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As controversies mount, circumcision policies need a rethink

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Abstract:

The recent criminal sentencing of a UK-based former paediatric surgeon for performing unauthorised childhood circumcisions for cultural and religious purposes -- despite having been previously struck off the General Medical Council (GMC) medical register for performing unsafe circumcisions -- has renewed debate and concern over how societies should regulate this practice. Current clinical guidance on nontherapeutic childhood penile circumcision engages a complicated intersection between medicine, religion, and secular culture, giving rise to conflicting arguments over how medical advice should be approached. Some argue there is greater need for medical oversight in licencing, while others attest that the procedure itself is unethical and thus should be discouraged outright. Still others suggest that clearer guidance is needed regardless of one's position, as the lines between medical and non-medical advice have been muddled. As the complex interplay of medicine, religion, and culture in relation to circumcision is most pronounced in the United States, where the practice of nontherapeutic newborn circumcision is common, this article examines the subject through a novel assessment of the most recent and highly influential American Academy of Paediatrics (AAP) policy statement on the practice, with an eye to seeing what might be learned by health and regulatory authorities as they grapple with this issue. Commentary given for the article by key contributors to the AAP policy, as well as consideration of the mixed reception of the policy by the medical community and members of the public, suggests that (at minimum) guiding authorities in the US, UK, and elsewhere must more clearly articulate the line between medical and non-medical practice.

Introduction

Earlier this year in the UK, a former pediatric surgeon received a prison sentence over running an "unsafe and unsanitary" [1] male circumcision practice, with the judge describing the need for regulation of child penile circumcision "a matter of urgency."[1] The judgment also follows controversies in Ireland, where a traditional circumciser was arrested last year for performing circumcisions without a local license;[2] in Australia, where a child died in 2021 while undergoing penile circumcision in a medical clinic;[3] and a criminal investigation of traditional circumcisers in Belgium.[4] Even as this article was going to press, a

circumcision-related controversy erupted in the US when Robert F. Kennedy, Jr., the Health and Human Services Secretary, gestured towards two highly inconclusive studies linking circumcision to an increased risk of autism spectrum disorder, purportedly due to the likely use of Tylenol (acetaminophen, or paracetamol in the UK) to address infant pain following the surgery.[1]

In all these cases, the ensuing discussion has had to grapple with the uncomfortable status of childhood penile circumcision as something that is simultaneously a religious or cultural practice in some communities, as well as something that is often performed by doctors. This creates confusion over how regulation and medical guidance ultimately ought to be approached. Because non-medical (or traditional) child circumcision is currently un(der) regulated in many countries, some argue there is a need for greater medical oversight and licencing of practitioners.[1] However, there are also those who argue that the practice, when nontherapeutic or "medically unnecessary," fails to meet the standards for evidence-based, ethical medicine and thus at minimum ought not be performed by clinicians working in their professional capacity.[5] Some go so far as to argue that the practice ought to be prohibited altogether out of respect for the child's *right to bodily integrity.*[6]

Another argument that has been raised, with a focus on the most recent British Medical Association (BMA) position, is that current guidance is, at best, *unclear*—and at worst, contradictory—thus painting "a confused and conflicting portrait of the law and ethics of the procedure" [7, p.1]. According to this perspective, whatever approach is ultimately taken in relation to clinical policy or broader regulation of nontherapeutic circumcision, guiding authorities should avoid sending the public *mixed signals* about medical versus non-medical considerations.

In this piece, I suggest that as medical and national bodies weigh their options, they should keep in mind the example of the United States, where medical and non-medical factors are especially tightly intertwined when it comes to child penile circumcision practices. This is due to the uniquely high rate of nontherapeutic, nonreligious circumcision of newborns in the United States, where the custom has become entrenched through a history of medicalisation and remains relatively popular in the wider culture (that is, even outside of minority religious communities).

[1] See https://www.medpagetoday.com/washington-watch/washington-watch/117885

Yet, the American Academy of Pediatrics (AAP) has not produced an official statement since their much-debated 2012 policy [8] automatically expired in 2017. The 2012 policy statement from the AAP caused considerable controversy when it was released. It claimed, for the first time, and against the prevailing consensus in other countries, that "the health benefits of newborn male circumcision outweigh the risks." Because this framing was typically interpreted as a tacit recommendation, it was widely viewed as out of step with contemporary paediatric standards, and was criticized by international physicians and heads or representatives of other paediatric societies.[9] Yet, the language of benefits outweighing risks carried over[2] (see also[10]) to the U.S. Center for Disease Control and Prevention (CDC) and American Medical Association (AMA) policies; this language continues to feature in US based materials on the subject and factors centrally in current scholarly debates over the permissibility and potential regulation of medical and traditional circumcision.

In pursuit of clarity on the issue for this article, I spoke to key contributors to the AAP policy, who offered generous insights. Their comments make clear that the 2012 position—in particular its centerpiece statement that the health benefits of nontherapeutic newborn circumcision outweigh the risks—was not solely a scientific conclusion based on a dispassionate evaluation of the totality of the evidence. Rather, it was also shaped in part by legal, cultural and other extra-medical concerns. These acknowledgements do not settle the overarching ethical debates. However, they do shed light on the resultant confusion caused by the policy, its status as a medical recommendation, and the importance of reflexive analysis in issuing guidance going forward.

New statements from task force members:

Quotations in what follows are from recorded interviews with two task force members, Dr. Douglas Diekema and Dr. Andrew Freedman. The interviews were recorded, with permission, between 18 December 2024 and 18 February 2025; consent to be quoted was also obtained. Further requests for statements were issued to task force chair Dr. Susan Blank, and to task force member Dr. Michael Brady. However, they could not be reached for comment.

Dr. Douglas Diekema, the task force's bioethicist, told me that while he remained confident in the task force's review of the scientific literature as it existed at the time, he was dissatisfied with their ultimate recommendation. In fact, he said that he personally raised

[2] A less formal CDC committee made a similar claim in 2007 around the time the AAP task force began work on what would become the 2012 policy. However, the AAP task force position remains the primary site of the claim that the health benefits of the procedure outweigh the risks.

caution over the 2012 conclusion during its development. He said that if the Academy were to ask him today, he would advise that, “When you look at all the data, I don’t think you can honestly say in a recommendation that the benefits outweigh the risks.”

Because Diekema served as corresponding author for the policy in official AAP response articles,[11] many critics of nontherapeutic newborn circumcision have labelled him as committed to a “pro-circumcision” stance. However, his own position on the topic is complex, as he attempts to balance competing moral concerns. “It was really a legal question for me,” Dr. Diekema told me. “My feeling was that there was not sufficient data to suggest that this is a procedure that should be outlawed, particularly given that there were multiple religious communities for whom this was an important practice. But I also didn’t think paediatricians should be recommending it.” He added, “The only situation in which I would give a recommendation is to the parent who is on the fence. To them I would say they are probably better off not doing the procedure.” As regards the policy’s expired status, Dr. Diekema said, “I think it’s time [to update],” and he noted, “The scientific literature on this issue has continued to expand. But the ethics literature on this topic has also expanded and is significantly more robust than it was fourteen years ago. Any future committee should also be taking a look at that work.”

In terms of the application of the actual phrasing of “benefits outweigh risks,” Dr. Andrew Freedman, the task force’s representative paediatric urologist, takes responsibility. However, he explains that the formulation was suggested as a compromise between members of the task force who took a more “pro-circumcision” stance than those like himself who aimed for something more neutral.[3] While Freedman stresses that his position should not be taken as representative of the rest of the 2012 task force, he believes that most parents circumcise their children for non-medical reasons, and that the potential health benefits alone are not enough to recommend circumcision. In his view: “It is a non-therapeutic procedure. If it can be called a preventative medicine, it is at the very weakest level. There is nothing wrong with

[3] Dr. Freedman notes that the policy may be viewed as innovative in relation to past AAP policies, as it was the first to at least minimally engage with the reality that parents considering circumcising their children do so for reasons other than medical benefits (or at least, in addition to medical benefits). His own support for parental discretion on this issue is rooted in respect for non-medical concerns. However, he also notes that there were other contributors—particularly those approaching the topic from the perspective of infectious disease prevention—who sincerely viewed the health benefits as a weighty consideration. Focus was placed on then-emergent claims that circumcision reduces the risk of HIV transmission (and this was being assessed at a time when HIV was more life-threatening than today). Thus, the policy’s ultimate recommendation is a balancing position between what might have been an even stronger medical recommendation, and a position which would have characterised circumcision as merely permissible. While both of those positions have been subject to considerable critique, it warrants mention that the state of the issue in general could have been improved had the AAP policy at least noted that such disagreement existed between individual contributors.

the [uncircumcised] penis; you cannot recommend circumcision based on the medical benefit alone. Nothing about the potential benefits is communicable, so I don't see how it could be called a public health concern."

According to Dr. Freedman, "the best analogy is that the AAP guidelines are a 'permission slip' for those who want to circumcise their children so that society cannot say they are bad parents or outlaw the practice." In fact, in Freedman's estimation, there is a sound argument to be made that future guidance ought to fall more in line with a public safety position or advisory on certification, rather than a medical recommendation (in line perhaps with other AAP commentary on non-medical practices such as cheerleading, football, etc). "Maybe the AAP should get out of the [circumcision] business," he said, "since it's not really a medical practice. It's only a 'medical procedure' in the sense that medical professionals are performing it."

Analysis:

What these statements from Diekema and Freedman make clear is that the task force, as a whole, did not intend to actively influence parental decision-making one way or another. Rather, as per Freedman, the consensus ultimately landed on developing an ostensibly neutral "permission slip," for parents who were antecedently invested in the procedure. The public, on the other hand, largely received the policy as a medical recommendation in favor of the procedure. Examples of major press reactions include:

- Scientific American: *Pediatrics group praises the benefits of circumcision* [12]
- NPR: *Pediatricians decide boys are better off circumcised than not* [13]
- LA Times: *Pediatricians' group shifts in favor of circumcision* [14]
- The Daily Beast: *Circumcise me, baby: The nations top pediatricians are recommending circumcision for the first time* [15]

Many US-based medical professionals arrived at a similar conclusion, some of whom expected the policy to influence an increase in the rates of US circumcisions (see, for example, [16]). However, as the rate has instead fallen, other researchers have posited that this could be explained by *distrust* in medical guidance (see for example, this past September from a research team at Johns Hopkins Medicine, who viewed the AAP policy as clearly recommending infant circumcision [17]).[4]

[4] The article in *JAMA Pediatrics* suggests that the inpatient US male circumcision rate has, for the first time in decades, likely fallen below 50%.

What accounts for this widespread divergence in intent and reception, and what can policymakers learn from this going forward? I offer a few considerations below.

1. **How should health benefits be presented?**

According to the 2012 technical report, "US parents most often reported that they chose to have their newborn son circumcised for health/medical benefits, including hygiene and cleanliness of the penis."[8] Given this fact, the presentation of potential health benefits and their relative weight is a point of key significance going forward. But if relevant authorities are to take Dr. Diekema's suggestion that the science be presented as neutrally as possible, how can that be achieved without the implication of a recommendation?

For an illustrative example of how the issue has been misconstrued in the current environment, consider the following quote from science magazine *Big Think*, in an article titled "Defying science, American parents are turning away from male circumcision":

> Parents are, of course, free to make their own decisions in regard to their young children. The American Academy of Pediatrics said as much in their latest position statement on circumcision, noting that the benefits do outweigh the risks, but ultimately parents should make the choice. *However, the simple fact is that if parents choose not to circumcise, they are denying their sons clear medical benefits that will improve their health and the health of their future partners.* (emphasis added) [18]

The quote above speaks to what the public really wants clarified about circumcision. Many parents, especially in the US context, are currently left to wonder, *"It may technically be an 'unnecessary' procedure, but if there are health benefits then why wouldn't I want my child to have them?"* This thinking leads to a potential erroneous interpretation, exemplified by the *Big Think* article above, that the attainment of medical benefits through circumcision may be *technically unnecessary yet medically preferable*, contrary to Dr. Diekema's and Dr. Freedman's claims that this was not the task force's intent.

The broader framing of the potential benefits and risks of childhood penile circumcision in the US context has been misleading, especially in terms of presenting the claimed health benefits in such a way that they are easy for interpreters to overvalue.[5]

[5] The challenge of communicating the relevance of health benefits in a non-emergency, nontherapeutic procedure is not a matter of merely binarily observing whether circumcision confers a degree of benefit, but rather determining the relative weight and value of the benefit. While there is not

For example, see the current parent-facing materials by the AAP, on their companion website HealthyChildren.[19] The page (updated as recently as February 2025) currently lists “reasons why parents choose to circumcise” as predominantly data-backed benefits, while it depicts parents choosing not to circumcise as doing so out of “fear of the risks,” and “belief that the foreskin is needed.” As Cambridge Professor Clare Chambers notes in *Intact: A Defense of the Unmodified Body*, this phrasing is far from neutral:[20] rather, it portrays one set of parents as using science to make their decisions while the other is guided by fear and belief. It’s easy to see how when the issue is presented this way, lay people and science communicators alike are going to interpret the AAP as recommending circumcision.

The choice of language and tone are important regardless of position. For example, other paediatric societies with permissive circumcision policies (in the sense that they believe the ultimate decision should be left for parents to make), such as the Canadian Paediatric Society (CPS), include information about health benefits yet they are contextualized transparently as minor effects. Notably, the CPS describes the overall procedure not merely as “medically unnecessary” but as “not medically indicated.”[21] The latter phrasing is optimal as it removes the potential to interpret the former as suggesting “circumcision is technically unnecessary but medically preferable,” as per the above *Big Think* example.

2. How should non-scientific values be incorporated?

Freedman has said, “There can be no doubt that religion, culture, aesthetic preference, familial identity, and personal experience all factor into [this] decision” and thus, for the 2012 task force, “protecting this option [for parents] was not an idle concern when there are serious efforts both the United States and Europe to ban the procedure outright.”[22] Based on these extra-medical factors, Dr. Freedman holds that medicalized circumcision can be best understood as medical assistance for a non-medical practice.

The larger issue of whether or not it is ethically appropriate for medical professionals to perform a non-medical practice affecting the genitals of a minor in a clinical setting is beyond

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space here for a complete breakdown of each of the benefits presented in the AAP technical report, perhaps the clearest example of the overvaluation of benefits is that of the prevention of phimosis, paraphimosis, and balanitis (a group of conditions impacting the relevant anatomy which are often presented together). Phimosis, for example, refers to a condition where the foreskin becomes too tight to retract from the glans. The purely scientific fact is that circumcision indeed prevents these negative conditions. Yet classifying this effect as a “health benefit,” is unusual, since the removal or loss of any body part prevents injury and the development of other negative conditions to that body part; that alone clearly fails to ethically justify surgery on an otherwise healthy child. However, while such a benefit appears to gain greater relevance when placed alongside other concerns (including perhaps, other health benefits), when communicated without due qualification the significance of a health benefit like preventing phimosis is overstated by its mere inclusion.

the scope of this article. But, importantly, it was not clear to the public that non-scientific values weighed into the formula for the 2012 policy statement at all, let alone to a significant degree. In fact, it is more often the case that non-scientific values are what the public expects the institution to *ignore* in issuing advice. Lay people and doctors expect that when the guiding medical authority publishes a policy reading “health benefits outweigh risks,” it means they have reached that conclusion on scientific grounds alone.

Compounding the problem, the specific claim that the benefits outweigh the risks carried over to the CDC (which AAP 2012 task force chair Dr. Susan Blank described as a “converging policy” after serving on both committees)[23] and AMA policies.[24] These subsequent policies amount to endorsements of the AAP 2012 position, yet in these latter cases, the guidance omits any mention of non-scientific, extra-medical values. In many other places, the 2012 policy has been cited as *scientific* position; for example, Lempert et al. note that the BMA prominently cited the AAP policy as scientific grounding for their own policy.[7, p.9] So, although the AAP policy broadly, and the specific term “benefits outweigh risks,” more specifically, were created as a compromise to *include* non-medical concerns, it has had the opposite effect of improperly bolstering the profile of the potential health benefits relative to their significance in the total formula, both for the AAP and for other medical bodies.

Doubtless, some will argue that non-medical elements are not appropriate to incorporate in a medical recommendation at all. Regardless of that argument, however, if medical bodies do continue to utilize or cite the AAP formulation, they must engage transparently with the significant role “religion, culture, aesthetic preference, [and] familial identity”[22] played in its conception. However, if policymakers do include religious and other non-medical concerns in their circumcision guidance (as was done in the most recent AAP and BMA policies), it bears further consideration of how those concerns—and the communities they engage—may best be served. Medical bodies should avoid infantilizing cultural groups via policies that nominally support a practice but omit engagement with typical medical ethics standards. Presuming for the sake of argument that traditional circumcision would not be legally prohibited even if medical guidance discouraged it; if the practice indeed conflicts with medical ethics, that is still an important point for parents and relevant groups to take into consideration. It should not be assumed that medical ethics are a non-factor in, for example, intra-religious-group decision making. To the contrary, medical guidance is an active factor in historical as well as contemporary internal religious reasoning.[25, 26] Thus, while a permissive policy may genuinely intend neutrality, that intention falls short if it suggests to

traditionalists that medical authorities approve of (or even recommend) their practice, enabling rote dismissal of in-group reformers who would otherwise have a stronger case.

Conclusion

While secularized child circumcision practices are relatively uncommon outside of North America (and especially the United States), the continued emergence of controversies related to the practice abroad suggests that ongoing engagement by medical authorities is necessary everywhere. Yet, as demonstrated by the varied reactions to the recent controversies, disagreement persists on exactly what form medical policy ought to take. Critics charge that in the current environment, medical bodies have remained non-committal on the procedure, in an attempt "to accommodate, or patch over, the polarized stances on [child circumcision] within the wider society."[7, p.18]

The issue may be contentious, but one aspect that is not debated is that the relevant populations deserve the most up-to-date, highest standard of information available. However, there is more at stake here. Beyond the issue itself, we must also consider guidance on circumcision in the full context of healthcare standards, and science literacy writ large. This is especially salient in the current political environment where trust in medicine and public health is under threat. The public must be able to look to medical authorities to correct myths, and yet rather than correcting myths about circumcision (in particular the idea that it is medically recommended or preferable), the AAP has plausibly become the source of the myth itself.

If trust in the scientific community is to be sustained, scientific institutions must adhere to the highest standards for policy-making, apply ethical guidelines consistently, and demonstrate an eagerness to improve and correct ill thought-out positions. Thus, as national bodies grapple with the medico-ethical, legal, and regulatory status of infant or child penile circumcision in all contexts, careful engagement is necessary. At minimum—the line between medical and non-medical practice must be clearly defined.

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