK - SCIENCE BLOG (Mar. 15, 2013), available at <http://scienceblog.cancerresearchuk.org/2013/03>

If that much is right, the analysis returns to the necessary effects of circumcision, outlined earlier: (1) the loss of the foreskin itself, along with the loss of all sensations and erotic activities that rely on its being preserved, and (2) the loss of free choice in the matter if the procedure is performed in infancy or early childhood. As we have seen, men's attitudes regarding these necessary outcomes vary widely, and such attitudes are likely to be much more predictive of their satisfaction with circumcision than any minor discrepancies in surgical risk profiles as a function of timing.¹⁴²

5. RELEVANCE OF CULTURAL AND SUBJECTIVE FACTORS: A SUMMARY

To summarize, whether NTC is harmful depends in large part upon the value one assigns to the foreskin. If the foreskin has value – or if it is reasonable for a man to regard his foreskin as having value – then its sheer removal can be counted as a harm. In the United States, Israel, and in some Muslim-majority countries, where infant and child circumcision remain common, the majority of adult males and their partners have never experienced sex with a foreskin. The bulk of their information comes from informal sources, such as TV shows or magazines, where the natural penis is likely to be referred to as “uncircumcised” – an arguably pejorative term that treats the surgically modified penis as the default¹⁴³ – and where it may also

/15/absolute-versus-relative-risk-making-sense-of-media-stories/.

¹⁴² See Darby, *Targeting Patients Who Cannot Object*, *supra* n.90. Darby argues that the historical development of a strong preference for circumcising infants and children, rather than offering the operation as an elective to adults, had little to do with the interests of the child, the lower risk of complications, or the superior efficacy of early circumcision, but was rather related to the convenience of the operator, established habit, and the asymmetrical power relations between adults and children. Darby suggests that the argument that infancy is the “best time to circumcise” can be seen, in part, as making the false assumption that circumcision is desirable for all and will be necessary for most at some stage.

¹⁴³ Compare with a woman's chest, which we do not refer to as “un-mastectomized,” or her vulva, which we do not call “unlabiaplastied.” A further problem with this term is that it can be confused with foreskin restoration—an attempted act of “un-circumcising.” See William 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)*, 28(5) CLIN. ANAT. 563 (2015).

be regarded as a source of crude humor.¹⁴⁴ In these cultural settings, even among health professionals, the foreskin may be erroneously regarded as a “useless flap of skin” that is prone to infection and other medical problems. Since the foreskin itself is assumed to have little value in such contexts, the principal perceived drawback of NTC becomes simply the risk of surgical complications. Especially when compared against the various medical and non-medical benefits that are often attributed to NTC in these societies, such a minor perceived risk can easily be discounted.

In contrast, in societies where NTC is relatively rare—i.e., most other industrialized nations—the foreskin is typically regarded with greater favor,¹⁴⁵ and it is the circumcised penis that is perceived as strange-looking and less than functionally optimal.¹⁴⁶ This contrast serves to highlight the contingent and at least partially arbitrary nature of such judgments: some men regard their own neonatal or childhood circumcisions as representing an aesthetic or sexual enhancement compared to the natural state, while others see it as a disfigurement or even a mutilation.¹⁴⁷ Since the cultural norms that inform such judgments are not stable, however, as noted *supra*—especially given advanced information technology, other forces of globalization, and accelerated cross-cultural exchange—there is a growing risk that parents’ valuations of a proposed circumcision will differ from those of the child himself when he is older.

By authorizing the removal of an infant or young child’s foreskin, therefore, a trade-off is initiated whose overall status rests upon future

¹⁴⁴ See generally, Hugh Young, ‘That Thing’: Portrayal of the Foreskin and Circumcision in Popular Media, 37 CIRCUMCISION & HUMAN RIGHTS 239 (Denniston et al. eds., 2009).

¹⁴⁵ One measure of the value placed on the foreskin in these countries is the number of prepuce-sparing procedures that have been developed for males with penile problems. For example, rather than resorting to circumcision as a treatment for pathological phimosis (an inability to retract the foreskin causing problems), a steroid cream will typically first be applied and, as a last resort, a minor procedure called preputioplasty will be attempted, which removes as little of the foreskin as possible while still resolving the problem. See, e.g., T. M. Lane & L. M. South, SURGICAL TECHNIQUE-Lateral Preputioplasty for Phimosis, 44(5) J. ROYAL COL. SURG. EDIN. 310 (1999). See also Pa Dewan et al., Phimosis: Is Circumcision Necessary?, 32(4) J. PAEDIATR. & CHILD HEALTH, 285 (1996).

¹⁴⁶ See, e.g., Androus, *supra* n.112, at 266-80.

¹⁴⁷ For extensive discussion of this point, see Earp, *Between Moral Relativism and Moral Hypocrisy*, *supra* n.33, at 105-144 and E1-E28. See also Boyle et al., *supra* n.72, at 329-34; Hammond, *supra* n.96, at 85-92.

subjective norms and preferences that will become increasingly hard to predict. As Hannah Maslen and colleagues argue:

Whilst adults are in a position to decide whether effect X is valuable enough (to them) to justify incurring [loss] Y, children do not yet have the capacity or the life experience to make such trade-off decisions. They do not know what they will value when they grow up and nor do their parents. Whilst an intervention that improves X may count as an enhancement for the individual who does not care much about Y, another individual, valuing Y over X, will view the very same outcome as an impairment. In such cases – that is, cases in which the very status of an intervention's being an (overall) enhancement vs. an impairment is controversial – the weight of considerations should shift toward delaying the intervention until the individual who will actually be affected by it has sufficient capacity to decide. The more permanent and substantial the trade-off, the more this argument has force.¹⁴⁸

6. TENTATIVE CONCLUSION: TOWARD GENDER EQUALITY?

The foregoing analysis does not necessarily show that parents should be legally prohibited from making decisions about the nontherapeutic surgical alteration of their children's genitals.¹⁴⁹ But once again we must emphasize that in the case of female children, such alterations are already illegal in countries such as Germany and the United States, and the law in these countries appears to be settled. As Munzer notes, these laws cover alterations to the vulva that are less physically invasive than male circumcision (such as pricking of the clitoral hood), as well as interventions that may be performed, at least in some groups, for similar if not identical reasons on both boys and girls.¹⁵⁰ As Dena Davis argued more than a decade ago with respect to the

¹⁴⁸ Hannah Maslen et al., *Brain Stimulation for Treatment and Enhancement in Children: An Ethical Analysis*, 8(953) FRONT. HUM. NEUROSCI. 1, 4 (2014).

¹⁴⁹ For the view of one of the present authors on the question of a legal prohibition, see Brian D. Earp, *Things I Have Learned (So Far) About How to Do Practical Ethics*, PRACTICAL ETHICS (2014), available at blog.practicaethics.ox.ac.uk/ (arguing that pushing a ban before cultural readiness can often backfire).

¹⁵⁰ The most important and exhaustive analysis of these points is due to Dena Davis, *Male and Female Genital Alteration*, *supra* n.32. For further discussion, see Debra L. DeLaet, *Framing Male*

United States, this creates a legal “collision course” that can no longer be avoided:

When one begins to question the normative status of male newborn alteration in the West, and when one thinks of female alteration as including even an hygienically administered ‘nick,’ one sees that the two practices, dramatically separated in the public imagination, actually have significant areas of overlap. [In fact] the two practices lack a legally defensible distinction, given the current wording of state and federal statutes. Thus, a complete laissez-faire attitude toward one practice coupled with total criminalization of the other, runs afoul of the ‘free exercise’ clause of the First Amendment. There are also troubling implications for the constitutional requirement of equal protection, because the laws appear to protect little girls, but not little boys, from religious and culturally motivated surgery.¹⁵¹

Munzer deserves credit for dedicating a section of his article to this “problematic” legal situation, as it is often side-stepped in these debates.¹⁵² As he notes, in the aftermath of the Cologne judgment, just as the law was being clarified to ensure the legality of nontherapeutic circumcision of male infants, the law against any form of nontherapeutic female genital cutting (FGC) was being strengthened. This sort of inconsistency arises in part from the inherent subjectivity in harm judgments we have emphasized, which allows for gendered and other cultural assumptions to seep in. One such assumption may be that boys are (or should be) “tougher” than girls and therefore less liable to suffer harm given a comparable injury. As Bettina Shell-Duncan and Yvla Hernlund note, “there appears to exist in the West a tolerance of, and perhaps

Circumcision as a Human Rights Issue? Contributions to the Debate over the Universality of Human Rights. 8(4), J. HUM. RTS., 405, 405 (2009) (arguing that “the most common forms of male and female circumcision are not sufficiently divergent practices to warrant a differential response from the international community and that there are more similarities between the two practices than is typically acknowledged”). See also Brian D. Earp, *Boys and Girls Alike: The Ethics Of Male And Female Circumcision* in WOMEN, HEALTH, & HEALTHCARE: READINGS ON SOCIAL, STRUCTURAL, & SYSTEMIC ISSUES 113-16 (E. C. H. Gathman ed., 2016) (arguing that there is substantial overlap between male and female genital cutting practices in terms of physical effects, underlying rationales, and symbolic meanings, when the full range of each is considered and like compared with like).

¹⁵¹ Davis, *supra* n.32, at 448.

¹⁵² Munzer, *supra* n.1, at 560.

appreciation for, the assumption that masculine [but not feminine] ideals are honed through painful initiations that respond to group needs.”¹⁵³ Similarly, Fox and Thomson argue:

Debates concerning [female] bodies have often focused on their vulnerability to harm – as is evident in the framing of debates around female circumcision. By contrast, male bodies are typically constructed as safe, bounded and impermeable ... this may make it more difficult to uncover harms to boys – a contention which seems to be borne out by the tendency of Anglo-American legal commentators to minimise the harms inflicted on boys by circumcision with a concomitant propensity to exacerbate the risks occasioned by less invasive forms of female circumcision.¹⁵⁴

Such an analysis has implications for interpreting the obligations contained in the UN Convention on the Rights of the Child (CRC), particularly the ambiguous article 24 (3): “States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.”¹⁵⁵ In his recent discussion of what this phrasing means, John Tobin points out:

this phrase does not appear to require that the harm suffered to a child’s health reach a certain threshold before the obligations of a State are invoked under Article 24 (3). On the contrary, it suggests that any aspect of a traditional practice which in any way has a negative impact on the health of a child, whether mental or physical, temporary or permanent, must be abolished. Moreover, the assessment as to the prejudicial impact of such a practice is not to be based on assumptions or speculation, which are invariably informed by social and cultural values, but on medical evidence which quantifies its physiological and or psychological impact.¹⁵⁶

¹⁵³ Shell-Duncan & Hernlund (eds.), *FEMALE “CIRCUMCISION” IN AFRICA*, *supra* n.152, at 16.

¹⁵⁴ Marie Fox & Michael Thomson, *Short Changed? The Law and Ethics of Male Circumcision in CHILDREN’S HEALTH AND CHILDREN’S RIGHTS* 161, 175–76 (Michael Freeman ed., 2006).

¹⁵⁵ U.N. Convention on the Rights of the Child, art. 24(3), *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 2 (entered into force Sept. 2, 1990).

¹⁵⁶ John Tobin, *The International Obligation to Abolish Traditional Practices Harmful to Children’s Health: What Does It Mean and Require of States?*, 9(3) HUMAN RTS. L. REV. 373, 378 (2009).

Unfortunately, as discussed *supra*, taking medical evidence as the benchmark “obscures the complex debates as to the purported objectivity of medical knowledge.”¹⁵⁷ The advantage of relying on medical claims, from the UN committee’s point of view, was that it allowed them “to avoid the explicit condemnation of cultural practices by diverting attention from their cultural significance to their health impact.”¹⁵⁸ Such a distinction is, however, difficult to maintain in practice because

cultural and social values will invariably influence the understanding of harm, especially psychological harm. Ritual initiation ceremonies provide a good example of such a dilemma. They may involve the infliction of significant physiological harm which would *prima facie* fall within the scope of Article 24 (3).¹⁵⁹

The contrary argument, as we noted earlier, is that if the traditional practice were prohibited or abolished, children who were not subject to the relevant initiation might be excluded or suffer other social setbacks which could lead to psychological harm. This empirically unsubstantiated proposition has long been prominent in the arguments of those who support the preservation of genital cutting rites, not only for boys, but also for girls, who may similarly suffer ridicule or discrimination from their peers for having failed to undergo the prescribed rituals.¹⁶⁰ Yet this way of arguing ignores the

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ See, e.g., Tobe Levin, *Nura Abdi, Fadumo Korn: No More Pudendal Desecration* in FEARFUL SYMMETRIES: ESSAYS AND TESTIMONIES AROUND EXCISION AND CIRCUMCISION 129, 135 (Chantal Zabus ed. 2008) (discussing the fact that in some communities, “[m]ale circumcision builds community; so does [circumcision of] girls ... for desire to be included, to escape being mocked, drives” both practices. “The unaltered vagina is wet; it drips. Its effluvium emits an unpleasant smell. It must be erased,” according to proponents of female genital cutting; this is similar to the claims of many proponents of male circumcision that the unaltered penis is “dirty” or difficult to clean, and therefore circumcision should be pursued); FEMALE “CIRCUMCISION” IN AFRICA: CULTURE, CONTROVERSY, AND CHANGE (Bettina Shell-Duncan & Yvla Hernlund eds. 2000) (with numerous contributing authors discussing various social pressures that drive female genital cutting practices in many communities, including the prospect of teasing). With respect to boys, note that according to one study, the most common penile characteristic to provoke teasing in school locker rooms in the US Midwest – where circumcision prevalence is especially high (87% in the study sample) – was penile size. Teasing for not being circumcised was far less common.

fact that a successful prohibition would alter the social norms all at once: no child can be teased for being “different down there” if all children have intact genitalia.

Notwithstanding this and other similarities between male and female genital cutting, Tobin notes that the CRC “has failed to make any substantive comments with respect to male circumcision, also a traditional practice.”¹⁶¹ In attempting to explain this discrepancy, Tobin refers to the (Anglophone) tendency to construct male circumcision as a “standard and benign medical practice,”¹⁶² and observes that while the negative impact of FGC on a girl’s health is “virtually uncontested,”¹⁶³ the evidence with respect to male circumcision is equivocal, at least when performed in a clinical setting. This would not, however, explain the “absence of concern for the practice in non-medical settings, where performance of the procedure is associated with significant levels of pain and the risk of infection.”¹⁶⁴ Thus, again, the

Regardless of the experience of teasing, very few of the men surveyed were unsatisfied with their penile appearance, and “experiencing teasing or witnessing others being teased about penile appearance did not have an effect on the desire for a different penile appearance.” Moreover, compared to being circumcised, “being uncircumcised did not increase the rate of personally experienced teasing.” Siobhan E. Alexander et al., *Teasing in School Locker Rooms Regarding Penile Appearance*. 193 J. UROL. 983, 985 (2015).

¹⁶¹ Tobin, *supra* n.153, at 382-3.

¹⁶² Citing Marie Fox & Michael Thomson, *Short Changed? The Law and Ethics of Male Circumcision*, 13 INT’L J. CHILDREN’S RTS. 161, 161-81 (2005).

¹⁶³ However, see Carla M. Obermeyer, *The Health Consequences of Female Circumcision: Science, Advocacy, and Standards of Evidence*, 17(3) MED. ANTHROPOLOG. Q. 394, 394 (2003) (showing that “few studies are appropriately designed to measure health effects, that [female] circumcision is associated with significantly higher risks of a few well-defined complications, but ... for other possible complications the evidence does not show significant differences”); Carla M. Obermeyer, *The Consequences of Female Circumcision for Health and Sexuality: An Update on the Evidence*, 7(5) CULT. HEALTH SEX. 443, 443 (2005) (a systematic review of published sources between 1997 and 2005 showing that “female circumcision is associated with some health consequences but that no statistically significant associations are documented for a number of health conditions.” So, “statistically higher risks are documented for some but not all types of infections; the evidence regarding urinary symptoms is inconclusive; the evidence on obstetric and gynecological complications is mixed.” For example, “increased risks have been reported for some complications of labour and delivery but not others, and for some symptoms such as abdominal pain and discharge, but not others such as infertility or increased mortality of mother or infant.” Finally, “[c]oncerning sexuality, most of the existing studies suffer from conceptual and methodological shortcomings, and the available evidence does not support the hypotheses that circumcision destroys sexual function or precludes enjoyment of sexual relations”). See also *Seven Things to Know About Female Genital Surgeries in Africa*, *supra* n.33, at 19 (arguing that “in their passion to end the practice, antimutilation advocacy organizations often make claims about female genital surgeries in Africa that are inaccurate or overgeneralized or that don’t apply to most cases”).

¹⁶⁴ Tobin, *supra* n.153, at 383.

construction of harm appears to be influenced not only by “objective” factors, such as the degree of pain or the likelihood of surgical complications, but also by the sex or gender of the affected individual.

How the law, in Germany and elsewhere, will begin to address these inconsistencies is unclear. Given the special significance of the genitals as compared to other body parts, however, the widely varying cultural and individual attitudes concerning the state of them—cut or uncut—and the growing number of adults of all sexes and genders who are “coming out” as feeling harmed by their childhood genital surgeries, the inconsistencies will need to be addressed somehow. Whichever way the debate proceeds, the relative statuses and acceptability of male, female, and indeed intersex genital cutting¹⁶⁵ are likely to remain prominent in the legal and bioethical literatures for many years to come.

¹⁶⁵ We have not been able to address intersex genital cutting in this article for lack of space. For key insights, see generally Nancy Ehrenreich & Mark Barr, *Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of Cultural Practice*, 40 HARV. CR-CLL REV. 71 (2005); J. Steven Svoboda, *Promoting Genital Autonomy*, *supra* n.38; Elizabeth Reis, *Intersex Surgeries, Circumcision, and the Making of “Normal,”* in GENITAL CUTTING: PROTECTING CHILDREN FROM MEDICAL, CULTURAL, AND RELIGIOUS INFRINGEMENTS 137-47 (2013); Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law’s Failure to Protect Intersex Infants*, 21(59) BERKELEY J. GENDER L. & JUST. 59 (2006); Kishka-Kamari Ford, *“First, Do No Harm”: The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants*, 19(2) YALE L. & POL’Y. REV. 469 (2001).