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Short Changed? The Law and Ethics of Male Circumcision

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Introduction

Routine neonatal male circumcision has generally failed to excite medico-legal attention. Notwithstanding recent debates in the ethical literature, notably in special issues or symposia in the *Journal of Medical Ethics* (2004, 30) and *American Journal of Bioethics* (2003, 3), the law has yet to engage seriously with this issue. In a forthcoming contribution to an emerging medico-legal debate we have suggested that neglect of this issue is partly attributable to the way in which routine infant male circumcision (and its attendant effects and risks) is typically characterised in opposition to female circumcision for rhetorical and political reasons (Fox and Thomson, 2005). The result is that, while female circumcision is constructed as morally and legally unacceptable within a civilised society, male circumcision is characterised as a standard and benign medical practice. In this article our focus turns to the related failure to engage in a full cost/benefit analysis of the practice and the harm it causes to boy children.

This article starts by outlining, briefly, how routine male circumcision has come to be debated in contemporary ethical, professional and (the limited) legal literature. Particular attention is devoted to the privileging of parental choice, notwithstanding documented medical risks and the absence of conclusive evidence of medical benefit. We suggest that the medico-legal failure to take seriously the risks involved is understandable if we recognise that the concept of harm is inherently fluid and that pain (particularly where it is experienced by infants) is often incapable of articulation. This insight means that it is crucial to address the ways in which specific harms are contextualised. We explore this process of constructing harm through a consideration of the law's response to circumcision in the leading case of *Brown* and in the Law Commission's recommendations on circumcision in its report *Consent in the Criminal Law*. By problematising the legal reasoning in these English legal texts we seek to contest legal orthodoxy which construes the decision to circumcise a male infant as a legitimate parental decision.

We also suggest that this prevailing legal consensus is largely a product of the way in which the practice has historically emerged. Thus we trace a brief

history of neonatal male circumcision, focusing on the early justifications for the procedure and interrogating the types of harm that were constructed or imagined in these justifications. In these medical histories, the emphasis is placed on harms risked by *not* circumcising rather than the risks inherent in the procedure. Importantly, such justifications are based on matters of hygiene coupled with the control of disease, madness and masturbation. Although clearly spurious, as we shall highlight, echoes of these justifications recur in current debates and continue to carry potent symbolic resonance. Our contention is that in order to effect a shift in attitudes to the practice, the early justifications need to be articulated and challenged, and this has to be coupled with an emphasis on the real risks of the procedure.

Before continuing, it is important to qualify what bodies we are talking of. In this paper our primary concern is with Anglo-American bodies. More specifically, we focus on the neonatal body subjected to this procedure for social (rather than legitimate medical) reasons.[1] Other European/industrialised nations do not share the same history of routine neonatal circumcision[2] (although Canada and Australia too have historically had high rates of neonatal circumcision (Waldeck, 2002; Queensland Law Reform Commission, 1993)). As well as geographical specificity, there is also a chronology to note, since the shared history of routine circumcision in these countries has not endured. Thus, based on Army records, it has been estimated that before World War II 50% of working class and 85% of upper class men in England were circumcised (Gollaher, 1994: 25; see also Gairdner, 1949). Whilst US rates remain high, in the UK the numbers, though significant, are now comparatively small. Estimates suggest that approximately 30,000 procedures are performed annually in the UK, most on young children (Williams and Kaplila, 1993a); and 1993 figures indicate that 5–6 per cent of British men were circumcised (Williams and Kaplila, 1993b).[3] With the introduction of the NHS, procedures that could not be demonstrated to be clearly medically efficacious were no longer to be provided by the state.[4] Whilst this process has had mixed success, circumcision was one procedure to be dropped early in the life of the NHS. The results under a private insurance system have been quite different, although available statistics do appear to suggest a decline in the recent incidence of circumcision in the US. The American Academy of Pediatrics estimated that, in 1999, 85 percent of male newborns were circumcised; (American Academy of Pediatrics, 1999) while statistics for the following year record a rate of around 65 percent (National Center for Health Statistics, 2001). Some commentators have argued that a downward trend in the statistics points to routine circumcision being experienced by only a minority of newborns within a generation (Miller, 2002). The picture is, however, more complicated that this suggests, since the statistics fail to display a linear decline, are affected by under reporting, and do not reflect regional and racial differences (Waldeck, 2002).

Contemporary Medico-Legal Debates

> Ritual circumcision of male infants as religious and cultural practice is lawful in this country. . . . We allow parents to agree to a relatively minor, albeit irreversible procedure, in the interests of observing religious freedoms in the upbringing of their male child but that freedom stops short at the seriously invasive procedure on young girls (Bridge, 2002: 279).

Caroline Bridge's statement characterises most contemporary legal responses to the issue of male circumcision. Bridge constructs a simplified oppositional relationship between male and female circumcision whereby male circumcision is self-evidently different from the practice of female circumcision. As we have argued elsewhere, this form of response contributes to the negation of male circumcision as an issue within medico-legal literature (Fox and Thomson, 2005). Here we want to consider a related aspect of the contemporary debate. A notable feature of work on female circumcision is the attention paid to the harms and risks inherent in the procedure(s). In sharp contrast, and related to the rhetorical strategy we have noted above, the harms inherent in male circumcision are generally downplayed, as in Bridge's essay, with risks being minimised as part of a strategy that privileges parental choice and freedoms.

A special issue of the *American Journal of Bioethics* in 2003 further illustrates this discursive pattern. The issue's lead article 'Between Prophylaxis and Child Abuse' purports to offer a third way within the polarised circumcision debate (Benatar and Benatar, 2003). Stating that 'the ethics of a surgical procedure cannot be assessed independently of whatever harms and benefits it does or does not have' (Benatar and Benatar, 2003: 36), the authors, Michael and David Benatar, provide a detailed analysis of the numerous studies that have aimed to validate or challenge the various prophylactic justifications that have emerged over time. Significantly, the authors conclude that none of the scientific evidence 'is anywhere near conclusive' (Benatar and Benatar, 2003: 42). Yet, notwithstanding their stated commitment to a full cost/benefit analysis, the authors dedicate just two paragraphs to pain, and only a single paragraph to consideration of possible complications (Benatar and Benatar, 2003: 38). In relation to costs, they conclude that 'the most significant cost of neonatal circumcision is the pain that accompanies it. . . . Where [anesthesia] is used, this major cost can be eliminated or at least significantly reduced' (Benatar and Benatar, 2003: 42). Other risks involved are even more cursorily dealt with. Conversely, the authors argue that scientific opinion suggests medical benefits stem from circumcision. For instance, they propose that circumcision may offer some protection against urinary tract infection (Benatar and Benatar, 2003: 39). Yet these proposed benefits are not quantified in a way whereby they can be measured against quantifiable risks (such as the risks of haemorrhage,

sepsis, ulceration or laceration of the penis or scrotum, psychological complications (Benatar and Benatar, 2003: 92–6),[5] or a morbidity rate of one in 500,000 (Benatar and Benatar, 2003: 42)). Ultimately, then, the Benatars themselves fail to provide an adequate cost/benefit analysis and their 'third way' amounts simply to an argument for parental choice based on minimising the inherent risks of infant circumcision. Downplaying the risks permits the authors to embrace the cultural and social benefits that might flow from its exercise. Thus, they state, 'if we are correct that no clear and significant *medical* benefits derive from circumcision, there still might be *other* kinds of benefits' (Benatar and Benatar, 2003: 44). They conclude:

> [W]e think that neonatal circumcision cannot unequivocally be said to yield a net medical gain or loss. In other words, it is not something that can be said to be routinely indicated, nor something that is routinely contra-indicated. It is a discretionary matter. The decision whether or not to circumcise a child should thus be made by the parents, who, within certain limits, are entitled to employ their own value judgments in the furtherance of their child's best interests. These limits are not exceeded in most decisions about neonatal circumcision, given the nature of the medical evidence (Benatar and Benatar, 2003: 42).

As we have noted, a similar discursive strategy characterises the wider circumcision debate, as is evidenced by the recently revised BMA guidance to doctors (BMA, 2003). It too foregrounds the need for a cost/benefit analysis and, significantly, within this it highlights the contested nature of the claimed benefits. At various points evidence for the supposed beneficial effects of circumcision is described as 'equivocal' (BMA, 2003: 2, 4) 'inconclusive' (BMA, 2003: 4), 'not convincingly proven' (BMA, 2003: 5), 'contradictory' causing 'significant disagreement', lacking consensus and, ultimately, 'insufficient', leading to the conclusion that 'evidence concerning the health benefit from non-therapeutic circumcision is insufficient for this alone to be justification' (BMA, 2003: 7). Yet, while this is coupled with a recognition that there are inherent 'medical and psychological' risks in the procedure (BMA, 2003: 5), the dominant message remains that parental beliefs should be respected, despite not being grounded in claims to health benefits:

> The medical harms or benefits have not been unequivocally proven but there are clear risks of harm if the procedure is done inexpertly. The Association has no policy on these issues. Indeed it would be difficult to formulate a policy in the absence of unambiguously clear and consistent medical data on the implications of the intervention. As a general rule, however, the BMA believes that the parents should be entitled to make choices about how best to promote their children's interests, and it is for society to decide what limits should be imposed on parental choices (BMA, 2003: 3).[6]

As such, while the BMA's recognition of both the equivocal nature of the claimed benefits and the clear risks of harm (although this is subsequently min-

imised) may be interpreted as a progressive position, it nonetheless continues to construct male circumcision as an expression of parental privilege. This downplays both the pain experienced by the neonate (see Benatar and Benatar, 2003: 37–8 and accompanying references; Warnock and Sandrin, 2004) and the fact that while complication rates from routine circumcision are low, the chances of these complications being mutilatory, infective or haemorrhagic are high (Willliams and Kaplia, 1993b; Gerharz and Haarmann, 2000). Indeed, complications are potentially catastrophic, since death, gangrene, and total or partial amputation are known adverse outcomes (Hodges *et al.*, 2002).

This pattern of reasoning is also evident in *Re J (Re J (A Minor) (Prohibited Steps Order: Ciricumcision)*, and *Re J (Specific Issue Orders: Muslim Upbringing & Circumcision)* [2000] 1 FLR 571; (2000) 52 BMLR 82, the only case where UK courts have directly considered circumcision). A similar conclusion has been reached in the Court of Appeal in *Re S (children) (Specific Issue: Religion: Circumcision)* [2005] 1 FLR 236. The case concerned a five year old boy – 'J' – who following his parents' separation lived with his mother, a non-practising English Christian. His father was a non-practising Turkish Muslim, who wanted J to be circumcised so as to identify him with his father and confirm him as a Muslim. Having considered the factors relevant to J's upbringing, the Court of Appeal concluded that J should not be circumcised because he was not, and nor was he likely to be, brought up in the Muslim religion. Instead he had "a mixed heritage and an essentially secular lifestyle" and was unlikely to have such a degree of involvement with Muslims as to justify circumcising him for social reasons. In these circumstances, Wall J held that the boy was unlikely to derive any social or cultural benefit from circumcision:

> [T]he mother, as J's primary carer, would find it extremely difficult to present the question of circumcision to J in a positive light, and unlike ritual circumcision occurring in the context of a Muslim family . . . J's circumcision would be likely to be surrounded by tension and stress. . . . The strained relationship between the parents, and the fact that as a circumcised child J would be unlike most of his peers, increases the risk that J will suffer from adverse psychological effects from being circumcised.

Having reached this conclusion, the court was able to avoid squarely confronting the legality of non-therapeutic circumcision, and could simply state that, for such a procedure, the consent of both parents would be desirable. On appeal Thorpe LJ reaffirmed that the judge had correctly balanced the father's right to manifest his religion against the welfare of the child and the rights of the mother. However, the more fundamental issue of *why*, in the event of agreement, this should be a familial decision is not addressed by either court. For our purposes the interest of the case lies in how it reveals law's reluctance to calculate the (admittedly complicated) risks of circumcision, and its

readiness to set the social, religious or cultural benefits believed to flow from the practice against medical harms. Implicit in the judgements in this case is the assumption that the socio-religious benefits accruing in cases where a child is brought up in a Muslim or Jewish environment would be sufficient to outweigh the medical risks – a conclusion endorsed by a number of leading medico-legal commentators. For instance Margot Brazier notes that:

> The child suffers momentary pain. Although medical opinion may not necessarily regard it as positively beneficial, it is in no way medically harmful if properly performed. The community as a whole regards it as a decision for the infant's parents (Brazier, 1992: 350).[7]

In the Court of Appeal, Thorpe LJ seems more cautious but does cite with approval Wall J's view that:

> [C]ircumcision is an effectively irreversible surgical intervention which has no medical basis in J's case. It is likely to be painful and carries with it small but definable physical and psychological risks. For it to be ordered there would accordingly have to be clear benefits to J which would demonstrate that circumcision was in his interests notwithstanding the risks (at 574).

Yet, although he summarily dismisses the contrary view of the father's counsel that any considerations against circumcision were either transient or speculative, it is noteworthy that there is no explication of the precise nature of these physical and psychological risks. This is curious in an age when judges in health care cases appear to require ever more detailed quantifications of risks prior to authorising medical interventions.[8] Although a potential disadvantage is that reducing cost benefit analyses to statistical calculations may be very contested and may render judges especially susceptible to medical evidence if it is framed in quantifiable terms, we would argue that it is important that some attempt is made to quantify the nature of risks, especially when the purpose is non therapeutic, as in the contexts of research and vaccination, as well as circumcision.

As well as minimising risks, commentators are equally prone to exaggerate putative benefits of infant circumcision. As noted above, Caroline Bridge reads *Re J* as authority for the proposition that doctors must embrace cultural pluralism by recognising and acting upon religious wishes, even if this involves a medically unnecessary procedure which interferes with the bodily integrity of the child, provided both parents agree and to the extent that the child benefits (Bridge, 2002: 282). However, in weighing these benefits, she not only characterises the practice as not causing significant harm, but also includes highly contested protective benefits against sexually transmitted diseases which are said to flow from male circumcision. Bridge's conclusion in facilitated by the rhetorical strategies we have outlined:

> Male circumcision is relatively harmless albeit, like tattooing, irreversible. The risks are minimal, the cultural and religious significance very great to large number of people, and it is now reported as having long term protective effects. This enhances its rational basis. Just as significantly, it is not a practice belonging to the fringes of society but is almost part of the mainstream. Female circumcision is the reverse (Bridge, 2002: 284).

Though conceding that this is "an arguably medically unnecessary and irreversible invasive procedure on male infants" and that it is "arguably, unnecessary mutilation for religious or cultural reasons", Bridge concludes that "[a]rguably the long term protective benefits of circumcision, coupled with its religious significance, contribute to the child's overall welfare and is in his best interests" (Bridge, 2002: 281). The repeated qualifier 'arguably' signals how much scope there is for debate over the alleged benefits and risks of the practice, while construing male circumcision as "almost part of the mainstream" signals a reluctance to challenge cultural norms.

The process of down-playing medical risks

Addressing the question of why such risks continue to be routinely denied or downplayed, thus casting this as a non-issue for law, pulls in several directions. Responses – or rather the failure to respond – to risk may be partly attributable to a widespread unwillingness to recognise certain forms of harm, especially those which are child specific. Below we address the ambivalent and contested nature of harm and pain. However, notwithstanding the historical and continuing cultural devaluation of the risks posed by male circumcision, it is impossible for commentators to ignore them completely and they are now beginning to be acknowledged in ethics and law.

Turning first to professional ethical guidance issued to physicians. The American Paediatric Association guidance concedes that the infant experiences pain, with the resulting wound taking approximately ten days to heal. However, provided it is performed properly it concludes that there are generally no acknowledged ramifications (American Pediatric Association, 1995). As we have noted, the British Medical Association's advice on circumcision focuses on potential benefits rather than risks, although it acknowledges that, whereas "the practice of circumcision has previously been considered to be morally neutral", it is now increasingly open to challenge. The BMA advises that:

> Individual doctors approached by parents requesting circumcision for their sons must counsel the parents about the implications of the procedures, including the health risks involved. Any surgical procedure, including one of a minor nature, carries with it risks, and parents must be made aware of these in order to give valid

> consent to the operation. In addition, doctors usually consider appropriate anaesthesia a requirement and this also carries an element of risk.[9]

Yet, notwithstanding this tacit acknowledgement of its inherent risks, the practice is clearly to be tolerated. There seems little will on the part of the medical profession, whether institutionally or at the level of the individual practitioner, to challenge the acceptability of the procedure. In this respect attitudes to male circumcision may usefully be contrasted with other areas of health care law, where the ethics and legality of exposing infants to risk has generated considerable controversy and debate. We would suggest that a more productive comparison than female circumcision is to draw analogies with enrolment of infants in clinical research or vaccination programmes. In these contexts children are clearly vulnerable to being used for the benefit of others, raising similar concerns about the limits, if any, to parental powers to consent to controversial and invasive procedures on very young children. Yet, despite the possibility of real benefit to the individual child or other children, an extensive literature debates the ethics of engaging children in such practices (see, for instance, Nicolson, 1985; Bridgeman, 2002). The lack of tangible individual or societal benefit accompanying circumcision makes it surprising that the routine nature of this practice has escaped similar legal controversy. Law's failure to scrutinise adequately the risky nature of this practice is particularly indefensible, since tort actions have forced law to confront and quantify the damage that has resulted from negligently performed circumcisions.[10]

One glaring example of UK law's failure is an influential Law Commission consultation paper, whose reasoning forms the basis for the BMA's guidance. In *Consent in the Criminal Law* the Law Commission addressed the limits that law should impose on the degree of injury to which a victim might lawfully consent. Its conclusion – that English law should permit the causing of intentional consensual injury provided that it fell short of being "seriously disabling" (Law Commission, 1995: para 4.51) – would represent a significant liberalisation of English law in relation to a range of consensual practices, such as sado-masochism, branding, piercing and tattooing. In adopting this position, the Commission was highly critical of the landmark House of Lords' decision in *R v. Brown* (*R v. Brown* [1993] 2 All ER 75), which criminalised the infliction of injury during consensual sado-masochistic practices.[11] However, the notable feature of the practices considered by the Law Commission in Part IX of this report is that, aside from male circumcision, all of them are consensual actions engaged in by adults. To place infant male circumcision in this context seems bizarre, and explicable only by the Commission's implicit endorsement of an *obiter* comment by Lord Templeman in *Brown*, categorising male circumcision as a deliberately inflicted, but apparently lawful injury:

> Surgery involves intentional violence resulting in actual or sometimes serious bodily harm but surgery is a lawful activity. Other activities carried on with consent by or on behalf of the injured person have been accepted as lawful notwithstanding that they involve actual bodily harm or may cause serious bodily harm. Ritual circumcision, tattooing, ear piercing and violent sports including boxing are lawful activities.[12]

In the single paragraph which it subsequently devotes to circumcision the Commission simply states, without reference to any legal authority, that "[m]ale circumcision is lawful under English common law." There is no discussion of what the practice involves, and, crucially, harms occasioned are downplayed or wholly ignored in the following statement:

> It is generally accepted that the removal of the foreskin of the penis has little if any effect on a man's ability to enjoy sexual intercourse, and this act is not, therefore, regarded as a mutilation (Law Commission, 1995: para 9.2).

There is no acknowledgement that this position is heavily disputed in the medical literature, given that "[t]he prepuce plays an important role in the mechanical functioning of the penis during sexual acts, such as penetrative intercourse and masturbation" (Warren, 1997: 89). Moreover, the Law Commission omits any consideration of the greater risks inherent in circumcision. The elision of these risks leads it to propose that: '[I]t would be useful to put the lawfulness of ritual male circumcision beyond any doubt' (Law Commission, 1995: 9.3).

In relation to body piercing of young children the Law Commission is equally tolerant of parental preferences (Law Commission, 1995: 11.22) and Jo Bridgeman suggests this may be rooted in our cultural unwillingness to recognise young children as possessors of bodily integrity (Bridgeman 2002: 111). Moreover, not only does the Commission fail to support its position on these interferences with bodily integrity, but David Ormerod and Michael Gunn have highlighted the inconsistencies underpinning its reasoning. Elsewhere it takes the view that female circumcision should remain completely banned, yet suggests that adults should be allowed to consent to even seriously disabling injury occasioned by gender reassignment or cosmetic surgery (Ormerod and Gunn, 1996).[13] We would argue that in its failure to engage fully with a risk/benefit assessment of these various practices, the consultation document, like the *Brown* decision itself, is characteristic of legal reasoning. *Brown* has attracted a wealth of critical comment, one strand of which centres on the way in which it grossly exaggerated the risks of the sexual practices involved.[14] In the case of circumcision a reversal of this process may be traced in law's willingness to downgrade risks of harm. This allows the Law Commission to ignore the fundamental challenges posed by male circumcision, including whether it can be categorised as a seriously disabling injury,

whether the practice should be banned or limited to specific religious groups and whether it can be regarded as in the best interests of the child (Ormerod and Gunn, 1996: 703).

It is significant that a range of different ethico-legal texts, from court decisions, to professional guidance, to law reform proposals, reveal a similar understanding of and response to circumcision. Together these texts form an influential discourse according to which infant male circumcision is perceived as low risk and hence a matter of parental choice, notwithstanding the lack of scientific justification for the practice. Only limited consideration is given to the seemingly obvious fact that circumcision is the excision of healthy tissue from a child unable to give his consent for no demonstrable medical benefit. In the rest of this article we wish to explore why this might be the case. It is necessary in doing so to address the reasons why and conditions in which this discourse and legal norms have emerged. The next section offers a brief genealogy of the emergence and routinization of the practice of circumcision in order to reframe male circumcision by rebutting contemporary medico-legal complacency as to its justifications. This also serves to highlight the way in which the historical justifications foreground the idea of marking and managing the sexed infant body and male sexuality.

Historical medical narratives

In February 1870 the highly respected and influential orthopaedic surgeon Dr John Lewis A. Sayre visited a young patient suffering paralysis. Initially he was unable to ascertain the cause, but soon discovered that the five year old boy's penis, whilst otherwise normal, had 'very small and pointed' glans 'tightly imprisoned in the contracted foreskin. In an effort to escape, the meatus urinarius had become puffed out and red as in a case of severe granular urethritis.' As he concluded:

> An excessive venery is a fruitful source of physical prostration and nervous exhaustion, sometimes producing paralysis, I was pleased to look upon this case in the same light, and recommended circumcision as a means of relieving the irritated and imprisoned penis (Sayer, 1870: 206).

The circumcision led to almost immediate improvements in the boy's health and before long he was walking with normal limbs. Sayer went on to perform a number of such operations. Subsequently he informed his colleagues that circumcision was the answer to a range of ailments: 'Many of the cases of irritable children, with restless sleep, and bad digestion, which are often attributed to worms, is [sic] solely due to the irritation of the nervous system caused by an adherent or constricted prepuce' (Sayer, 1870: 210). This marked the begin-

ning of the rise and rise of Phimosis, an ill-defined and fluid pathology (Hodges, 1999) and the recoding of the foreskin as pathological. Beyond the ailments of children, circumcision came to be seen as a cure for more problematic and elusive illnesses, as Miller notes:

> Within fairly short order, circumcision was promoted as a remedy for alcoholism, epilepsy, asthma, gout, rheumatism, curvature of the spine and headache . . . paralysis, malnutrition, night terrors, and clubfoot; eczema, convulsions and mental retardation; promiscuity, syphilis, and cancer (Miller, 2002: 527).

Medical circumcision developed during a well-documented period of experimentation in genital surgery. This experimentation was motivated in part by the theory of reflex neurosis, a belief that 'there was an intricate web of nervous affinity running through the spine of every organ of the body and that, in turn, each organ had its own sphere of influence on physical and mental health' (Gollaher, 1994). On this understanding, circumcision emerged as a cure for a range of mental as well as physical illnesses. It was promoted as a cure for the related Victorian scourges of masturbation and insanity, and the more amorphous neurasthenia, a condition entailing:

> morbid fears, fear of society, of solitude, or travelling, of places, of disease, or morbid impulses, to kill oneself or others, mental depression, wakefulness, headache, impaired memory, [and] deficient mental control (Beard, 1882).

Importantly, at the same time that circumcision emerged in a therapeutic context for a growing number of problems, clitoridectomies and other medical treatment of the clitoris were enthusiastically revived for the alleviation of psychological symptoms (Gollaher, 1994).

As with this form of female circumcision, a belief emerged that male circumcision cured masturbation, a 'well known' cause of degeneracy and insanity. The role played by the emerging fear of the masturbating child in the history of the normalisation of circumcision needs to be acknowledged. Circumcision allowed the Victorians to manage cultural anxieties regarding masturbation,[15] which had prompted an extensive campaign against masturbation and spermatorrhoea ('wet dreams') (Miller, 2002: 534). It was forcefully argued that circumcision diminished the incidence of masturbation by removing or preventing adhesions which would otherwise lead to the penis being handled and – almost invariably – to self-abuse (Miller, 2003: 527). Arguably, curing masturbation was understood as the most important health benefit of circumcision (Miller, 2002: 527).[16] Peter Charles Remondino's polemical and misleadingly titled *History of Circumcision* provides an indication of the role played by the spectre of the masturbating child, and illustrates the ultimate status that the 'tight-constricted, glans-deforming, onanism-producing, cancer-generating' foreskin attained:

> The prepuce seems to exercise a malign influence in the most distant and apparently unconnected manner; where, like some of the evil genii or sprites in the Arabian tales, it can reach from afar the object of its malignity, striking him down unawares in the most unaccountable manner; making him a victim to all manner of ills, sufferings, and tribulations; unfitting him for marriage or the cares of business; making him miserable and an object of continual scolding and punishment in childhood, through its worriments and nocturnal enuresis; later on, beginning to affect him with all kinds of physical distortions and ailments, nocturnal pollutions, and other conditions calculated to weaken him physically, mentally and morally; to land him perchance, in jail or even in a lunatic asylum (Remondino, 1891: 187, 255–6).

Associated with the 'war' on masturbation was the more general desire to curb or tame masculine sexuality. Thus, in the *British Medical Journal* in 1935, R.W. Cockshut argued that a (further) benefit of removing the foreskin was the diminishment of the libido:

> I suggest that all male children should be circumcised . . . Civilization . . . requires chastity, and the glans of the circumcised rapidly assumes a leathery texture less sensitive than skin. Thus the adolescent has his attention drawn to his penis much less often . . . (Cockshut).[17]

The efficacy of circumcision was so widely accepted that it was enthusiastically advocated as a prophylactic, and by 1910 had become the most common operation in the United States (Miller, 2002: 532).[18] The case for prophylactic circumcision was forcefully made by J.M. McGee, though he remained unconvinced by Sayer's dramatic claims:

> I would favor circumcision . . . independent of existing disease, as a sanitary precaution [because] . . . (1.) The exposure of the glans to friction etc., hardens it, and renders it less liable to abrasion in sexual intercourse, and consequently venereal ulcer. (2.) It is acknowledged to be useful as a preventative of masturbation. (3.) It certainly renders the accident of phymosis and paraphymosis impossible. (4.) It prevents the retention of sebaceous secretion and consequent balanitis. (5.) It probably promotes continence by diminishing the pruriency of the sexual appetite (McGee, 1882, cited in Gollaher, 1994).

Finally, within this history it is important to note the class and race dynamic that emerged. The fact that routine male circumcision long out lasted the sanitary movement may be explained in part through the recognition of how circumcision status became a signifier of social standing or distinction. Within this period childbirth for the middle- and upper-classes moved from the domestic setting to a medical moment subject to the management of physicians. As midwives rarely performed the procedure, to be circumcised was literally a marker of the child's birth rite/right. Similarly, it also existed as a barometer of the medicalisation of childbirth and the social status of the profession (Gollaher, 1994). In 1949, on the eve of the decline in circumcision rates in the UK, one study of university entrants noted that 84 percent of students coming

from the 'best-known public schools' were circumcised, in comparison to only 50 percent from other schools (Gairdner, 1949: 1433–37. This worked through from the association between health and morals and also through the association with the physician 'class'. Gollaher notes that: 'the trend was inspired by a kind of medical class who persuaded their private patients of . . . the utility of emulation' (Gollaher, 1994). This emulation of class was of growing importance within the changing demographics of turn of the century America. With the influx of immigrants from Southern and Eastern Europe a racist discourse of pollution and contagion emerged. Circumcision status as a social marker flourished within this. As Gollaher concludes:

> So it happened that the foreskin, despised by the medical profession, came to broadly signify ignorance, neglect, and poverty. As white middle-class gentiles adopted circumcision, those left behind were mainly recent immigrants, African Americans, the poor, and others at the margins of respectable society (Gollaher, 1994: 22–23).

The distribution across class continues to the present day (Miller, 2002: 532), and may be a material factor in the persistence of the procedure. As Sarah Waldeck has argued, 'norms that are rooted in concerns about esteem and reputation often work to lock in inefficiencies' (Waldeck, 2002).

Constructing harm to boy's bodies

In the more recent medical narratives surrounding circumcision that we examined above the discourse of risks and harms looms large. Significantly, however, the preoccupation in this literature is again with harms that are portrayed as flowing from a failure to circumcise, rather than those potentially or directly inflicted by the practice of circumcision itself. We would argue that this is a typical feature of law, which as we have noted, tends differentially to construct harms, attaching weight to some, while downplaying others. In a society characterised by a proliferation of risks, the notion of 'harm' remains conceptually fluid. As Beck, Wells and others have argued, societal perceptions of risk are culturally specific and dependent on contemporary notions of what harms are acceptable (see, for instance, Beck, 1992; Wells, 1998). Medicine and law function as key social institutions to not only manage risks, but to produce knowledge about them. Ideally, this should translate into some forum for disseminating and debating the legal and moral issues raised, but in the context of male circumcision, we would argue that current ethical guidance and law fails to do this.

We would suggest that a number of factors facilitate the downplaying of risks and harm this context. It is worth noting that the notion of harm is inherently subjective and open to manipulation. The texts we have analysed above

demonstrate Carol Smart's contention that 'harm' is not "a transcendental notion which is automatically knowable and recognisable at any moment in history by any member of a culture" (Smart, 1999: 392).[19] Moreover, the notion of harm to children is particularly open to manipulation given the inability of a young child to articulate his pain and the contradictions which are evident in law's understanding of children. As Katherine O'Donovan has argued, law routinely denies the subjectivity of children, and has structured the parent/child relationship in terms of parental responsibility (O'Donovan, 1993). Of course, this general construction of the child as a legal object rather than subject is reflective of a broader confusion in our society about the status of children. Throughout the twentieth century Valerie Zelizer has traced a profound cultural transformation in our attitudes to children, which she terms the 'sacrilization' of children's lives. This process involves a shift from viewing children as an object of utility to valuing them as an object of sentiment (Zelizer, 1985: Chapter 1). These competing constructions of the child – as expendable property and as a sentimental object of concern – can both be tracked in the history of circumcision we have outlined. Although the latter construction is now dominant, in the Victorian era children were much more readily deemed expendable – as exemplified by high rates of infant mortality, and even new born child murder (Jackson, 1998). Thus, it is scarcely surprising that "[c]hildhood has lurched from privacy, non regulation and minimal legal protection into regulation by a phalanx of specialist agencies" (Evans, 1993: 392). Yet, as exemplified by the circumcision debates, such regulation remains partial, as certain decisions pertaining to children remain unchallenged in the private zones of family and religion. Thus, although they may indeed be cast as objects of concern, frequently this does not translate into benefits or protection for the child.

In our discussion of how the Law Commission discounted risks to children at pp. 164–5 above, we noted Bridgeman's argument that we remain culturally unwilling to recognise the bodily integrity of young children. She argues persuasively that "within law, children's bodies are constructed as potential and what is permitted by the law is determined by consideration of the future which the child embodies and without consideration of the present reality of the child" (Bridgeman, 202: 103). We would suggest that, in the circumcision context, this construction of the child results in undue priority being accorded to parental assessments of his best future interests and a concomitant downplaying of harms inflicted in the present. The harm which we would particularly flag up in this context is the pain inflicted on the child. As Elaine Scarry has argued in her influential consideration of the topic, it is inherently difficult to make sense of pain. Unlike any other state of consciousness it lacks a referential context – "it is not *of* or *for* anything. It is precisely because it takes no object that it, more than any other phenomenon, resists objectification in lan-

guage" (Scarry, 1985: 5). Scarry suggests that pain's resistance to, or active destruction of language, results in it being radically unshareable:

> [F]or the person in pain, so uncontestably and unnegotiably present is it that 'having pain' may come to be thought of as the most vibrant example of what it is to 'have certainty', while for the other person it is so elusive that 'hearing about pain' may exist as the primary model of what it is 'to have doubt'. Thus pain comes unshareably into our midst as at once that which cannot be denied and that which cannot be confirmed (Scarry, 2002: 4).

Clearly such difficulties in communicating and sharing the experience of pain are compounded in the case of young children since they have no language at all in which to attempt to communicate their experience. In this regard we would argue that the medical profession have been culpable in their failure to articulate the pain inherent in circumcision.

Indeed, as Miller points out, doctors took advantage of the fact that performing the procedure on neonates who were incapable of resisting made it considerably easier to practise (Miller, 2002: 530). Furthermore, then prevailing beliefs that neonates did not experience pain allowed physicians to argue that surgical interventions at this early stage carried reduced risks, since they could be accomplished without anaesthetic and with less invasive cutting than would be necessary with an older child. Additionally, even physicians who acknowledged that the procedure inflicted pain could justify this by pointing to a salutary association thereby created between pain and masturbation, thus reinforcing the campaign against masturbation.[20] Miller notes that a further practical advantage of early circumcision was that bad results, even death, were easily explicable in an era where neonatal death was unremarkable (Miller, 2002: 530–1). It is more surprising that modern understandings of children as objects of intense concern (Evans, 1993: 209), coupled with significantly reduced rates of infant mortality, and growing evidence of the capacity even of late foetuses to feel pain (Fitzgerald, 1995), have not conspired to make doctors more conscious of the need to underline the infant capacity for pain and to contest practices which inflict it unnecessarily. As Scarry notes, "the success of the physician's work will often depend on the acuity with which she can hear the fragmentary language of pain, coax it into clarity and interpret it" (Scarry, 1985: 7). In this regard we argue that the medical profession have failed children.

We would also suggest that gender is crucially implicated in this failure. In health care, as in other legal disciplines, male bodies have functioned as the norm and therefore tended to be less politically contentious than other bodies. Thus, feminist critiques of health care law have done much to foreground harms that are specific to women's bodies, while foetal rights advocates have argued strenuously for foetal protection policies that avert harm to the foetus. Debates concerning these 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.[21] We would argue that this construction is problematic in a number of ways. Within the immediate context it fits somewhat uneasily with law's rather vexed construction of children's bodies, rendering the construction of the boy's body in law inherently contradictory. We would suggest that 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. Our suggestion is that within law the role of abuse victim is feminised, so that the discursive construction of victims may produce a greater acknowledgment of harms perpetrated against girls. As Carol Smart has noted, boys were seemingly "not constituted as part of the historical story of child sexual abuse" (Smart, 1999: 395).

On this view gender is an important component of the subjective construction of harm. This contention is also borne out by the historical medical narratives outlined above, which continue to be implicated in contemporary reluctance to acknowledge male circumcision as harm. Moreover, we would tentatively flag up here an argument that, for boys, the pain inflicted by circumcision may even be seen as beneficial in fostering a necessary training in masculinity. In aesthetic terms it serves to medically enhance his body, thereby conferring important social benefits through signalling his membership of privileged religious, racial or social groupings. We would argue that understanding circumcision as an initiation into masculinity underpins the deep-rooted cultural preference for male circumcision in Anglo-American world and is useful both in accounting for the persistence of the practice and in suggesting ways to eradicate it.

Conclusions

> Although the sensation of pain is entirely subjective, how it is perceived, configured, communicated and, explained, relieved or amplified, and its effect upon a person's relationship to others and themselves, are shaped inter-subjectively by cultural beliefs and social practices, including, not least by prevailing medical categories and beliefs (Morgan, 2002: 88).

This paper has aimed to question the general legal and social acceptance of the practice of routine male circumcision. Contesting current legal approaches to issues of harm, risk and the rights of children, we have argued that the dominant permissive approach to male circumcision is indefensible. Historically law has tolerated male circumcision as a benign practice, but we hope to have

demonstrated that many of the underlying reasons for construing it as harmless need to be re-assessed. Doing so would, we argue, help to challenge the view that simply because a practice is perceived as mainstream in our society (Bridge, 2002: 282) it is to be legally tolerated in the absence of a compelling case that its medical benefits outweigh its clear harms. We concur with Sarah Waldeck's position that imposing legal reforms will not work unless the social norms which underpin them and parental motivations for circumcising their children are understood and subjected to challenge. Consequently we suggest that further consideration is needed of the specific form which legal regulation might take, on this and other issues where parents are entrusted with deciding in the best interests of their children. Any legal reform proposals must be coupled with a clear demonstration of their rationale, and we would argue that the medical profession has a key role to play in education. As was the case with child sexual abuse, we suggest that the contested nature of key conceptions in the circumcision debate – such as 'child', 'harm' and 'pain' – combined with the fact that such pain is inflicted within the sanctity of the family account for law's resistance to attempts to regulate the practice or fully evaluate its risks. In this context, as with the uncovering of child abuse, we would argue that there is a need for law to be alert to its power in defining risks and manipulating the concept of harm, and to interrogate why parents should be entrusted with decisions about their children's best interests. For so long as children continue to function as the repository of various contradictory meanings, concerns that they evoke will often speak more to the implications for adults of issues surrounding the child, than child protection.[22] Our contention is that in cases of demonstrable harm, such as the unnecessary and painful excision of healthy tissue, law and professional guidance should be motivated by child protection until that child can make his or her autonomous decisions.

Notes

[1] Circumcision is a legitimate medical treatment primarily for Phimosis. Phimosis refers to a constricted or adherent foreskin. Most male infants are, however, born with an adherent foreskin that only subsequently becomes fully functioning. The vast majority of male children will have fully retractable foreskins by the age of five. In addition, many persistent problems can be remedied manually without having to rely on circumcision. Medical understandings of Phimosis have been 'elastic' and overly inclusive (See Rickwood *et al.* 2000; Hodges, 1999: 37).

[2] Other developed Western European nations have a cumulative national circumcision rate of only c 1.6% for boys under 15 years of age (See Warren, 1997: at 86; Frisch *et al.*, 1995).

[3] In 1995 the rate was reported as 'less than 10%' (Rangecroft, 1995). Warren suggests that 'since 1950 the cumulative circumcision rate in boys has dropped from about 30% to about 6 or 7%' (Warren, 1997).

[4] It is interesting to note that the recent substantial cuts in state government budgets have lead to the termination of public funding for circumcision in a number of states. (Skipp, 2002).

[5] Bleeding is a particularly common complication because of the vascular structure of the prepuce, while infection is estimated to occur in 10 per cent of cases. (See also Williams and Kapila, 1993b.) Miller is more graphic:

> Memories of the pain may impair his intellectual or emotional development. And the procedure, although safe as surgeries go, is not risk free. Boys experience haemorrhage, infection and ulceration; the urethral opening narrows due to scarring; and the penis may be bent, deformed, split, perforated, amputated or burned off (Miller, 2002: 574).

[6] This echoes the similar position defended by Benatar and Benatar, 2003.

[7] Interestingly in the later edition of her text, having discussed *Re J*, and then female circumcision, Brazier poses the question "If ritual male circumcision is permissible, why not female circumcision if carried out by surgeons in aseptic conditions" (Brazier, 2003: 359).

[8] See, for instance, the discussions in *Re MB (An Adult: Medical Treatment)* [1997] 8 Med. LR 217 and *St George's HealthCare NHS Trust v S* [1998] 3 All ER 673 and *Pearce v. United Bristol Healthcare NHS Trust* (1998) 48 BMLR 118 on the risks involved in refusing caesarean sections for the pregnant woman and foetus.

[9] This acknowledgment of risks makes Lord Templeman's position on male circumcision in *Brown* still more puzzling given his stress on all the potential risks which did not materialise in that case.

[10] The American cases include: *Doe v Raezer* 664 A.2d 102 (Pa. Super. Ct. 1995); *Felice* v. *Valleylab, Inc*., 520 So. 2d 920 (La. Ct. App. 1987). (See further Miller, 2002; and more generally and from an Australian perspective, see Graycar, 2002.) In the UK, see *Iqbal* v. *Irfan* [1994] CLY 164; *B (A Child)* v. *Southern Hospital NHS Trust* [2003] 3.Q.R. 9.

[11] Perhaps significantly one of the charges laid in the *Brown* case was the following: Count 28 (Malicious wounding . . . The victim . . . had his penis hit and rubbed with sandpaper, then his scrotum was clamped and pinned to a board with three pins. His foreskin was nailed to a board. Matthew Weait notes the similarities between these injuries and forms of punishment which the courts used to sanction, noting the ritual degradation and humiliation present in both (Weait, 1996: pp. 166–7).

[12] At pp. 78–9. In this, *Brown* echoes the earlier unreported decision in *R* v. *Adesanya* (1974) which was the first case to consider the issue of circumcision. A Nigerian woman was convicted of assault occasioning actually bodily harm (s. 47 OPA 1861) having scarred her 14 and 9 year old sons by making incisions with a razor on cheeks in accordance with ritualistic customs practiced by the Yoruba tribe to which she belonged. King-Hamilton J. held that this practice carried a real potential for serious injury to the eyes if the child had moved his head. He suggested that this distinguished the practice from the ritual circumcision, which he accepted was lawful.

[13] On the illogical manner in which existing law treats female circumcision and cosmetic surgery, see Sheldon and Wilkinson, 1998.

[14] See Stychin, 1995: Chapter 7; Moran, 1996, chapter 8; Weait, 1996.

[15] For a comprehensive analysis of transatlantic anxiety regarding masturbation see Miller, 2000–2001. Whilst this was a transatlantic phenomenon, it should be noted that anxieties ran higher in the United States. As Hodges notes:

> American doctors saw sexuality as more of a threat to public health and social stability than did their European contemporaries. The American medical profession's intense focus on sexuality was due in part to economic pressures, the lack of a rigidly defined class system, the rise of the middle class, the rise of immigration, and other sources of social tension (Hodges *et al*. 2002).

[16] This assertion is better understood if we look at the construction of masturbation as at the root of nearly all illness. (See, Miller, 2000–2001: 244.)

[17] This theory was also supported by E. Harding Freeland in his call for universal circumcision as a means to prevent syphilis:

> But it has been urged as an argument against the universal adoption of circumcision that the removal of the protective covering of the glans tends to dull the sensibility of that exquisitely sensitive structure and thereby diminishes sexual appetite and the pleasurable effects of coitus. Granted that this is true, my answer is that, whatever may have been the case in days gone by, sensuality in our time needs neither whip nor spur, but would be all the better for a little more judicious use of curb and bearing-rein. (Freeland, 1900).

[18] It was still the most frequently performed operation in 1977 (Miller, 2002: 501).

[19] See also Miller, Aside from child abuse, another clear example of law's discursive construction of harm occurs in relation gay sado-masochistic sex in the *R* v. *Brown* case considered below.

[20] In this vein J.H. Kellogg suggested 'the pain attending the operation will have a salutary effect on the mind, especially if it be connected with the idea of punishment' (Kellogg, 1888: 295).

[21] See for instance, Sally Sheldon's discussion of foetal protection policies in the workplace, which she use to demonstrate how "the negation of male reproductive capacity has been harmful to individual men in the same way as women's reduction to nothing more than reproductive capacity has been harmful to women" (Sheldon, 2002: 26–7; see also Thomson, 2002).

[22] For instance, in the case of circumcision, for many fathers the key motivation for circumcising their child has been a desire that their son physically resemble them (see, Hutson, 2004).

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