knmg

Non-therapeutic circumcision of male minors

KNMG viewpoint

knmg voor verantwoorde medische zorg

Colophon

The non-therapeutic circumcision of male minors is a publication setting out the Position of the Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG), adopted by the Board of the Federation and effective as from 27 May 2010.

The KNMG physicians' federation represents over 53,000 physicians and medical students. KNMG member organisations include the Koepel Artsen Maatschappij en Gezondheid (Umbrella organisation for physicians and health – KAMG), the Landelijke vereniging van Artsen in Dienstverband (National society of employee physicians – LAD), the Landelijke Huisartsen Vereniging (National society of general practitioners – LHV), the Netherlands Society of Occupational Medicine (NVAB), the Nederlandse Vereniging voor Verzekeringsgeneeskunde (Netherlands society of insurance medicine – NVVG), the Orde van Medisch Specialisten (Order of medical specialists – OMS) and the Dutch Association of Elderly Care Physicians and Social Geriatricians (Verenso).

www.knmg.nl/jongensbesnijdenis
www.knmg.nl/circumcision

Design buro-Lamp, Amsterdam

Contact details KNMG PO Box 20051, 3502 LB Utrecht, The Netherlands - +31(0)30 282 38 00
www.knmg.nl/english

Index

Preamble

Position of the KNMG with regard to non-therapeutic circumcision of male minors

Non-therapeutic circumcision of male minors is a practice that has been carried out for centuries by a variety of different cultures for a variety of different reasons. It is estimated that 13 million boys around the world are circumcised each year. In the Netherlands, the annual figure is between ten and fifteen thousand.
Following on from other medical organisations, the Royal Dutch Medical Association (KNMG) has adopted an official viewpoint with regard to this issue. This viewpoint was formulated following consultation with relevant scientific organisations, who also support this stance. This ensures that this viewpoint has a broad basis of support from the relevant professional associations.
The reason for our adoption of an official viewpoint regarding this matter is the increasing emphasis on children's rights. It is particularly relevant for doctors that children must not be subjected to medical proceedings that have no therapeutic or preventative value. In addition to this, there is growing concern regarding complications, both minor and serious, which can occur as a result of circumcising a child. A third reason for this viewpoint is the growing sentiment that there is a discrepancy between the KNMG's firm stance with regard to female genital mutilation and the lack of a stance with regard to the non-therapeutic circumcision of male minors, as the two have a number of similarities.
The initial objective of this viewpoint is to initiate public discussion of this issue. The ultimate aim is to minimise non-therapeutic circumcision of male minors.
The KNMG realises that this particular practice has deep religious, symbolic and cultural meaning. For this reason, it is unrealistic to expect that this practice can be eradicated, even if it was prohibited by law. However, the KNMG does believe that a powerful policy of deterrence should be established. As long as this practice takes place, the KNMG aims to reduce the number of complications as much as possible.
The KNMG therefore emphasises that circumcision is a surgical procedure covered by the Individual Healthcare Professions Act. This means that circumcision may only be performed by qualified professional practitioners, in this case, doctors. Doctors who perform circumcisions must also follow all applicable scientific guidelines. This entails, amongst other matters, that circumcisions can only be carried out under local or general anaesthetic, after thorough and precise advice and information has been given to the child's parents. The fact that this practice is not medically necessary and entails a genuine risk of complications means that extra-stringent requirements must be established with regard to this type of information and advice.

27 May 2010

Prof. Dr. Arie Nieuwenhuijzen Kruseman
Chairman of KNMG

KNMG viewpoint

Non-therapeutic circumcision of male minors

- There is no convincing evidence that circumcision is useful or necessary in terms of prevention or hygiene. Partly in the light of the complications which can arise during or after circumcision, circumcision is not justifiable except on medical/therapeutic grounds. Insofar 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.
- Contrary to what is often thought, circumcision entails the risk of medical and psychological complications. The most common complications are bleeding, infections, meatus stenosis (narrowing of the urethra) and panic attacks. Partial or complete penis amputations as a result of complications following circumcisions have also been reported, as have psychological problems as a result of the circumcision.
- Non-therapeutic circumcision of male minors is contrary to the rule that minors may only be exposed to medical treatments if illness or abnormalities are present, or if it can be convincingly demonstrated that the medical intervention is in the interest of the child, as in the case of vaccinations.
- Non-therapeutic circumcision of male minors conflicts with the child's right to autonomy and physical integrity.
- The KNMG calls on (referring) doctors to explicitly inform parents/carers who are considering non-therapeutic circumcision for male minors of the risk of complications and the lack of convincing medical benefits. The fact that this is a medically non-essential intervention with a real risk of complications makes the quality of this advice particularly important. The doctor must then record the informed consent in the medical file.
- The KNMG respects the deep religious, symbolic and cultural feelings that surround the practice of non-therapeutic circumcision. The KNMG calls for a dialogue between doctors' organisations, experts and the religious groups concerned in order to put the issue of non-therapeutic circumcision of male minors on the agenda and ultimately restrict it as much as possible.
- There are good reasons for a legal prohibition of non-therapeutic circumcision of male minors, as exists for female genital mutilation. However, the KNMG fears that a legal prohibition would result in the intervention being performed by non-medically qualified individuals in circumstances in which the quality of the intervention could not be sufficiently guaranteed. This could lead to more serious complications than is currently the case.

This viewpoint by the KNMG is jointly endorsed by the following scientific associations:

- The Netherlands Society of General Practitioners
- The Netherlands Society of Youth Healthcare Physicians
- The Netherlands Association of Paediatric Surgeons
- The Netherlands Association of Plastic Surgeons
- The Netherlands Association for Paediatric Medicine
- The Netherlands Urology Association
- The Netherlands Surgeons' Association

Background study for KNMG viewpoint

Non-therapeutic circumcision of male minors

INTRODUCTION

Circumcision of male minors is a centuries-old practice. It is part of many different cultures and is carried out for many different reasons. An estimated 13 million boys are circumcised every year worldwide, and in the Netherlands, the annual figure is estimated at ten to fifteen thousand.

Until a few years ago, the attitude towards circumcision was fairly permissive, and circumcision was legitimised by appealing to freedom of religion and supposed medical benefits. In recent years, the attitude towards circumcision appears to have been changing. This is probably partly the result of the debate about female genital mutilation (FGM). With the global condemnation of this practice, including in its non-mutilating, symbolic form, the question regularly arises why circumcision should be judged differently than FGM. These days, more critical articles are being published about circumcision.[1] These articles point to the rights of children, the absence of medical benefits and the fact that this is a mutilating intervention that regularly leads to complications and can cause medical and psychological problems, both at a young and a later age.

In recent years, a large number of doctors' organisations have adopted declarations in which they state that circumcision is not associated with any medical benefits sufficient to justify the intervention. There is currently not a single doctors' organisation that recommends routine circumcision for medical reasons. There are now anti-circumcision organisations active in many countries. In many cases, participants include doctors.[2] There is resistance to this practice within the Jewish community, too.[3] There are also organisations active which explicitly focus on the surgical or mechanical restoration of the foreskin.[4] As yet, there are no legal prohibitions in force, although Sweden has introduced a law which permits non-therapeutic circumcision only in the first two months after birth and only under local or general anaesthetic.

The increasing criticism of routine circumcision, also from doctors' organisations, has led to a situation in which the incidence of circumcision is falling significantly in many countries and is less and less accepted as 'normal'. In the United Kingdom, the number of circumcisions in newborns has fallen from 35% in the 1930s to 6.5% in the 1980s, to 3.8% in 2000.[5] In the US, the incidence fell from 85% in 1965 to 56% in 2006. Canada saw a fall from 47.4% in 1973 to 31.9% in 2007,[6] while Australia witnessed a fall from 90% in 1955 to 12% in 2000.[7]

OBJECTIVE OF THIS MEMO

The objective of this memo is to offer some background to the KNMG's viewpoint with regard to this subject. This discussion memo examines the practice and background of circumcision. It describes the current practice, historic background and moral debates. The positions of various doctors' organisations are also discussed.

REASONS FOR CIRCUMCISION

In the literature, four reasons are described for circumcision in boys: medical/therapeutic, medical/preventative, religious and cultural.[8] In practice, it is hard to separate these reasons from one another, and parents often have more than one reason to have their sons circumcised. Cultural or religious reasons are also often linked to supposed medical benefits. In Islam, for example, circumcision is carried out for reasons of religion but also of hygiene. Sometimes there is a shift: routine circumcision in the United States used to be carried out particularly for medical reasons, but this has now shifted to a cultural norm. The various reasons are described in the following paragraphs.

MEDICAL/THERAPEUTIC

There are a number of complaints for which circumcision is an accepted medical therapy, in particular phimosis (abnormal tightness of the foreskin), paraphimosis and balanitis (inflammation of the glans). In the medical world, there is debate as to whether circumcision is prescribed too often for medical reasons, when there are sometimes good alternatives such as plastic surgery or local application of a steroid cream - for example to treat phimosis.[9] However, in general, circumcision for medical/therapeutic reasons is not controversial and will not be dealt with in any further detail at this time.

MEDICAL/PREVENTATIVE

In the past, circumcision was performed as a preventative and treatment for a large number of complaints, such as gout, syphilis, epilepsy, headaches, arthrosis, alcoholism, groin hernias, asthma, poor digestion, eczema and excessive masturbation.[10] Due to the large number of medical benefits which were wrongly ascribed to circumcision, it is frequently asserted that circumcision is 'a procedure in need of a justification'.[11] In recent decades, evidence has been published which apparently shows that circumcision reduces the risk of HIV/AIDS[12], but this evidence is contradicted by other studies.[13]

Moreover, the studies into HIV prevention were carried out in sub-Saharan Africa, where transmission mainly takes place through heterosexual contact. In the western world, HIV transmission is much more frequently the result of homosexual contact and the use of contaminated needles.[14] That the relationship between circumcision and transmission of HIV is at the very least unclear is illustrated by the fact that the US combines a high prevalence of STDs and HIV infections with a high percentage of routine circumcisions.[15] The Dutch situation is precisely the reverse: a low prevalence of HIV/AIDS combined with a relatively low number of circumcisions. As such,

behavioural factors appear to play a far more important role than whether or not one has a foreskin.

Further, there is apparent evidence that circumcision offers protection against complaints such as HPV infection, urinary tract infections and penis cancer. However, these studies, too, are controversial.[16] Moreover, urinary tract infections can be successfully treated with modern healthcare. Children with inborn abnormalities to the urinary tract can generally be successfully helped by a foreskin-widening operation, which makes the foreskin easier to clean.

In response to the possible medical benefits, a large number of complications resulting from circumcision are described: infections, bleeding, sepsis, necrosis, fibrosis of the skin, urinary tract infections, meningitis, herpes infections, meatisis, meatal stenosis, necrosis and necrotising complications, all of which have led to the complete amputation of the penis.[17] Deaths have also been reported.[18] The AAFP estimates the number of deaths as 1 in 500,000.[19] That would mean that in the United States, two children die each year as a result of the intervention.

Alongside these direct medical complications, psychological problems[20] and complications in the area of sexuality have also been reported,[21] as have extreme pain experiences in newborns causing behavioural changes which are still apparent years later.[22] [23] Similarly, the high social costs of circumcision as a result of complications have been cited.[24]

Even if there were slight medical benefits connected with circumcision for medical-preventative reasons, it is questionable whether these possible medical benefits would compensate for the risk of complications. Certainly when it comes to children, who cannot make this assessment themselves, the possible medical benefits should be significant and the risk of complications small for the intervention to be justifiable.

It is a generally accepted moral principle that children may only be exposed to medical treatments if illness or abnormalities are present, or if it can be demonstrated that the medical intervention is in the interest of the child, as is the case for vaccinations, for example. In the case of preventative medical interventions, there needs to be a clear individual or public health benefit which cannot be achieved in another, less intrusive way.

Thus circumcision as a preventative against urinary tract infections or HIV/AIDS would need to be weighed against other, less intrusive forms of prevention (such as antibiotics, condom use, sex education or behavioural changes) and a scientific cost/benefit analysis made. Only if the results of this cost/benefit analysis were positive should the intervention be offered to all parents of small boys on public health grounds.

In addition, it would need to be demonstrated that it was essential that the circumcision be performed during childhood or infancy, rather than waiting until the boy had reached an age at which the risk was relevant (such as in HIV infection) and he could

make a decision about the intervention for himself. After all, in many cases, such as in HPV or HIV prevention, it will be possible to put off circumcision until the boy reaches an age at which he can elect to have the intervention himself or instead choose alternatives such as using condoms, HPV vaccination or abstinence.

DOCTORS' ORGANISATIONS ABROAD

A large number of doctors' organisations have pronounced on the supposed medical benefits of circumcision for medical/preventative reasons, set against the risk of complications.

In 2003, the British Medical Association stated: 'The medical benefits previously claimed have not been convincingly proven. (…) The British Medical Association considers that the evidence concerning health benefits from non-therapeutic circumcision is insufficient for this alone to be a justification for doing it.'[25]

The American Academy of Pediatrics stated in 1999: 'Existing scientific evidence … [is] not sufficient to recommend routine neonatal circumcision.'[26] The American Medical Association endorsed this position in December 1999 and now rejects circumcision for medical/preventative reasons. The AMA further states: 'parental preference alone is not sufficient justification for performing a surgical procedure on a child'.[27]

Other doctors' organisations in Australia and Canada have taken similar positions.[28] For example, the Royal Australasian College of Physicians asserts: 'Review of the literature in relation to risks and benefits shows there is no evidence of benefit outweighing harm for circumcision as a routine procedure in the neonate.'[29]

In its viewpoint, the Australasian Association of Paediatric Surgeons states: 'the AAPS does not support the routine circumcision of male neonates, infants or children in Australia. It is considered to be inappropriate and unnecessary as a routine to remove the prepuce, based on the current evidence available'.

The Canadian Paediatric Society states: 'The overall evidence of the benefits and dangers of circumcision is so evenly balanced that it does not support recommending circumcision as a routine procedure for newborns'.[30]

The American Academy of Family Physicians believes that the medical benefits of circumcision are 'conflicting or inconclusive'. The decision should therefore be left to parents: 'The American Academy of Family Physicians recommends physicians discuss the potential harms and benefits of circumcision with all parents or legal guardians considering this procedure for their newborn son'.[31]

In Sweden, a law was introduced in 2001 after a child died after NTC as a result of an incorrect dose of the painkiller Ketogan. A first version of the law implied a total prohibition of circumcision for non-therapeutic reasons up to the age of 18. Under

pressure from Jewish organisations, and out of fear that the practice would be driven underground, the law was later watered down. The law now states that non-therapeutic circumcision may only be performed in the first two months after birth and only under local or general anaesthetic. This anaesthetic may only be administered by a doctor or a qualified nurse. The circumcision itself may only be performed by a doctor or a mohel specially trained for the procedure, who has followed a course and has a licence from the Ministry of Health.

The prevailing consensus in the medical world is that there may be some medical benefits associated with circumcision but that these benefits, weighed against alternatives and the risk of complications from circumcision, are insufficiently great to be able to recommend routine circumcision for medical/preventative reasons. There is currently not a single medical association that recommends routine circumcision for medical/preventative reasons.

Given the above, the rest of this memo uses the term non-therapeutic circumcision (NTC). This refers to circumcision in boys and men for reasons other than medical/therapeutic reasons.

Religious and cultural reasons for circumcision

NTC for religious reasons occurs in the Netherlands mostly among Jewish and Islamic groups. NTC is viewed in Judaism as a religious command that is laid down in the Torah. It is seen as a symbol of the bond between God and Abraham; it is of considerable religious and emotional value, and has an important identifying significance.[32] Rabbi Evers puts it like this:

'It is not so much about a ritual that happens to be a Jewish custom, but about sealing admission into a centuries-old, unbreakable covenant. Many Jews who do not attach great value to religious traditions do have their sons circumcised. Together with 'Jewish marriage' and being buried in a Jewish cemetery, circumcision is a kind of religious minimum'.[33]

In Judaism, circumcision is generally performed on the eighth day after birth, usually without anaesthetic.[34] Circumcision may be performed in a hospital by a doctor but also by a *moheel*, a specially trained Jewish ritual circumciser, generally not a doctor.

Although NTC has a central significance within Judaism and is an important element of identification, the practice is not without its critics within the Jewish community. In recent years, movements calling for an end to NTC have grown up within, as well as outside, the Jewish community. Examples are *Jews Against Circumcision* and *The Israeli Association Against Genital Mutilation*.

The British Jewish philosopher Jenny Goodman consciously opted against NTC for her son because she regards the intervention as a violation of the integrity of the body. Upon the birth of her son she wrote a poem, of which the final stanzas are as follows:

All of us pray for rest
For Sabbath
We shall not rest
Until every child on earth
Is as cherished as you are, my love
And no one, no one shall raise a knife to a child
Ever again [35]

In the Netherlands, too, contrary views are often expressed within the Jewish community, although it remains unclear how large this group is.[36]

ISLAM

NTC is similarly viewed as a religious duty in Islam, although it is not literally mentioned in the Koran. As such, it is not so much a religious injunction as an act worthy of imitation, after the example of the prophet Mohammed. In Islam, circumcision also has the meaning of fully acceding to the religious community. Because of this, circumcision is often accompanied by festivities. In addition to its religious value, NTC also has a hygienic significance in Islam. There are different views about the age at which circumcision should take place within Islam, but in practice it is generally some time between seven and ten. Circumcisions are often performed in the country of origin but also in special circumcision centres set up for the purpose, particularly in major cities.

There is resistance against the practice of female genital mutilation (FGM) and NTC from within the Muslim community too, although the focus is mainly on FGM.[37]

Female genital mutilation vs. NTC

The practice of FGM has been prohibited by law in the Netherlands since 1993 in both adult and minor women and girls. In various viewpoints, the KNMG and NVOG have rejected all forms of FGM, including the most mild form, in adult women, as well as reinfibulation[38] following childbirth. The form which most closely resembles NTC, circumcision, is also unanimously rejected in virtually all the literature.[39] [40] In spite of this, the practice of FGM still occurs regularly, particularly among girls from North Africa. This led the internist Jannes Mulder to call in Medisch Contact for the mildest form of FGM, 'sunna light', to be tolerated.[41] This intervention proposed by Mulder consists of a small prick in the foreskin of the clitoris, causing a drop of blood to be released.

No tissue is removed, and the girl suffers no damage to her body, and there is no effect on sexual function. According to Mulder, the practice of FGM could in this way eventually be redirected into innocent, symbolic forms.

His proposal attracted purely negative reactions, generally based on the principled position that any form of FGM, including a symbolic one, must be treated as child abuse. "When it comes to the integrity of the girl's body, no single compromise must be made", states Pharos, knowledge centre for the prevention and tackling of female circumcision. The Netherlands Municipal Health Services (GGD) stated: "A girl is fine as she is." Even so, this 'sunna light' is far less intrusive than NTC, in which part of the erotogenic tissue of the penis is removed.

In a response to the criticism of his article, Jannes Mulder points to the difference in how NTC and FGM are judged: 'No one says a word about the Jewish practice of circumcising boys. This traditional 'abuse' involves more than my single drop of blood. Some see the circumcision of Muslim boys as a hygienic intervention. That argument conceals a deeper motive. After all, there is no culture that preventatively deals with dirty ears by cutting them off.'[42]

In an article in *Medisch Contact*, Karim and Hage (former board members of the Netherlands Association for Plastic Surgery, NVPC) similarly point to what they see as the discriminating fact that circumcision in girls is categorically rejected (even in its non-mutilating form) but that it is permitted in boys.[43] However, in the authors' view, there are no reasons why FGM and NTC should be judged differently in moral or legal terms.

The Partij voor de Vrijheid (Freedom Party) responded to the article by Karim and Hage through the person of Ms Agema with questions in the Dutch Lower House calling on the State Secretary not to prohibit the circumcision of boys. 'Can we be assured that the Dutch government will not bow to this discrimination argument and that circumcision of boys will remain permitted?[44]

FGM and NTC are generally seen as two separate practices, which need to be evaluated differently. For example, doctors' organisations often devote different statements to the two practices.

In the literature, little attention is given to legitimating the different treatment given to the two practices: apparently the difference is regarded as self-evident.[45] FGM is generally viewed as a serious violation of the rights of the child, while NTC is seen as something which parents may decide on for themselves. In the literature that exists, a number of arguments are made which are intended to justify a different evaluation of FGM and NTC.

SEXUAL FUNCTION

One of the most frequently used arguments for treating the two interventions differently is that FGM leads to the impairment of sexual function in the woman; supposedly, NTC has no such impact on the man.

However, FGM takes many forms. There is the most severe form, infibulation, in which the inner and outer labia are stitched together and the clitoris is removed. However, there are also much milder forms of FGM, in which only the foreskin of the clitoris is removed. However, sunna light, as proposed by Mulder and previously proposed by Bartels[46], in which no tissue is removed, is also universally rejected. The WHO also rejects all forms of FGM: 'Female genital mutilation of any type has been recognized as a harmful practice and a violation of the human rights of girls and women'.[47] The WHO explicitly includes in this the mild forms of FGM, in which no tissue is removed. So the argument for rejecting FGM is not that FGM interferes with female sexuality, but that it is a violation of the rights of the woman.

'The guiding principles for considering genital practices as female genital mutilation should be those of human rights, including the right to health, the rights of children and the right to non-discrimination on the basis of sex'.[48]

Another part of this argument says that NTC does not affect male sexuality. The foreskin is regarded as a part of the body that has no function at all in male sexuality. Many sexologists contradict this idea: in their view, the foreskin is a complex, erotogenic structure that plays an important role 'in the mechanical function of the penis during sexual acts, such as penetrative intercourse and masturbation'.[49] The many attempts by men to restore their foreskins by mechanical or surgical means also contradict the idea that the foreskin is a useless part of the body.[50]

NTC is sometimes compared to interventions such as tattoos and piercings.[51] On this view, Jews and Muslims see NTC not as an infringement of physical integrity, but as an innocent perfectioning of the body, comparable to tattoos and piercings. However, an important legal distinction between NTC in children and piercings and tattoos is that it is prohibited to tattoo or pierce children under the age of 16.[52] In other words, tattoos and piercings can only be done if a child is old enough to ask for them itself.

NO THEORY OF OPPRESSION

A second much-used argument to separate FGM from NTC is that FGM comes from a theory of female oppression, of which FGM is an expression. Since there is no such theory of oppression at play in NTC, this would make FGM morally more reprehensible than NTC.

This argument can be refuted in two ways. Firstly, the historical background of NTC is extremely complex, and is in any case rooted in the desire to control male sexuality. Thus NTC was deployed in the past to combat excessive onanism, and it was also

used to 'brand' slaves.[53] So the background to NTC is not as unambiguous as is often thought.

There is another reason why the argument does not hold. The reason why FGM is condemned is not because it comes forth from a theory of female oppression but because it is harmful to them and represents a violation of their physical integrity. FGM would also be condemned if it were done out of aesthetic considerations or as a way of 'venerating' women. Even if women were to want FGM themselves at a later age, doctors would probably not be permitted to meet their request.

The right to physical integrity is an inalienable human right, like the right to life and the right to personal freedom. These are inalienable rights, which is to say that the patient's permission does not offer sufficient justification to be allowed to perform the intervention. Besides permission, there must also always be an additional reason, such as a medical interest. From this it follows that even if women did not regret the intervention, doctors would not be permitted to commit serious infringements of the integrity of the body, such as FGM.

EMBEDDED IN CULTURE

A third argument often made for drawing a distinction between FGM and NTC is that NTC is a much older practice than FGM, and that NTC is far more embedded in existing religious groups such as Islam and Judaism. However, this is open to question: both NTC and FGM have been practised for centuries by many different peoples and for many different reasons. And FGM also has an important ritual, religious and identifying significance for many peoples. So it cannot be said with certainty that NTC is older than FGM. Even if it were, it is still questionable whether this argument is morally relevant. It is not the history of a practice which is of decisive importance, but whether a particular practice is a violation of the rights of the child.

Religious freedom vs. physical integrity

NTC in minors is regarded by many authors as a violation of physical integrity.[54] However, they subsequently often conclude that NTC falls under the right to religious freedom, and that parents may therefore decide for themselves whether they wish to have this intervention carried out.

The right to religious freedom means that parents are free to raise their children in a religion or philosophy of their own choosing. However, the right to religious freedom does not apply only to parents, but also to children. The right to religious freedom of the child implies that the child must at a later age have the right to choose a religion or philosophy of life for itself, or to reject the one in which it was raised.

The child is not only protected by the right to religious freedom, but also by the right to physical integrity. This right, as laid down in article 11 of the Constitution and article 8 of the ECHR, is one of the most important basic rights. It protects people against unwanted interventions in or to the body, and can only be overridden by permission of the person concerned or their representative, by a presumed interest (for example vaccination in children), or by a statutory requirement (such as the compulsory taking of DNA when suspected of a crime).

Some religious groups see NTC as a necessary intervention in order to be able to admit a boy fully to the religious community. In that sense, it could be claimed that it was in the presumed interest of the child to undergo NTC because it was associated with important cultural and religious benefits. A child that did not undergo NTC might have trouble developing its own identity and feel that it was 'different' and belonged 'nowhere'. Such feelings might be a consideration for doctors to perform NTC after all. It should be pointed out that there is no evidence for this assumption in the literature.

Moreover, any feelings of shame, problems with developing identity or 'not belonging' suffered by the child would not so much be a consequence of the non-performance of NTC, but of the child's being judged by others because he had not undergone NTC. To the extent that NTC becomes a less common practice, as is already the case in Australia and Canada, it will become increasingly 'normal' for boys not to be circumcised.

There is no evidence in the literature that non-circumcised boys have difficulty developing their identities. This may be because parents who choose not to have their children circumcised probably do so out of conviction, and will probably also raise their children in that same conviction.

The right to physical integrity and the right to religious freedom of the child imply that religiously motivated, irreversible interventions to the body of the child should be avoided. After all, this leaves the child the freedom to make up its own mind whether and in what form he/she wishes to relate to a particular religious community. Baptising children, for example, leaves no irreversible marks on the body, and as such is not a curtailment of the child's religious freedom, whereas irreversible NTC is.

Conclusion

- There is no convincing evidence that circumcision is useful or necessary in terms of prevention or hygiene. Partly in the light of the complications which can arise during or after circumcision, circumcision is not justifiable except on medical/therapeutic grounds. Insofar 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.
- Contrary to what is often thought, circumcision entails the risk of medical and psychological complications. The most common complications are bleeding, infections, meatus stenosis (narrowing of the urethra) and panic attacks. Partial or complete penis amputations as a result of complications following circumcisions have also been reported, as have psychological problems as a result of the circumcision.
- Non-therapeutic circumcision of male minors is contrary to the rule that minors may only be exposed to medical treatments if illness or abnormalities are present, or if it can be convincingly demonstrated that the medical intervention is in the interest of the child, as in the case of vaccinations.
- Non-therapeutic circumcision of male minors conflicts with the child's right to autonomy and physical integrity.
- The KNMG calls on (referring) doctors to explicitly inform parents/carers who are considering non-therapeutic circumcision for male minors of the risk of complications and the lack of convincing medical benefits. The fact that this is a medically non-essential intervention with a real risk of complications makes the quality of this advice particularly important. The doctor must then record the informed consent in the medical file.
- The KNMG respects the deep religious, symbolic and cultural feelings that surround the practice of non-therapeutic circumcision. The KNMG calls for a dialogue between doctors' organisations, experts and the religious groups concerned in order to put the issue of non-therapeutic circumcision of male minors on the agenda and ultimately restrict it as much as possible.
- There are good reasons for a legal prohibition of non-therapeutic circumcision of male minors, as exists for female genital mutilation. However, the KNMG fears that a legal prohibition would result in the intervention being performed by non-medically qualified individuals in circumstances in which the quality of the intervention could not be sufficiently guaranteed. This could lead to more serious complications than is currently the case.

Endnotes

1 Mullen MA. *Who speaks for sons?* Am J Bioeth 2003;3(2):49–50; Svoboda JS. *Circumcision - a Victorian relic lacking ethical, medical, or legal justification*. Am J Bioeth 2003;3(2):52–4; Ruissen A, *Niet-therapeutische jongensbesnijdenis in Nederland: passende zorg of genitale verminking?* TGE 14, 2004; 3: 66

2 For an summary, visit: *http://www.nocirc.org/centers/affiliates.php*

3 Among others from *Jews against circumcision* and *The Israeli Association Against Genital Mutilation*

4 De Foreskin Restauration Movement, *http://www.circumstitions.com/Restore.html*

5 S E Kenny, S C Donnell. *Towards evidence based circumcision of English boys: survey of trends in practice*, BMJ 2000;321:792-793 (30 September)

6 *http://www.courtchallenge.com/refs/yr99p-e.html*

7 *http://www.circinfo.org/case.html*

8 Wim Dekkers, Cor Hoffer, JP Wils. *Besnijdenis, lichamelijke integriteit en multiculturalisme.* Damon 2006.

9 Nieuwenhuijs, J.; *Y-V plasty of the foreskin as an alternative to circumcision for surgical treatment of phimosis during childhood.* Journal of Pediatric Urology (2007) 3, 45e47

10 Miller GP. *Circumcision: cultural-legal analysis.* Virginia Journal of Social Policy and the Law 2002;9:497–585.

11 M Fox and M Thomson; *A covenant with the status quo?* Male circumcision and the new BMA guidance to doctors J. Med. Ethics 2005;31;463-469

12 O'Farrell, R.S.; M. Egger (March 2000). *International Journal of STD's and AIDS* 11 (3): 137-142 *Circumcision in men and the prevention of HIV infection*: a 'meta-analysis' revisited; WHO/UNAIDS Technical Consultation on Male Circumcision and HIV Prevention: Research Implications for Policy and Programming Montreux, 6 - 8 March 2007

13 Van Howe, R.S. *Circumcision and HIV infection: review of the literature and meta-analysis.* International Journal of STD's and AIDS 10: 8–16; Thomas AG, Bakhireva LN, Brodine SK, Shaffer RA *Prevalence of male circumcision and its association with HIV and sexually transmitted infections in a U.S. navy population.* Abstract no. TuPeC4861. Presented at the XV International AIDS Conference, Bangkok, Thailand, July 11-16, 2004. Chao A, Bulterys M, Musanganire F, et al. *Risk factors associated with prevalent HIV-1 infection among pregnant women in Rwanda.* National University of Rwanda-Johns Hopkins University AIDS Research Team. Int J Epidemiol 1994; 23(2):371-80. Grosskurth H, Mosha F, Todd J, et al. *A community trial of the impact of improved sexually transmitted disease treatment on the HIV epidemic in rural Tanzania: Baseline survey results.* AIDS 1995;9(8):927-34.
Barongo LR, Borgdorff MW, Mosha FF, et al. *The epidemiology of HIV-1 infection in urban areas, roadside settlements and rural villages in Mwanza Region, Tanzania.* AIDS 1992;6(12):1521-8.
Changedia SM, Gilada IS. *Role of male circumcision in HIV transmission insignificant in conjugal relationship* (abstract no. ThPeC7420). Presented at the Fourteenth International AIDS Conference, Barcelona, Spain, July 7-12, 2002. Connolly CA, Shishana O, Simbayi L, Colvin M. *HIV and circumcision in South Africa* (Abstract No. MoPeC3491). Presented at the 15th International AIDS Conference, Bangkok, Thailand, July 11-16, 2004. Thomas AG, Bakhireva LN, Brodine SK, Shaffer RA. *Prevalence of male circumcision and its association with HIV and sexually transmitted infections in a U.S. navy population* (Abstract no. TuPeC4861). Presented at the 15th International AIDS Conference, Bangkok, Thailand, July 11-16, 2004

14 Centers for Disease Control and Prevention. *CDC HIV/AIDS Science Facts: Male Circumcision and Risk of HIV Infection: Implications for the United States.* Atlanta: Centers for Disease Control and Prevention. August 23, 2006

15 Van Howe RS. *Circumcision and infectious diseases revisited.* Pediatr Infect Dis J 1998;17:1–6

16 Aynaud O, Piron D, Bijaoui G, Casanova JM. *Developmental factors of urethral human papillomavirus lesions: correlation with circumcision.* BJU Int 1999;84(1):57-60. Frisch M, Friis S, Kjaer SK, Melbye M. *Falling incidence of penis cancer in an uncircumcised population* (Denmark 1943-90) BMJ. 1995 Dec 2;311(7018):1471

17 Central disciplinary tribunal for healthcare for the Healthcare *Decision in case number 2003/061*. Gee WF, Ansell JS. Neonatal circumcision: a ten-year overview: with comparison of the Gomco clamp and the Plastibell device. *Pediatrics*. 1976;58:824-827. Harkavy KL. The circumcision debate. *Pediatrics*. 1987;79:649-650. Williams N, Kapila L. Complications of circumcision. *Br J Surg*. 1993;80:1231-1236. Griffiths DM, Atwell JD, Freeman NY. *A prospective study of the indications and morbidity of circumcision in children. Eur Urol*. 1985;11:184-187. Kaplan GW. Complications of circumcision. *Urol Clin North Am*. 1983;10:543-549. Williams N, Kapila L. Complications of circumcision. Br J Surg 1993;80:1231–6. Gerharz EW, Haarmann C. *The first cut is the deepest? Medicolegal aspects of male circumcision.* BJU Int 2000;86:332–8. Hodges FM, Svoboda JS, Van Howe RS. Prophylactic interventions on children: balancing human rights with public health. J Med Ethics 2002;28:10–6. Niku SD et al. Neonatal circumcision. Urol Clin North Am 1995;22:57-65. King LR. Neonatal circumcision in the United States in 1982. J Urol 1982;128:1135-6.

18 Paediatr Child Health Vol 12 No 4 April 2007: *Circumcised three-year-old died from anaesthesia Aftonbladet* February 9, 2001

19 AAFP, *Circumcision: Position Paper on Neonatal Circumcision*, August 2007

20 Boyle, G., *Male Circumcision: Pain, Trauma and Psychosexual Sequelae*, Journal of Health Psychology, Vol. 7, No. 3, 329-343 (2002)

21 O'Hara K, O'Hara J. *The effect of male circumcision on the sexual enjoyment of the female partner.* BJU Int 1999; 83; Richardson D, Goldmeier D. *Premature ejaculation - does country of origin tell us anything about etiology?* J Sex Med 2005; 2: 508–12 (Suppl. 1): 79–84

22 Amand KJS, Hickey PR: *Pain and its effects in the human neonate and fetus.* N Engl J Med 1986; 317: 1321-1326

23 Cynthia R. Howard, MD; Fred M. Howard, MD; and Michael L. Weitzman, MD. *Acetaminophen analgesia in neonatal circumcision: the effect on pain.*, Pediatrics, April 1994 Janice Lander, PhD; Barbara Brady-Freyer, MN; James B. Metcalfe, MD, FRCSC; Shermin Nazerali, MPharm; Sarah Muttit, MD, FRCPC *Comparison of Ring Block, Dorsal PenileNerve Block, and Topical Anesthesiafor Neonatal Circumcision*, J Med Assoc., Volume 278 No. 24, Pages 2157-2162, December 24/31, 1997. *A Randomized Controlled Trial Procedural Pain in Newborn Infants: The Influence of Intensity and Development*, Fran Lang Porter, PhD*, Cynthia M. Wolf, PhD*, and J. Philip Miller, AB Pediatrics, Vol. 104 No. 1 July 1999, p. e13

24 Robert S. Van Howe, MD, MS, FAAP, *A Cost-Utility Analysis of Neonatal Circumcision* Medical Decision Making, Vol. 24, No. 6, 584-601 (2004)

25 BMA: *The Law and Ethics of Male Circumcision: Guidance for Doctors*

26 American Academy of Pediatrics, Task Force on Circumcision, Circumcision policy statement

27 Report 10 of the Council on Scientific Affairs (I-99) Report 10 of the Council on Scientific Affairs (I-99) AMA, 1999

28 Task Force on Circumcision, American Academy of Pediatrics. Circumcision policy statement. *Pediatrics*. 1999;103:686-693. Fetus and Newborn Committee, Canadian Paediatric Society. Neonatal circumcision revisited *CMAJ*. 1996;154:769-780. Australian College of Paediatrics. Position statement: routine circumcision of normal male infants and boys. 1996. The Australian Association of Paediatric Surgeons. *Guidelines for Circumcision*. Queensland, Australia. April 1996.

29 *Policy Statement On Circumcision*. Royal Australasian College of Physicians. September 2004

30 Neonatal circumcision revisited Fetus and Newborn Committee, Canadian Paediatric Society (CPS) Approved by the CPS Board of Directors in 1996,CMAJ 1996;154(6):769-80 Reference No. FN96-01

31 AAFP, Circumcision: Position Paper on Neonatal Circumcision

32 Dekkers et al, p. 74

33 Evers, L., (1999) *Jodendom voor beginners. Een heldere inleiding.* p. 40. Quoted in Dekkers et al, p. 76

34 *Religious circumcision: A Jewish view*, J.M. Glass, BJU International Volume 83 Issue S1, Pages 17 – 21; Mor Y, *The Israeli Point of View, Dialogues in Pediatric Urology*, Volume 30, Number 6 October, 2009, p 5-6

35 Goodman, J. (1999), *A jewish perspective on circumcision.* In Denniston, GC, male and female circumcision. Medical, ethical and legal considerations in pediatric practice. p.179-182

36 Veen-Vietor, M. van (2000), *Het verbondsteken*. Een cultuursociologische studie over de besnijdenis in verschillende perioden van het jodendom

37 George C. Denniston, *Male and female circumcision: medical, legal, and ethical considerations.* See also: Male Circumcision: Scriptural Perspective by International Community of Submitters *http://www.masjidtucson.org/publications/books/SP/1996/may/page2.html*

38 *Sewing the vagina back up, for example after childbirth*

39 R.S.B. Kool, *Vrouwelijke genitale verminking in juridisch perspectief* (Comparative law) study of the legal options for preventing and combating female genital mutilation Willem Pompe Instituut, Criminal Law Section, Universiteit Utrecht, Background study to the recommendation on fighting female genital mutilation by the Commission for Preventing Female Genital Mutilation, Zoetermeer, 2005

40 Slack A. *Female circumcision: a critical appraisal.* Human Rights Quarterly 1988;10:437–86.Brennan K. *The influence of cultural relativism on international human rights law: female circumcision as a case study.* Law and Inequality 1989;7:367–98.Atoki M. *Should female circumcision continue to be banned?* Feminist Legal Studies 1995;3:223–35. Bibbings L. *Female circumcision: mutilation or modification?* In: Bridgeman J,Millns S, eds. *Law and body politics.* Aldershot: Dartmouth, 1995:151–70.468 Fox, Thomson Wood AN. *A cultural rite of passage or a form of torture: female genital mutilation from an international law perspective.* Hastings Women's Law Journal 2001;12:347–86

41 Mulder, J, *Een druppeltje bloed*, Medisch Contact, Nr. 21 - 20 May 2008, p. 912

42 Jannes H. *Mulder Medisch Contact* Nr. 36 - 03 September 2008 Pages 1476 - 1477

43 Karim, B, Hage, *Jongens wel, meisjes niet*. Medisch Contact, 19 September 2008, 63 nr. 38

44 Questions in response to the report *'Jongens wel, meisjes niet'* in Medisch Contact (19 September 2008). Submitted 22 September 2008, nr. 2080900570

45 Freeman M. *A child's right to circumcision.* BJU Int 1999;83:74–8

46 Bartels, E, *Rituelen van bloed en medische ethiek*, TGE, 1998, 4, 1-8

47 Eliminating Female genital mutilation: an interagency statement, WHO, 2008

48 Ibid, p. 28

49 Taves DR. *The intromission function of the foreskin.* Med Hypotheses 2002;59:180–2. Cited in: Warren JP. *NORM UK and the medical case against circumcision: a British perspective.* In: Denniston GC, Milos MF, eds. *Sexual mutilations: a human tragedy.* New York: Plenum Press, 1997:85–101

50 See, among others: *The National Organization of Restoring Men* and *http://foreskinrestorationchat.info*

51 Wim Dekkers in bundel *De Kwestie*

52 *http://www.minvws.nl/nieuwsberichten/vgp/2007/wetgeving-tatoeren.asp*

53 Nicola Zampieri, Emanuela Pianezzola, Cecilia Zampieri, *Male circumcision through the ages: the role of tradition.* Acta Pædiatrica, 97, NO: 9, PG: 1305-1307 YR: 2008

54 For example: Wim Dekkers, wat doen we met de voorhuid? In *De kwestie, praktijkboek ethiek voor de gezondheidszorg.* Lemma, 2008, p. 125-130

knmg voor verantwoorde medische zorg

The non-therapeutic circumcision of male minors *is a publication setting out the Position of the Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG), adopted by the Board of the Federation and effective as from 27 May 2010.*

The KNMG physicians' federation represents over 53,000 physicians and medical students. KNMG member organisations include the Koepel Artsen Maatschappij en Gezondheid (Umbrella organisation for physicians and health – KAMG), the Landelijke vereniging van Artsen in Dienstverband (National society of employee physicians – LAD), the Landelijke Huisartsen Vereniging (National society of general practitioners – LHV), the Netherlands Society of Occupational Medicine (NVAB), the Nederlandse Vereniging voor Verzekeringsgeneeskunde (Netherlands society of insurance medicine – NVVG), the Orde van Medisch Specialisten (Order of medical specialists – OMS) and the Dutch Association of Elderly Care Physicians and Social Geriatricians (Verenso).