

Elective Child Circumcision and Catholic Moral Principles

David Lang

Abstract. The ethical propriety of routine male infant circumcision has been debated in journals of medicine and law for many years. This article explores the issue from historical, medical, and moral perspectives. Two essentially different forms of circumcision (one more drastic than the other) are distinguished. Discussion focuses on the effects of the more radical kind of nontherapeutic surgery on a normal healthy child's body: whether it constitutes a mutilation, whether it is medically warranted, and whether it is ethically defensible in light of general philosophical principles and Catholic moral doctrine. The conclusion questions the social bias favoring parental choice to circumcise a non-consenting son. *National Catholic Bioethics Quarterly* 12.1 (Spring 2012): 99–128.

Traditional ethical principles have generally proscribed proxy consent to unnecessary surgery, especially to an operation that permanently alters normal anatomy or detracts from natural organic functionality.¹ It has rightly been taken as a major premise of moral reasoning that personal dignity (encompassing the right to bodily integrity and a high degree of autonomous choice) precludes medical compliance with a third-party petition for surgical intervention unless therapeutic urgency

David Lang, PhD, holds doctoral degrees in philosophy and mathematics and has taught both subjects for many years at the college level. Recently, he has held adjunct positions in mathematics at Wentworth Institute of Technology and Northeastern University in Boston, along with adjunct positions in logic at Boston College and in systematic Thomistic philosophy at Our Lady of Grace Seminary (operated by the Oblates of the Virgin Mary) in Boston.

¹ See Benedict M. Guevin, "The Principles of Informed (Proxy) Consent and Totality in the Reputable Practice of Medicine," *American Journal of Jurisprudence* 41 (1996): 189–202.

demands the involvement of a non-competent patient's kin or guardian according to an ethically correct application of the principle of totality. Since even direct requests by a patient himself for amputation of one of his own healthy bodily members should be rejected by a surgeon on ethical grounds,² *a fortiori* no one else should be permitted to authorize non-remedial surgery.³

A curious exception, however, has been made in the case of elective male infant circumcision (EMIC) since the late nineteenth century, when Victorian physicians successfully campaigned to inaugurate the practice for purportedly prophylactic reasons (both physical and spiritual) in the United States and several other predominantly Protestant countries within the British dominion.⁴ The introduction of EMIC here was anomalous, circumcision never having been a social custom in the nations of Western Christendom nor in most of the world outside the Middle East and Africa. Although the incidence of routine male infant circumcision (RMIC) declined to fairly low levels (well under 40 percent) after several decades of prevalence in England, Canada, and Australia, the rate remained high in the United States for a century (peaking at 80 to 90 percent from the late 1960s to the late 1970s and apparently stabilizing at about 60 percent from 1990 to 2002),⁵ with recent reports

²See Nicanor Pier Giorgio Austriaco, "Requests for Elective Amputation," and Edward N. Peters, "Canon Law and Apotemnophilia," in *Ethics & Medics* 36.2 (February 2011); see also John M. Haas, "The Totality and Integrity of the Body," *Ethics & Medics* 20.2 (February 1995).

³Robert S. Van Howe, "Why Does Neonatal Circumcision Persist in the United States?" in *Sexual Mutilations: A Human Tragedy*, ed. George C. Denniston and Marilyn Fayre Milos (New York: Plenum Press, 1997), 113: "The physician is all the more obligated to refuse third-party requests to perform a non-therapeutic, mutilative surgery on unconsenting individuals."

⁴Rosemary Romberg, *Circumcision: The Painful Dilemma* (South Hadley, MA: Bergin and Garvey, 1985), 96–132; David L. Gollaher, *Circumcision: A History of the World's Most Controversial Surgery* (New York: Basic Books, 2000), 73–108; Paul M. Fleiss and Frederick M. Hodges, *What Your Doctor May NOT Tell You about Circumcision* (New York: Warner Books, 2002), 118–125; Geoffrey P. Miller, "Circumcision: Cultural-Legal Analysis," *Virginia Journal of Social Policy and the Law* 9 (Spring 2002): 497–585; Leonard Glick, *Marked in Your Flesh: Circumcision from Ancient Judea to Modern America* (New York: Oxford University Press, 2005), 139–178; Robert Darby, *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain* (Chicago: University of Chicago Press, 2005), 167–310; Morris L. Sorrels, "The History of Circumcision in the United States: A Physician's Perspective," in *Male and Female Circumcision: Medical, Legal, and Ethical Considerations in Pediatric Practice*, ed. George C. Denniston, Frederick Mansfield Hodges, and Marilyn Fayre Milos (New York: Kluwer Academic/Plenum, 1999), 331–338; and World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS), *Male Circumcision: Global Trends and Determinants of Prevalence, Safety and Acceptability* (Geneva: WHO, 2007), 11.

⁵WHO, *Male Circumcision*; see also Dan Bollinger, "Normal versus Circumcised: U.S. Neonatal Male Genital Ratio," 2004, white paper, <http://www.cirp.org/library/statistics/bollinger2004/>, and http://www.circinfo.net/rates_of_circumcision.html. WHO estimates that "approximately 30% of the world's males aged 15 years or older are circumcised. Of these, around two thirds (69%) are Muslim (living mainly in Asia, the Middle East and

of a dramatic drop from 56 percent in 2006 to 33 percent in 2009.⁶ This historical puzzle raises a number of critical questions. Is EMIC truly an innocuous procedure, or is it instead an actual mutilation? Does EMIC really prevent any disease? If so, could such prophylaxis be achieved by a less drastic means than the performance of surgery on a healthy bodily organ? Is there a proportionate trade-off between the inherent injury done (along with the risks of unintended adverse consequences) and the potential benefits? When the surgery is not strictly medically indicated, do parents have the moral right to authorize it for cultural or cosmetic reasons or as a preemptive intervention against statistically possible future hazards?

The Multiple Meanings of Circumcision

Right from the start, a crucial distinction must be drawn between the modern version of so-called “circumcision” and the ancient ceremony properly called “circumcision,” which was commanded by God under the Abrahamic–Mosaic covenant as a prefiguring of the passion of Christ and the baptism of Christians. There is a grievous equivocation in predicating the term “circumcision” of two objectively different kinds of acts.⁷ The original ritual did indeed consist in simply “cutting around” (*circumcisio* in Latin and *peritomai* in Greek, as used by St. Paul in Phil. 3:3 and elsewhere), because it entailed a circumferential clipping of the protruding flap or tapered neck (the *akroposthion*) of the prepuce (the tubular sac-like sheath extending from the shaft of the penis near the coronal sulcus over the glans and usually beyond it in infants). But this cut, though painful, was merely a token truncation of the overhang tip of the foreskin, symbolizing the “circumcision of the heart, in the spirit” (Rom. 2:29) that would be perfectly fulfilled through baptism, faith, and repentance in the new law, thanks to the application of the merits of the Messiah’s redemptive suffering (Col. 2:11–13).⁸ This Old Testament rite involving a limited incision is named *brit milah* (“covenant cut”) in Hebrew.

In contrast, the version of genital surgery imported to the Anglophone countries of the West by the Victorian medical establishment was modeled on what is called in Hebrew *brit periah* (“opening” or “uncovering”), which consists in the extirpation of the prepuce in its entirety, leaving the glans completely bare. This radical procedure was instituted around the middle of the second century AD by the rabbinical overseers of post–Old Testament Judaic religious identity. Since the Greeks deemed an exposed glans indecent in gymnasias and during athletic contests conducted for men in the nude, it had become a common practice for Hellenizing Jewish males to stretch forward their residual foreskins over the glans to conform to this Greek

North Africa), 0.8% are Jewish, and 13% are non-Muslim and non-Jewish men living in the United States of America,” 7.

⁶Roni Caryn Rabin, “Steep Drop Seen in Circumcisions in U.S.,” *New York Times*, August 16, 2010, D6.

⁷Romberg, *Circumcision*, 33–44; Gollaher, *Circumcision*, 6–17; Glick, *Marked in Your Flesh*, 43–54; and Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 104. See also Darby, *Surgical Temptation*, 251.

⁸Thomas Aquinas, *Summa theologiae* I-II, q. 102, a. 5, ad 1; and III, q. 37, a. 1, ad 1–3.

standard of modesty—a method (*epispasmos*) that would not have been feasible had they not still possessed substantial preputial remnants from *milah*. Convincing scriptural evidence for this is found in 1 Maccabees 1:16, which declares, “They made themselves prepuces” (Douay-Rheims)—*preputia sibi fecerunt* according to the old Latin translation of the Septuagint. The rabbis, incensed by what they construed as a perfidious betrayal of the covenant, determined to put an end to this practice of “uncircumcision” by instituting the further process of *periah* after *milah* in every *bris*. They decreed that henceforth all circumcisions must tear off and rip away the whole prepuce from the shaft, resulting in its total removal accompanied by irreversible denudation of the glans.⁹ This drastic extension of the original act of true circumcision may correspond to what is translated as “concision” (“cutting away,” or *katatomai*) in Philippians 3:2 (Douay Rheims).

Modern circumcision (though performed in hospitals with probes, forceps, clamps, and scalpels instead of the knives and long, sharpened fingernails of mohels) is essentially *periah*, hence characterized by definite consequences that would not have manifested themselves in the simple act of *milah* in the biblical epoch before the rabbinical intervention around 150 AD. Therefore, adequately addressing the questions posed at the outset of this inquiry demands two prior tasks: first, a more elaborate examination of exactly what this brand of surgery actually accomplishes and, second, an amplified clarification of precisely what constitutes a mutilation forbidden by the natural moral law, lest accusations of begging the question be incurred.¹⁰

What the Prepuce Is and What Modern Circumcision Does to It

Some expert authors, both physicians and nonmedical researchers, have recounted in learned and wondrous detail the nature and functions of the prepuce, to disabuse the public (including, unfortunately, some uninformed medical professionals) of the misconception that the prepuce is “just a bit of extra skin” that circumcision “snips off.”¹¹

⁹Glick, *Marked in Your Flesh*, 46–47, locates textual evidence for this novel rabbinical mandate in the *Mishnah*, under the order *Moed* (“Festivals”) in the tractate *Shabbat* (“Sabbath”) in chapter 19 (Shab. 19.2). *The Jewish Encyclopedia*, which describes the steps involved in both *milah* and *periah* in its article on circumcision, is referenced by Miriam Pollack, “Circumcision: If It Isn’t Ethical, Can It Be Spiritual?” in *Circumcision and Human Rights*, ed. George C. Denniston, Frederick Mansfield Hodges, and Marilyn Fayre Milos (Dordrecht, Netherlands: Springer Science, 2009), 189–194. See <http://www.jewishencyclopedia.com/view.jsp?artid=514&letter=C&search=circumcision>.

¹⁰David Benatar and Michael Benatar, “How Not to Argue about Circumcision,” *American Journal of Bioethics* 3.2 (Spring 2003): W1, have (perhaps rightly) leveled many such charges against the critics of their original “Target” article “Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision,” *American Journal of Bioethics* 3.2 (Spring 2003): 35–48. Their papers are briefly addressed later.

¹¹Douglas Gairdner, “The Fate of the Foreskin: A Study of Circumcision,” *British Medical Journal* 2.4642 (December 24, 1949): 1433–1437; William Keith C. Morgan, “The Rape of the Phallus,” *Journal of the American Medical Association* 193.3 (July 1965):

First of all, every primate (perhaps every mammal whatsoever), both male and female, is born with a prepuce as a normal endowment, covering the *glans clitoridis* in females and the *glans penis* in males. In fact, for human males (who among all mammals are, without doubt, the most susceptible to deliberate privation of it), the prepuce is best conceived of as an integral part of a holistic penile system. It features ordinary skin (the “outer foreskin”) and a highly specialized mucous membrane (the “inner foreskin”) with its ridged band and smooth mucosa analogous to the inner surface of the eyelid, the oral cavity and lips, the nasal passages, the urethral tunnel, and the anus. The intact prepuce also has a frenulum—a ligament tethering the ridged band to the ventral aspect of the glans, similar to the labiogingival and lingual frenula inside the mouth.¹² The entire male preputial tube serves as a protective and sensory organ, containing smooth muscle tissue (the *dartos fascia*), a dense supply of blood vessels (veins and arteries), and a richly innervated network laden with at least ten thousand nerve endings.

Francisco Garcia makes some pertinent, profound distinctions in his perspicuous explication of this intricate and technical matter:

The intact penis is covered by one single continuous skin sheath or skin system. The skin sheath is partly folded at different times. This folded part of the skin system is called the foreskin or prepuce.

The fold of skin is often mistaken as a single layer, or a flap of skin. This is wrong. Instead, it is a free, two-layer fold that forms when the skin coming down the penis from the shaft folds underneath itself somewhere near the tip of the penis then travels back to an attachment point behind the glans. The two sides of the fold do not adhere to each other even though they lie flat against each other appearing to form a single flap of skin.

Also, in the adult the skin system does not adhere to the glans so it can unfold back off of the glans, leaving it fully exposed. When we speak of this skin sheath we are not talking about the surface of the glans itself in the same way that we talk about the surface of the shaft, because the glans has no real skin.

123–124; William Keith C. Morgan, “Penile Plunder,” *Medical Journal of Australia* 1.21 (May 1967): 1102–1103; J.R. Taylor, A.P. Lockwood, and A.J. Taylor, “The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision,” *British Journal of Urology* 77.2 (February 1996): 291–295; C.J. Cold and J.R. Taylor, “The Prepuce,” *British Journal of Urology* 83.suppl 1 (January 1999): 34–44; Mervyn M. Lander, “The Human Prepuce,” in Denniston and Milos, *Sexual Mutilations*, 77–83; Steve Scott, “The Anatomy and Physiology of the Human Prepuce,” in Denniston, Hodges, and Milos, *Male and Female Circumcision*, 9–18; James L. Snyder, “The Normal, Natural Penis and the Effects of Circumcision,” in Denniston, Hodges, and Milos, *Circumcision and Human Rights*, 109–119; Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 1–30; and Thomas J. Ritter and George C. Denniston, *Doctors Re-examine Circumcision* (Seattle: Third Millennium, 2002).

¹²Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 8, 36; and Ritter and Denniston, *Doctors Re-examine Circumcision*, 40–2. Lander, calls the frenulum “God’s gift to man,” depicting it as “a male’s most sensitive erogenous zone,” which is “usually excised in neonatal circumcision” (“The Human Prepuce,” 79).

When we talk about the skin covering of the glans, this can only mean the foreskin. The foreskin is its skin covering.

A significant anatomical error has been made historically and continues today in describing the penis by delineating the “foreskin” as a separate anatomical structure from the shaft skin. . . . The foreskin is not a separate anatomical structure from the rest of the skin of the penis. This is actually an artificial separation. When the word foreskin is used, rather than referring to a separate part of the penis, it means the part of the continuous skin system which happens to be folded over the glans at any given time. So there is no real anatomical border to the “foreskin.” Since the proportion of the skin system that is folded over the glans increases and decreases by folding and unfolding to various degrees all the time, we realize that “foreskin” is a poor way of describing the anatomy of the penis. Instead, more accurate terminology might be to describe that part of the skin system which covers the glans as the “forefold of the skin system.”

Unlike the false border between “foreskin” and shaft skin, there is a real anatomical border which exists in the skin system. It is between the mucosal, or non-keratinized, part of the skin system (which consists of the inner lining of the foreskin along with the surface of the glans) and the keratinized part (which is the outer penile skin, including the outer foreskin). That border is at the most distal part, or tip, of the skin system—it is the tip of the forefold.

The entire skin system moves freely. In the intact (uncircumcised) male, the penis has a low friction gliding plane immediately beneath the surface of the skin which is like no other body structure. This means that the skin of the penis does not adhere to the underlying tissue the way that skin adheres to other parts of the body. This unique quality allows the entire skin of the penis to move as a unit back and forth longitudinally or around the shaft circumferentially making it the most mobile skin in the intact male. . . . The free fold of the skin system which we call “foreskin” unfolds and re-folds constantly to varying degrees, adjusting to the current state of the penis. It is a very dynamic system. The foreskin, among other functions, provides the penis with a reservoir of skin which is needed during erection. The skin of the erect, intact penis is still mobile and loose, allowing the mucosal inner foreskin to roll back and forth over the glans.¹³

Garcia goes on to emphasize that “the foreskin is not ‘extra’ skin which protrudes from the shaft. There is no extra skin on the body—this is a silly notion.” Indeed, his assertion squares with the law of divine economy articulated by Paul in 1 Corinthians 12:14–26, a passage expounding the reciprocity of all bodily members in an ontologically cohesive unit of integral necessity.

Similarly, a paper by J. Taylor, A. Lockwood, and A. Taylor culminates in a summation evocative of this Pauline version of the law of parsimony (or “Ockham’s razor”), as applied to the mutually advantageous roles played by the preputial apparatus and adjacent parts within the whole penile system. It thus exhibits the prepuce’s irreplaceable (non-substitutable) character:

¹³Francisco Garcia, “What Exactly Is Circumcision and What Is It Not?” *Circumcision Reference Library*, December 11, 1995, <http://www.cirp.org/library/anatomy/garcia/>.

Clearly, the penis is a complex organ with many different parts, each specialized for a specific role. The prepuce provides a large and important platform for several nerves and nerve endings. . . . In short, the prepuce should be considered a structural and functional unit made up of more and less specialized parts. . . . It is generally thought that the prepuce protects the glans. However, it is equally likely that the glans shapes and protects the prepuce. In return, the glans and penile shaft gain excellent if surrogate sensitivity from the prepuce.¹⁴

The modern method of circumcision (*periah*), with its full preputial ablation (unlike *milah*), destroys the folded part of the penile skin system, obliterating the following parts: the *dartos* muscular sheath, the ridged band and smooth mucosa of the inner foreskin, sebaceous glands, blood vessels, the nervous network together with its thousands of responsive nerve endings, a large fraction (estimated between thirty and eighty percent)¹⁵ of what would have been the adult male penile epithelium, and usually the frenulum. As the authors mentioned above (and many others) explain, this operation does not remove some superficial excess skin, but rather cuts off an integral component of the male reproductive organ itself: it is essentially reductive sexual surgery.¹⁶

Moreover, when *periah* is performed on a boy before his prepuce has naturally detached from his glans and become retractile (a process that can take many years, even up to puberty, for completion), the synechial membrane adhering the preputial and glans surfaces must first be forcibly ruptured by a blunt metal probe or hemostat. This operation (called “synechotomy”) is in itself an excruciating procedure preceding any terminal excision, which will only further intensify the already unbearable pain—so traumatic that the baby may “lapse into a semi-comatose state marked by non-REM brain disturbances.”¹⁷ This apparent shock of “dissociative silence” manifests a withdrawal (from a hostile environment) that is the body’s innate defense mechanism in the face of intolerable insult.¹⁸ Only in recent years have there been serious (and somewhat successful) attempts to mitigate the suffering inherent in *periah* and its aftermath.

An immediate result of this extensive subtractive surgery is externalization of the glans (naturally designed as an internal organ), thereby initiating the constant exposure of the infant’s urethral meatus to the contaminants of diaper wastes and

¹⁴Taylor, Lockwood, and Taylor, “Prepuce,” 294.

¹⁵Ritter and Denniston, *Doctors Re-examine Circumcision*, 18–1; Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 4 and 86. According to Fleiss and Hodges, “If the average adult foreskin were unfolded and laid out flat and unstretched, it would be approximately the size of a 3 x 5 index card. Moderately stretched, it would entirely cover a man’s forehead or the back of his hand and fingers,” 4.

¹⁶Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 51.

¹⁷George Denniston, “Tyranny of the Victims,” in Denniston, Hodges, and Milos, *Male and Female Circumcision*, 222–223.

¹⁸Pollack, “Circumcision,” 191; see also Ronald Goldman, *Circumcision: The Hidden Trauma* (Boston: Vanguard Publications, 1997), 20–28, and Romberg, *Circumcision*, 283–286.

increasing the likelihood of inflammation and infection. A protective emollient substance (smegma), which keeps the glans smooth, soft, supple, and moist, is no longer secreted.¹⁹

For a mature male, a delayed adverse consequence, which accompanies keratinizing of the glans, is the gradual diminution (eventual elimination with advancing age) of erogenous sensitivity and sexual potency to the point of requiring erectile dysfunction drugs.²⁰ According to Christopher Fletcher of Doctors Opposing Circumcision, “Circumcision is not simply a little snip, but a major and brutal surgery on the most sensitive part of a male’s anatomy, with lifetime consequences for all cut boys. Erectile dysfunction, increased infections in boys, such as multi-antibiotic resistant *staphylococcus aureus* (MRSA), lack of sensitivity, etc.”²¹ A study published in the *British Journal of Urology* concludes, “Circumcision ablates the most sensitive parts of the penis.”²²

Furthermore, the loss of tissue mobility, which would have been supplied by a dynamical integumentary complex, deprives a man of a gliding, cushioning, massaging, and lubricating mechanism that would have facilitated nonabrasive coitus—a loss that is also detrimental to his wife, who may thereupon suffer from excessive dryness, soreness, and irritation.²³ The frustrating problem of needing artificial lubricants and more intense modes of stimulation has a deleterious effect on the marital harmony of “two in one flesh.”²⁴ Thus, modern circumcision has negative

¹⁹Ritter and Denniston, *Doctors Re-examine Circumcision*, 6-1-6-2.

²⁰Garcia, “What Exactly Is Circumcision?”; Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 64 and 71-72; Denniston, “Tyranny of the Victims,” in Denniston, Hodges, and Milos, *Male and Female Circumcision*, 232.

²¹Fletcher continues, “I prescribe many times more Viagra, Cialis, etc. for circumcised guys than normal men.” Undated letter, History of Circumcision Web site, <http://www.historyofcircumcision.net/index.php?option=content&task=view&id=74>.

²²Morris Sorrells et al., “Fine Touch Pressure Thresholds in the Adult Penis,” *British Journal of Urology International* 99.4 (April 2007): 864-869.

²³Kristen O’Hara with Jeffrey O’Hara, *Sex As Nature Intended It: The Most Important Thing You Need to Know about Making Love, but No One Could Tell You Until Now* (Hudson, MA: Turning Point, 2001), 52-99 and 115-170; Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 26-28 and 86-88.

²⁴O’Hara and O’Hara, *Sex As Nature Intended It*; Fleiss and Hodges, *What Your Doctor May NOT Tell You*. According to Cold and Taylor, “The increased frequency of masturbation, anal intercourse and fellatio reported by circumcised men in the USA may possibly be due to the sensory imbalance caused by circumcision. Clearly, amputation of the prepuce causes changes in sexual behaviour in human males” (“The Prepuce,” 40). Fletcher claims “The Lauman lifestyle study (University of Chicago) . . . showed that circumcised men were more likely than uncircumcised (entire) men to need anal and oral sex, girlie magazines, X-rated movies, prostitutes, sex toys, masturbation, and were more likely to get syphilis and chlamydia, all simply the end results of seeking out avenues for stimulation because of the decreased functionality from lacking a foreskin and from the scarring caused by the mutilation itself.” Moses Maimonides speculated that curtailing erotic delectation, without interfering with procreative capacity, was indeed the main practical purpose of circumcision: “The fact that circumcision weakens the faculty of sexual excitement and sometimes perhaps

ramifications for both phallic sensitivity and gentle (non-frictional) coition.²⁵ Garcia concludes, “What the operation called circumcision actually does then is to interrupt and significantly reduce the skin system of the penis to a fraction of its normal anatomical and functional extent.”²⁶ Hence, modern circumcision (*periah*) does in fact constitute the excision of a major portion of the unified penile organic system (an operation called “posthectomy”); indeed, it is referred to by the American Academy of Pediatrics (AAP) as “amputation of the foreskin.”²⁷

The General Definition of Mutilation and Conditions for Its Moral Liceity

Thomas Aquinas treats maiming in the context of possible justifications for removing (or cutting off) a bodily member.²⁸ Edwin Healy defines “mutilation” as “an action (an excision or the equivalent) by which an organic function or the use of a member of the body is partially or wholly destroyed.”²⁹ Elsewhere, he elaborates further:

The action consists of cutting out, crushing, burning, x-raying, or in some such manner directly destroying a part of the human body or of rendering an organ permanently inoperative. The mutilation may result in the suppression of an organic function—for example, the destruction of one’s vision or power of procreation—or it may consist in the amputation of an arm or a leg.³⁰

According to Austin Fagothey, “Mutilation is an action by which some part of the body is injured, destroyed, or separated from the rest of the body. The body

diminishes the pleasure is indubitable. For if at birth this member has been made to bleed and has had its covering taken away from it, it must indubitably be weakened.” *Guide of the Perplexed*, trans. by Shlomo Pines (Chicago: University of Chicago Press, 1963), 609, www.cirp.org/library/cultural/maimonides. Thomas Aquinas admits the possibility that a secondary reason for circumcision in the Old Law was a diminution of concupiscence. *Summa theologiae* I-II, q. 102, a. 5, ad 1. Similarly, according to Gollaher, among at least some Muslims a motive for male circumcision (a universal religious obligation in any case) is spiritual purification from carnal uncleanness, along with hygienic physical reasons. Although Islamic cutting rituals are variable, they tend to be more conservative than *periah*, preserving more preputial tissue (perhaps along with the frenulum) (*Circumcision*, 44–52). The Jewish Encyclopedia admits this difference between the two rituals in its article on circumcision, <http://www.jewishencyclopedia.com/view.jsp?artid=514&letter=C&search=circumcision#1807#ixzz1IG15GA>. Regarding “tightness” of cut, see also <http://www.circlist.com/styles/page3.html>.

²⁵Morgan, “Rape of the Phallus,” 124; Morgan, “Penile Plunder,” 1103; and Gerard Zwang, “Functional and Erotic Consequences of Sexual Mutilation,” in Denniston and Milos, *Sexual Mutilations*, 71–72.

²⁶Garcia, “What Exactly Is Circumcision?”

²⁷Task Force on Circumcision, American Academy of Pediatrics (AAP), “Circumcision Policy Statement,” *Pediatrics* 103.3 (March 1999, reaffirmed September 2005): 686–693, <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;103/3/686>. See Ritter and Denniston, *Doctors Re-examine Circumcision*, 2-1–2-6.

²⁸*Summa theologiae* II-II, q. 65, a. 1, c, ad 1–3.

²⁹Edwin F. Healy, *Moral Guidance* (Chicago: Loyola University Press, 1942), 156.

³⁰Edwin F. Healy, *Medical Ethics* (Chicago: Loyola University Press, 1956), 121.

is mutilated not only by cutting away some organ or member, but also by rendering useless some function or ability.”³¹ Martin O’Keefe defines “mutilation” as “some act by which a part of the body is permanently injured or destroyed.”³² Thomas O’Donnell states that “the medical-moral definition [of mutilation] is simply: ‘the removal of an organ or the suppression of its function.’”³³ Edward Hayes and colleagues characterize mutilation as “any lessening of the integrity of the human body,” but distinguish further, subdividing it into a “major” or “strict sense” (destructive of functional integrity) and a “minor” or “broad sense” (non-destructive of functional integrity).³⁴ Christopher Kaczor expands on this definition:

By “mutilation” I mean the *intentional* destruction or removal of an organ (or other *vital* body part) that inhibits the function that the organ has *or will likely have* in maintaining the health of the one possessing the organ. The removal or destruction must be *intentional*, rather than a foreseen side effect of the action, since the foreseen side effects of action do not define an action as a certain kind of action. Further, removing body parts *simpliciter*, such as trimming finger nails, is not mutilation, since they are not *vital* parts, parts necessary for the healthy functioning of the organism. Further, removing organs that are not now but will likely in the future inhibit health (such as a mastectomy upon discovery of precancerous growths) also is not mutilation.³⁵

Perhaps a succinct all-encompassing definition would be that mutilation is the deliberate infliction of organic injury on a healthy bodily part (including its removal) that causes a foreseen direct loss (whether actually or potentially permanent) of normal physical functioning. Thus, as Kaczor notes, clipping long finger nails or head hair would not constitute mutilation under this definition, since no organic damage with loss of normal function results from their removal, as they consist of essentially dead (keratinized) tissue and will grow back anyway. On the other hand, it *would* be mutilation to uproot a child’s hair follicles or tear nails out of their underlying beds in a deliberate fashion. Committing either of these deeds can be foreseen to disrupt in a causally direct manner the body’s natural state of well-being and to bring about disfigurement: the former rendering the child irreversibly bald (with all that entails, including probable emotional torment) and the latter exposing the child’s delicate mucous membranes to loss of a natural protective shield (even if the area later becomes calloused over and toughened again, it derogates from comeliness).

³¹ Austin Fagothey, *Right and Reason*, 2nd ed. (St. Louis: C.V. Mosby, 1959), 301.

³² Martin D. O’Keefe, *Known from the Things That Are: Fundamental Theory of the Moral Life* (Houston: Center for Thomistic Studies, 1987), 208.

³³ Thomas J. O’Donnell, *Medicine and Christian Morality* (New York: Alba House, 1976), 65–66.

³⁴ Edward J. Hayes et al., *Catholicism and Ethics* (Norwood, MA: C. R. Publications, 1997), 153–154.

³⁵ Christopher Kaczor, “The Ethics of Ectopic Pregnancy: A Critical Reconsideration of Salpingostomy and Methotrexate,” *Linacre Quarterly* 76.3 (August 2009): 275, original emphasis.

As is commonly known, Catholic moral theology down through the centuries has developed some sophisticated intellectual tools to resolve quandaries about issues of mutilation—the main ones being the principles of integrity and totality (and charity insofar as it does not militate against these).³⁶ There are some key magisterial pronouncements invoking both the principles of integrity and totality, which, though conjoined in these declarations, are distinguishable premises in moral reasoning:

1. Pope Benedict XIV: “The amputation of any part of the human body is never legal, except when the entire body cannot be saved from destruction by any other method.”³⁷
2. Pope Pius XI: “Christian doctrine establishes, and the light of human reason makes it most clear, that private individuals have no other power over the members of their own bodies than that which pertains to their natural ends; and they are not free to destroy or mutilate their members, or in any other way render themselves unfit for their natural functions, except when no other provision can be made for the good of the whole body.”³⁸
3. Pope Pius XII (clarifying the range of applicability of the principle of totality): “The decisive point here is not that the organ that is removed or rendered functionless is itself diseased, but that its preservation or its function entails either directly or indirectly a serious threat to the whole body. It is quite possible that by its normal functioning a healthy organ may exercise an influence of such a nature on a diseased organ as to aggravate the disease and its consequences throughout the whole body. It can also happen that the removal of a healthy organ and the suppression of its normal functioning will remove from a disease, cancer, for example, its field of growth, or, in any case, essentially change the conditions of its existence. If there is no other means at our disposal, surgical intervention on the healthy organ is permitted in both cases. The conclusion that we have reached is deduced from the right of disposition that man has received from the Creator in regard to his own body, in accord with the principle of totality, which is valid here also, and in virtue of which each particular organ is subordinated to the whole body and must yield to it in case of conflict.”³⁹
4. The *Catechism of the Catholic Church*, n. 2297: “Except when performed for strictly therapeutic medical reasons, directly intended amputations, mutilations, and sterilizations performed on innocent persons are against the moral law.”

³⁶For example, see Germain Kopaczynski, “Totality and Integrity,” in *Catholic Health Care Ethics: A Manual for Practitioners*, 2nd ed., ed. Edward J. Furton with Peter J. Cataldo and Albert S. Moraczewski (Philadelphia: National Catholic Bioethics Center, 2009), 13–15.

³⁷Benedict XIV, *De synodo dioecessana* (1760), xi. 7.1, col. 1283.

³⁸Pius XI, *Casti connubii* (December 31, 1930), quoted in O’Donnell, *Medicine and Christian Morality*, 67.

³⁹Pius XII, Address to 26th Congress of Italian Association of Urology, *AAS* 45 (1953), 674–675, quoted in O’Donnell, *Medicine and Christian Morality*, 69–70.

5. The United States Conference of Catholic Bishops: “All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity. The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available. . . . The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side effects can be justified only by a proportionate benefit to the patient.”⁴⁰

All of these magisterial teachings make provision for therapeutic *physical* reasons for surgical intervention. None of them make allowance for the *spiritual* (i.e., morally preventive) aims motivating noble Victorian physicians to advocate the standard practice of circumcising all male babies—routine surgery whose ethical rationale seems implicitly to invoke the utilitarian premise that beneficial consequences (i.e., less available flesh for boys to experience potential carnal “irritation” or erotic excitation) are sufficient to justify the means employed.

Is EMIC a Medically Warranted Mutilation?

If the account given in the section on the nature of the prepuce (and how modern circumcision affects it) is accurate about the devastating trauma that this operation inflicts on the natural functioning of this normal organic network (the dynamic preputial system of skin, mucosa, blood vessels, muscle, and nerves), then it logically follows from the definition of mutilation adopted in the preceding section that intentional extirpation of it (as in male infant circumcision via *periah*) qualifies as a genuine mutilation. The question now is whether such routine surgery on male newborns can be defended as ethically legitimate. Since nearly everyone on both sides of the dispute grants at least the theoretical possibility that this medical intervention has potentially good and bad results (either or both arising at *some* point in time), an application of the principle of double-effect (PDE) would seem to be in order. According to this principle, (1) the medical intervention must be morally good (or at least neutral) in itself; (2) any negative consequences must not be directly intended but rather merely tolerated; (3) any beneficial results must not be caused by means of any of the harmful effects but instead must flow from the operation itself; and (4) there must be a prudentially sufficient reason to permit any evil effects (or a reasonably adequate proportion between the benefits and drawbacks).

Although in the abstract the procedure of complete posthectomy (*periah*) is certainly morally neutral (since it may need to be performed for genuinely curative reasons in the case of pathology or injury), the problem here is whether modern child circumcision taken concretely is indeed morally indifferent when it is elective, especially when it becomes a virtually automatic (or “routine”) operation on a non-consenting individual. According to the medical ethics subsumed under Catholic moral theology (as articulated in the magisterial pronouncements cited in the previous

⁴⁰U. S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), nn. 29 and 33.

section), the ethical permissibility of such regular mutilation could be defended on the basis of the principle of totality if there were a persistent (or “routine”) threat of adverse consequences stemming from the prepuce and afflicting (with prudential certitude) a virtually universal class of male babies—an abnormal state that could not be countered, for practical purposes, by a more conservative approach, which would of course be the ideal solution given the immense (though not absolute) good of preserving natural bodily integrity. Then the first condition of the PDE would be satisfied, but this hypothesis assumes a great deal (it concedes a so-called “big if”). On the other hand, it could turn out that this species of act (EMIC taken concretely in its ordinary circumstantial manifestations) has an intrinsically disordered objective end (aside from the further subjective motives of the agents, such as putative prophylactic or cosmetic benefits), thus derogating from its moral neutrality and rendering it inherently unethical. Therefore, it must be further explored whether the justification of an adverse situation obtains, or could plausibly obtain, in the real world.

For the second condition of the PDE, it can be presumed that no parent or doctor would intend direct harm to an infant already allowed to be born (contrary to a case of procured abortion, especially “partial-birth” abortion). The third condition of the PDE is clearly met by the benefits usually extolled as deriving from preputial removal. As is fairly typical in controversies over an act that, though morally neutral, has multiple side effects (some good and some bad), the fourth condition presents some serious difficulties for examination and resolution.

With regard to the fourth condition of the PDE, both proponents and opponents of EMIC juggle statistics and bandy studies back and forth, the former touting the surgery’s advantages (along with parental prerogatives to “act in the best interests of their son”) and the latter highlighting its risks and deleterious consequences (along with a child’s right to self-determination at an age when he can give informed consent). Confronted with conflicting data, the American Academy of Pediatrics (AAP) has in recent years attempted to balance both positions (or sought a compromise between them) by asserting that RMIC is nontherapeutic (“not essential to the child’s current well-being”) despite “potential medical benefits” that must be weighed by the parents, who are delegated to make the final decision:

Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision. In circumstances in which there are potential benefits and risks, yet the procedure is not essential to the child’s current well-being, parents should determine what is in the best interest of the child.⁴¹

Interestingly, fifteen years earlier the AAP was more forthright (even apodictic) in admitting the damage done by circumcision:

The glans at birth is delicate and easily irritated by urine and feces. The foreskin shields the glans; with circumcision this protection is lost. In such cases, the glans and especially the urinary opening (meatus) may become irritated or infected, causing ulcers, meatitis (inflammation of the meatus), and meatal stenosis (a narrowing of the urinary opening). Such problems

⁴¹See AAP, Task Force on Circumcision, “Circumcision Policy Statement.”

virtually never occur in uncircumcised penises. The foreskin protects the glans throughout life.⁴²

While the American Medical Association ultimately deferred to the AAP's 1999 (and implicitly 1989) statement, it released its own cautionary paper⁴³ with amplifications and qualifications. For instance, the AMA report notes that "recent policy statements issued by professional societies representing Australian, Canadian, and American pediatricians do not recommend routine circumcision of male newborns." It informs the reader, "In a joint publication with the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists (ACOG) concluded in 1997 that 'newborn circumcision is an elective procedure to be performed at the request of the parents on baby boys who are physiologically and clinically stable.'" It observes that the 1989 AAP statement, of which the 1999 statement was a modification, "reversed a long-standing opinion that medical indications for routine circumcision were lacking. It emerged primarily on the basis of data that suggested circumcision caused a large reduction in the risk of urinary tract infections [UTIs], particularly within the first year of life." The AMA report then enters into a discussion of a "risk-benefit analysis" in the midst of the "debate on the wisdom of routine circumcision," which "centers on the possible benefits offered by circumcision and whether they medically justify the risks associated with the procedure." The usual litany of ills is enumerated (phimosis, paraphimosis, balanitis, penile cancer in adult males, sexually transmitted diseases, and HIV/AIDS). But RMIC, insofar as it targets the very ailment (UTI) for which the AMA report contends that the AAP reversed its stance, is now questioned:

There is little doubt that the uncircumcised infant is at higher risk for urinary tract infection (UTI), although the magnitude of this risk is debatable. . . . The reliability of many studies examining circumcision status and UTI in infant males is weakened by lack of controls. . . . Despite the increased relative risk in uncircumcised infants, the absolute incidence of UTI is small in this population (0.4%–1%). Depending on the model employed, approximately 100 to 200 circumcisions would need to be performed to prevent 1 [one] UTI. In this case, a large relative risk reduction translates into a small absolute risk reduction because the baseline prevalence is low. One model of decision analysis concluded that the incidence of UTI would have to be substantially higher in uncircumcised males to justify circumcision as a preventive measure against this condition.⁴⁴

What the AMA report does *not* stress outright (though the authors are undoubtedly aware of it) is that this relatively rare illness can be treated with antibiotics in the comparatively few cases where it is contracted, thus rendering precautionary surgery

⁴²AAP, *Care of the Uncircumcised Penis: Guidelines for Parents* pamphlet (Elk Grove Village, IL: AAP, 1984).

⁴³Council on Scientific Affairs of the American Medical Association, "Report 10: Neonatal Circumcision" (Chicago: AMA, 1999).

⁴⁴Ibid.

utterly otiose.⁴⁵ Moreover, there is a double-standard afoot, because baby girls are far more prone to UTI than either cohort of baby boys (whether circumcised or not), yet there is no suggestion proffered (at least not in Western countries) for any form (however mitigated) of female circumcision.⁴⁶

Modern circumcision itself has potential complications more grievous than whatever theoretical benefits may accrue for the prevention of UTI, such as hemorrhage, glans disfigurement, penile ablation, and even death (as well as the meatal ulceration and meatal stenosis long recognized by the AAP).⁴⁷ In fact, to its credit, the AMA report recognizes these baneful possible sequelae, mentioning “bleeding and infection, occasionally leading to sepsis . . . taking too much skin from the penile shaft causing denudation or . . . concealed penis . . . formation of skin bridges between the penile shaft and glans, meatitis and meatal stenosis, chordee, inclusion cysts in the circumcision line, lymphedema, hypospadias and epispadias, and urinary retention.” It continues by noting that “case reports have associated circumcision with other rare but severe events including scalded skin syndrome, necrotizing fasciitis, sepsis and meningitis, urethrocutaneous fistulas, necrosis (secondary to cauterization), and partial amputation of the glans penis.”⁴⁸

As for the remaining prophylactic benefits allegedly deriving from RMIC, the UN World Health Organization avers, “Male circumcision is medically indicated for only a few conditions. There is substantial evidence that circumcised men have a lower risk of some reproductive tract infections, as well as penile cancer, but some of these conditions are rare while others are uncommon or treatable, and routine

⁴⁵Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 154–156; Glick, *Marked in Your Flesh*, 275; and Ronald Goldman, *Questioning Circumcision: A Jewish Perspective* (Boston: Vanguard Publications, 1998), 18–19.

⁴⁶Edward Wallerstein, “Circumcision: Information, Misinformation, Disinformation,” in Denniston, Hodges, and Milos, *Male and Female Circumcision*, 507–517. Critiquing Thomas Wiswell (and implicitly his ardent disciple Edgar Schoen), who promoted RMIC for prophylaxis against UTI in contending that “preputial folds that are not amenable to ordinary cleaning may harbor great quantities of bacteria,” thus proving that “the uncircumcised male urethra is more exposed to the contaminating fecal flora,” Wallerstein retorts, “These words could equally describe the potential problem with the external genitalia of females. Do Wiswell *et al.* recommend female circumcision and/or vulvectomy?” (516). Of course, in answer to Wallerstein’s rhetorical question, they do not advise it because in the West it would be deemed female genital mutilation and condemned. But this rightly antagonistic stance toward female genital mutilation evokes wonder why justifications for EMIC are so vigorously propounded and relentlessly pursued among certain quarters in the United States and a few other countries outside Western Christendom. Glick echoes Wallerstein’s rejoinder: “Although girls are far more likely than boys to develop a UTI, no one proposes ‘corrective’ surgery to protect them” (*Marked in Your Flesh*, 275).

⁴⁷Gairdner, “The Fate of the Foreskin”; Romberg, *Circumcision: The Painful Dilemma*, 198–234; Gollaher, *Circumcision: A History*, 152–157; Ritter and Denniston, *Doctors Re-examine Circumcision*, 5-1–5-5 and 32-1; Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 51–82; and Denniston, “Tyranny of the Victims,” in Denniston, Hodges, and Milos, *Male and Female Circumcision*, 230.

⁴⁸AMA, “Report 10.”

neonatal circumcision is not currently recommended on medical grounds.”⁴⁹ The AMA report itself concludes that “because this disease [penile carcinoma] is rare and occurs later in life, the use of circumcision as a preventive practice is not justified. . . . The low incidence of urinary tract infections and penile cancer mitigates the potential medical benefits compared with the risks of circumcision.”⁵⁰

Yet the controversy continues unabated, with statistical correlations put forward by proponents and refuted by opponents. As with UTI, opponents maintain (concurring with statements of the World Health Organization and the AMA) that penile cancer is rare anyway; furthermore, its incidence among elderly men in the circumcising United States is roughly the same as in non-circumcising Europe and is related more to proper hygiene than the mere presence of a foreskin.⁵¹ RMIC advocates reply that the foreskin is a primary site of this sort of carcinoma, which could be impeded with a nearly absolute guarantee by RMIC. Even if this claim were true, it would seem to prove too much. William Morgan points out that “cancer of the tongue occurs only in those subjects with tongues, and the possibility of developing glossal cancer can hardly be used as a pretext to prophylactically remove this organ.” He goes on to assert that “appendicitis is responsible for many more deaths than is penile cancer, but routine appendectomy is not yet the rule and is unlikely to become so”; in addition (quoting the verdict of V.F. Marshall), “if cancer prevention is to be an end in itself, then bilateral simple mastectomy in female infants would probably be an even more effective measure.”⁵²

There is an analogous situation with regard to sexually transmitted diseases and AIDS. On the one hand, the WHO states, “Promotion of male circumcision for medical benefit has always been controversial, largely due to the lack of evidence for a strong protective effect of male circumcision against common diseases. However, there is now conclusive evidence that male circumcision significantly reduces risk of HIV infection in men.”⁵³ But, even if this claim were true in places such as Africa, demonstration of circumcision’s power to prevent AIDS is woefully deficient within the developed nations. For example, the United States has one of the highest infant circumcision rates on earth as well as one of the highest rates of HIV infection among advanced nations, whereas non-circumcising European countries have the lowest incidence of AIDS.⁵⁴ Moreover, the most that would follow (according to secular norms) from the WHO reasoning is that, if the prepuce is really a harbor for infectious microorganisms, then males who have attained puberty and intend to indulge in sexual encounters should be willing to submit to a foreskin shearing ahead of time. Paul Fleiss and Frederick Hodges, along with David Gollaher, find fundamental

⁴⁹WHO, “Male Circumcision,” 21.

⁵⁰AMA, “Report 10.”

⁵¹See Romberg, *Circumcision*, 235–249, especially the comparative chart on 241 showing the distribution of penile cancer rates across various countries.

⁵²Morgan, “Penile Plunder,” 1102.

⁵³WHO, “Male Circumcision,” 29.

⁵⁴See Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 159–160. This is a well-known fact.

flaws in such African AIDS studies, faulting their failure to control for confounding variables. Anyway, it is hard to discern how the issue of EMIC in general is being addressed at all here, especially in light of the earlier WHO statement that “routine neonatal circumcision is not currently recommended on medical grounds.”⁵⁵ In any event, AIDS in the United States (and probably elsewhere) is a disease inexorably linked to the real culprit of unhealthy lifestyle choices and unsanitary living conditions, all of which are independent of the innocent presence of a prepuce.⁵⁶

On the other hand, counterbalancing the WHO document, AMA’s “Report 10” states,

At least 16 studies have examined the relationship between circumcision and sexually transmissible diseases other than HIV. In general, circumcised individuals appear to have somewhat lower susceptibility to acquiring chancroid and syphilis, possibly genital herpes, and gonorrhea compared to individuals in whom the foreskin is intact. The available data on nongonococcal urethritis and genital warts are inconclusive. Regardless of these findings, behavioral factors are far more important risk factors for acquisition of HIV and other sexually transmissible diseases than circumcision status, and circumcision cannot be responsibly viewed as “protecting” against such infections. . . . In the case of sexual transmission of HIV, behavioral factors are far more important in preventing these infections than the presence or absence of a foreskin.⁵⁷

Thus, rather than looking to RMIC as a preventive remedy for the scourges of sexually transmitted diseases and AIDS, governments and other organizations devoted to public health and safety would do better to persuade the populace to act more responsibly, remaining abstinent until monogamous (heterosexual) marriage. Moreover, performing this reductive surgery on a boy for reasons inextricably connected with promiscuous erotic activity—a youth who may never even engage in sexual intercourse in the future (God alone knows)—seems egregiously unethical, since it compels him to sacrifice his bodily integrity on the basis of the anticipated misconduct of other members of society.

UTIs, penile cancer, sexually transmitted diseases, and AIDS are the main contemporary maladies most often put forward to legitimize RMIC. In the past, phimosis, paraphimosis, poor hygiene, and cervical cancer (in female partners of uncircumcised males) were frequently cited. Douglas Gairdner’s landmark 1949 paper in the *British Medical Journal* settled these matters to the satisfaction of England, where the RMIC rate plummeted to the single digits (close to nil) within

⁵⁵WHO, “Male Circumcision,” 21.

⁵⁶Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 156–167; Gollaher, *Circumcision*, 149–152; Ritter and Denniston, *Doctors Re-examine Circumcision*, 33–1–33–2. Fleiss and Hodges accuse Aaron Fink of inventing the myth of a correlation between AIDS and an intact foreskin, claiming that he was a “militant crusader for compulsory newborn circumcision” who strove to promote “mass involuntary circumcision of American males” (159). Also see Matthew Hanley and Jokin de Irala, “Utility and the African Tradition: The Vanishing Customs of the Continent,” *Ethics & Medics* 35.11 (November 2010).

⁵⁷AMA, “Report 10.”

a few years of its publication.⁵⁸ (This ground-breaking article was mostly ignored in the United States.⁵⁹) Thanks to Gairdner's pioneering efforts and those of other medical researchers, it is now well known that so-called congenital phimosis is in reality a perfectly normal state of the prepuce in boys, whose foreskins may take many years to reach a point where they can be fully retracted. Cases of genuinely pathological phimosis in older males are uncommon and can frequently be remedied by corticosteroid creams or conservative surgery (such as a dorsal slit that spares much of the prepuce). Even the rare disease BXO (balanitis xerotica obliterans) can sometimes be treated conservatively, making routine preventive circumcision pointless.⁶⁰ Paraphimosis (foreskin dislocation), as Gairdner pointed out, is actually often caused by forcible attempts at premature retraction for the sake of "cleanliness," potentially leading to adhesions for which therapeutic circumcision may be suggested by well-meaning doctors (a kind of self-fulfilling prophecy). But Fleiss recommends trying simpler corrective measures first, and warns against a dorsal slit to remedy the dislocation.⁶¹

Lastly, according to Fleiss and Hodges, "The myth that male circumcision prevents cervical cancer in females was disproved long ago."⁶² Morgan corroborates this judgment by listing a series of negative studies that had appeared prior to the time of his own article.⁶³ Romberg devotes an entire chapter of her book to questioning and finally dispelling this thesis.⁶⁴

One of the most preposterous pretexts adduced for EMIC (beyond the aesthetic custom of "resembling" a son with his father or brother or classmates) was hygiene. As Gollaher remarks, in the early nineteenth century before a circumcision frenzy seized control of the American mentality, few people bathed regularly; paradoxically, however, just when indoor running water was becoming widely available, the Victorian medical establishment began urging RMIC for the sake of cleanliness (for both physical and moral ends).⁶⁵ Of course, surgery seems a drastic substitute for

⁵⁸Gairdner, "Fate of the Foreskin"; Gollaher, *Circumcision*, 114–117; and Darby, *Surgical Temptation*, 308–313.

⁵⁹Nevertheless, about twenty years later the AMA published something akin to an American sequel to Gairdner. See E. Noel Preston, "Whither the Foreskin? A Consideration of Routine Neonatal Circumcision," *Journal of the American Medical Association* 213.11 (September 1970): 1853–1858, in which the author similarly discredits various pretexts for EMIC.

⁶⁰Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 206–207.

⁶¹*Ibid.*, 204–206.

⁶²*Ibid.*, 174–176.

⁶³Morgan, "Jones and McDonald (1955), Boyd and Doll (1964) and Stern and Dixon (1961) have all been unable to demonstrate that circumcision in anyway prevents the development of carcinoma of the cervix" ("Penile Plunder," 1102).

⁶⁴Romberg, *Circumcision*, 259–276.

⁶⁵Gollaher, *Circumcision*, 86–88. In "Penile Plunder," Morgan alludes to the fact that some have tried to justify routine circumcision based on the problem of intact soldiers

plain water and mild soap.⁶⁶ But by this time in the evolution of British-American medical thinking, the foreskin and its secretions (especially the emollient smegma, which came to be perceived as carcinogenic) had been (in Robert Darby's terminology) "demonized."⁶⁷ Although the RMIC era ended in England in the mid-twentieth century (and somewhat later in other Anglophone lands), it has persisted into the twenty-first century in America. Darby theorizes a "sorcerer's apprentice" effect, wherein the master's disciples have learned well the incantation for the original spell, but once the magical energy has been unleashed for a long time with a certain self-propelling momentum, they have no idea how to reverse the runaway forces.⁶⁸

In an effort to determine whether the fourth condition of the PDE has been fulfilled, pro and con argumentation based on epidemiological statistical analysis can take us only so far. Medically and morally, the burden of proof would seem to rest on those who advocate prophylactic (nontherapeutic) interference with normal anatomy and physiology to demonstrate why the disruption is justified, instead of maintaining a *laissez-faire* attitude toward the prepuce. This ethical onus remains despite the aura of custom that RMIC (*periah*) has assumed in America. Although the risks of EMIC seem not to compensate for its supposed benefits according to official statements of organizations such as the WHO and the AMA (along with various national medical associations in other English-speaking countries where RMIC once held sway), some defenders of EMIC may still demur. Let us therefore return to the first condition of the PDE by undertaking a more profound examination of the "big if" issue (left suspended earlier) with the aid of the implements of philosophical ethics and moral theology.

getting sand in their foreskins when fighting in desert wars (1103). He does not respond with this particular retort, but the only sand that most boys will ever experience is in the sandbox or at the beach.

⁶⁶Morgan notes, "Perhaps the most fatuous reason advanced for the operation is that the uncircumcised penis is less hygienic. Soap and water work wonders with the body's other orifices and appendages and there would seem no reason to doubt their efficacy with respect to the foreskin. The pinnae also collect dirt but removal of the external ears does not find favor as a routine measure of hygiene." ("Rape of the Phallus," 123). See also Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 167–170. Denniston and Ritter express outrage over the hygiene canard: "It's an insult to presume that a child who would grow up to trim his fingernails, blow his nose, brush his teeth, and clean his anus would be too stupid to learn how to retract the foreskin and to wash the glans penis—a procedure no more difficult nor demanding in time than washing a finger," *Doctors Re-examine Circumcision*, 8-1. In fact, in their 1984 pamphlet *Care of the Uncircumcised Penis: Guidelines for Parents*, the AAP said much the same thing: "Care of the uncircumcised boy is quite easy. 'Leave it alone' is good advice. External washing and rinsing on a daily basis is all that is required. Do not retract the foreskin in an infant, as it is almost always attached to the glans. Forcing the foreskin back may harm the penis, causing pain, bleeding, and possibly adhesions. The natural separation of the foreskin from the glans may take many years."

⁶⁷Darby, *Surgical Temptation*, 236–259.

⁶⁸*Ibid.*, 315.

Is EMIC an Ethically Defensible Mutilation?

Not many Catholic moralists who treat mutilation in light of the principles of integrity, totality, and charity explicitly address EMIC. What conclusions are reached by those who do discuss it?

Under the heading “Circumcision of the Newborn,” Thomas O’Donnell first defines circumcision as “the surgical removal of the distal part of the prepuce of the glans penis” and then concludes that it is “obviously a justified surgical procedure when redundant foreskin interferes with micturation.”⁶⁹ This calls for several comments. First, O’Donnell is actually defining the clipping of the *akroposthion* (in *milah*) instead of true posthectomy (or *periah*), which is the complete preputial amputation characterizing modern circumcision. Second, there is no such thing as “redundant foreskin”; this is an outmoded notion from Victorian medical biology, which failed to appreciate its essential functions. Third, it is true that surgery would be ethically permissible in the therapeutic situation he envisions, but more conservative treatment may be available for this sort of phimosis.⁷⁰ Next, he cites with approval the views of Gerald Kelly, who holds that “the mutilation is slight (in fact, many moralists would not designate it as a mutilation).” For this reason and because “many doctors consider routine circumcision advisable unless there are contrary indications,” Kelly believes (and O’Donnell agrees) that “our hospitals are justified in adopting a tolerant attitude toward these doctors.” Of course, *milah* (if that is what he is indeed referring to) is not a mutilation, since it does not detract from normal organic functioning, but both moralists seem unaware of the crucial distinction between it and *periah*. It is troubling, moreover, that performing surgery is their default position, with a healthy foreskin (however much of it they mean) slated for eradication, its preservation assured only when surgery is contraindicated. Their thinking, inherited from the Victorian period and its aftermath, offers nothing new, boiling down to the same prophylactic concerns already refuted (preventing penile cancer, cervical cancer, and poor personal hygiene).⁷¹

⁶⁹O’Donnell, *Medicine and Christian Morality*, 75.

⁷⁰It was a case of phimosis hampering urination that drove the parents of identical twins Bruce and Brian Reimer to consent to the circumcision (posthectomy) of their sons. But because a catastrophic accident with an electrocautery machine during the first surgery (Bruce’s) caused penile charring, the medical team decided not to circumcise Brian. Brian’s urinary difficulty cleared up on its own without any surgery at all. Because of the damage to Bruce, the parents made the regrettable decision to subject him to feminizing genitoplasty and attempted to raise him as a girl named Brenda. However, he rebelled and later tried to reverse the so-called transgender process, changing his name to David. Both boys had utterly miserable lives. Brian died of a “toxic combination of antidepressants and alcohol” (ruled accidental) in 2002, and David committed suicide two years later. The tragic story is narrated by John Colapinto, in *As Nature Made Him: The Boy Who Was Raised as a Girl* (New York: Harper Perennial, 2006). Such possible iatrogenic calamity cannot be discounted when parents consider having *periah* performed on an infant.

⁷¹O’Donnell, *Medicine and Christian Morality*, 75–77.

Edwin Healy holds the diametrically opposite view. His default position is to omit the operation “unless there is a positive indication for circumcision.” His reasoning (evidently carried out in light of the fourth condition of the PDE) is that the possible complications, though remote, “would not be justified unless there were present a compensating reason.”⁷²

Hayes and colleagues, after quickly summarizing basic general reasons for and against RMIC, simply conclude, “The arguments in favor of elective circumcision seem rather weak to us.”⁷³

John Dietzen condemns EMIC as objectively immoral, based on the principle of integrity:

“While nontherapeutic male circumcision remains common in some places, as a general practice it is forbidden in Catholic teaching for more basic reasons of respect for bodily integrity. . . . It is an amputation and mutilation. . . . The above basic principles . . . clearly render it immoral. It violates the bodily integrity of infant male children and unnecessarily deprives them of a part of their body that can protect the glans of the penis during infancy and serve at least a sexual function for adults. . . . The procedure might be carried out in some places rather routinely, even if it is not what the child needs and no curative or remedial reason renders it ethical.”⁷⁴

Michael and David Benatar, though not Catholic themselves, have stirred up a controversy among Catholics. These brothers argue against the “polar” positions of the pro and con camps in the EMIC debate. Since (according to their findings) the overall benefits of EMIC somewhat outweigh its drawbacks, the ultimate decision (according to them) should be left to parental judgment: “We conclude that nontherapeutic circumcision of infant boys is a suitable matter for parental discretion.” In other words, for them it is ethically indifferent, so there is no moral problem regardless of which option parents choose. One enlightening section of their article critiques the double standard of Western antipathy toward even the most mitigated form of female circumcision (mere removal of the clitoral prepuce), showing that for the sake of consistency this cultural bias should be challenged to place the mildest versions of male and female circumcision on equal footing.⁷⁵ In replying to the interlocutors of their original *American Journal of Bioethics* article (mostly on the anti-EMIC side and thus critical in a pejorative sense),⁷⁶ the Benatars note that John Paul Slosar and

⁷²Healy, *Medical Ethics*, 128–129.

⁷³Hayes, *Catholicism and Ethics*, 155.

⁷⁴John J. Dietzen, “The Morality of Circumcision,” *The Tablet*, Diocese of Brooklyn, October 30, 2004, 33.

⁷⁵Michael Benatar and David Benatar, “Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision,” *American Journal of Bioethics* 3.2 (Spring 2003): 35–48.

⁷⁶Benatar and Benatar, “How Not to Argue about Circumcision,” W1.

Daniel O'Brien, two Catholic ethicists, concur with their reasoning about the moral permissibility of EMIC.⁷⁷

In rebuttal to the main conclusion drawn by the Benatars, Peter Clark (not one of the initial interlocutors) responds by articulating three key principles violated by EMIC: (1) respect for persons (“a requirement to acknowledge autonomy and a requirement to protect those with diminished autonomy”), (2) beneficence (which encompasses maximizing good for another and minimizing harm, entailing non-maleficence that is equivalent to “*primum non nocere*”), and (3) justice (which honors the right due to an individual for retention of his own bodily possessions).⁷⁸

If this operation were altruistic, say conveying a tissue graft to a recipient bereft of a prepuce, an argument could be made that it is justified by charity, provided the donor had no need of it himself. This would have to be assured, since (unlike the kidneys) the prepuce is not a paired organ and since (unlike bone marrow) it does not grow back. Aside from the fact that this sort of direct transplantation may not be feasible, there is no way to know whether a young prospective donor would ever make use of it in future coitus, but surely he (like every other child) would need it to keep his own glans covered and protected—unless he did not need it only because he was on the verge of death, in which case standard ethical precepts governing organ donation would apply. But all this is far removed from what really happens in EMIC. The only organ “donation” that actually transpires is the expropriation of amputated foreskins acquired through cooperating hospitals by biotechnology companies that profit commercially from the development of products derived from human prepuces.⁷⁹ It may be protested that the social collective (and ultimately individual members) would benefit from research on excised foreskins, but such utilitarian pragmatism transgresses against the dignity of the human person, who ought not be treated as a mere thing of material use by others—in this case, being made a victim of theft by taking one of his valuable bodily parts (without compensation, no less). A nihilistic objection might be that none of this matters anyway (get over it, who really cares about circumcision?), because the prepuce is not a vital organ. True enough (in the sense that its suppression does not usually lead to death), but this rejoinder incorporates the fallacy of proving too much, implying consequences too repugnant to embrace. There are many non-vital organs that are dispensable (i.e., one could live a long life without them), yet no one recommends their routine removal. Indeed, some non-vital organs (such as the tonsils, the appendix, the prostate, and the mammary glands) display a far greater propensity to disease than the

⁷⁷John Paul Slosar and Daniel O'Brien, “The Ethics of Neonatal Male Circumcision: A Catholic Perspective,” *American Journal of Bioethics* 3.2 (Spring 2003): 62–64.

⁷⁸Peter A. Clark, “To Circumcise or Not to Circumcise?” *Health Progress* 87.5 (September–October 2006): 30–39.

⁷⁹According to Paul M. Fleiss, “Human foreskins are in great demand for any number of commercial enterprises, and the marketing of purloined baby foreskins is a multimillion-dollar-a-year industry.” “Where Is My Foreskin? The Case against Circumcision,” *Mothering: Magazine of Natural Family Living* (Winter 1997): 39. See also <http://www.foreskin.org/f4sale.htm>; and http://www.norm-uk.org/where_do_foreskins_go.html.

prepuce. Hence, practically speaking, male infant circumcision is neither genuinely therapeutic (justifiable by totality) nor altruistic (justifiable by charity). Thus, the principle of integrity should be accorded maximum leverage, with the principle of totality invoked as weightier only when there is a patent necessity for curative or palliative surgical intervention.

A Metaphysical Resolution

At bottom, all ethical controversies have a metaphysical or theological orbit in some way (albeit in concealed form) revolving around the relation between man and the objective order of being (in other words, between man and the Creator of the real order). With this consideration in mind, there is a fundamental question whether the following conjunction of propositions is ontologically consistent: (1) God creates a bodily organ (in this instance the prepuce) as an endowment with which everyone is normally born. (2) From what we can discover based on the Scholastic principle of the essential correlation between being and activity (“*operatio sequitur esse*”), God ordains the use of this normal component of human corporeality as an aspect of natural functioning (in this instance various sexual purposes). And (3) God approves as good, or countenances as indifferent, its ordinary nontherapeutic excision (in this case EMIC via *periah*) for speculatively or statistically prophylactic claims. There seems to be a metaphysical conflict here.⁸⁰ Taken together, the three propositions seem to imply a logical contradiction, the first and third affirming but then denying that God wills all human beings to *have and keep* a prepuce, and the second and third affirming but then denying that He wills its *natural use*. Hence, if we accept the first two propositions, we must reject the third proposition. Someone may bring up the distinction between God’s antecedent and consequent will, granting that *antecedently* God wills the natural presence of the healthy prepuce in all human beings, but qualifying this assent with the caveat that *consequently* (given the vicissitudes of human life) He permits some people to lose theirs. Certainly the latter situation would obtain in the unfortunate case of medically necessary excision to treat an abnormality, but it would not seem to hold when it is a matter of the paring of the penis with *periah* in healthy babies (as is the usual situation in EMIC).

But even if it could be demonstrated with some further subtle distinctions that there is no strict or absolute logical contradiction entailed in these three propositions, they delineate an ontological state of affairs that is incompatible with the divine wisdom—and even a nonsensical state of affairs relative to the concrete cosmos where “we live and move and have our being” (Acts 17:26, 28). For, under a philosophical principle of sufficient reason, the very universality of the foreskin apparatus shows that it is not some incidental or vestigial accessory that can be casually dismissed out of hand and dispensed with as redundant. As St. Ambrose (who wrote after the introduction of *periah*) asseverated on foundational grounds, in obvious agreement with the Pauline doctrine of the divine economy (enunciated

⁸⁰O’Keefe discusses this issue in a general context: the Creator reveals his will for suitable human action through his very design of human nature, *Known from the Things That Are*, 138–139 and 148–149.

in 1 Cor. 12:14–26), “Nature has created nothing imperfect in man, nor has she bade it be removed as unnecessary.”⁸¹ William Morgan echoes Ambrose and Paul: “We should ask ourselves whether it is really likely that Nature in all her wisdom and pragmatism, would really permit every male child to be born into this world with a useless appendage, the presence of which, according to some, almost inevitably leads to serious consequences, including death.”⁸² It would seem to follow, then, that the routine, gratuitous, nontherapeutic destruction of the infant prepuce is, objectively speaking, an insult to the Creator and an infringement of a fundamental human right to bodily integrity, and hence intrinsically unjust. Nevertheless, given rampant ignorance about the role of the prepuce and the essentially diverse ways of cutting it (some suppressing its functions, others not), it would be rash to accuse anyone (whether physicians, parents, or religious leaders) of subjective culpability in perpetuating the practice of genital mutilation.

Along with uninformed decision making, are there other reasons why EMIC still reigns unchallenged in the United States? A number of writers have pondered this intriguing but perplexing question. As mentioned above, Robert Darby chalks it up to a “sorcerer’s apprentice” imbroglio. Morgan throws up his hands: “Why is the operation of circumcision practiced? One might as well attempt to explain the rites of voodoo! Ritual is seldom self-explanatory and still less frequently logical.”⁸³ He calls RMIC a “cult” and portrays it as a kind of “social status” surgery having “no valid medical reason.”⁸⁴ Likewise, Edward Wallerstein characterizes it as “cultural surgery, not very different from ear- and nose-piercing and tattooing.” He labels EMIC “the uniquely American medical enigma,” because it persists here without a basis in religious tradition (such as Judaism or Islam) and for no apparent health reasons, noting the idiosyncrasy that “the penis is the only organ subjected to routine prophylactic surgery.”⁸⁵ In fact, it is well-known that the United States is the sole nation in the world still performing elective circumcision on neonatal infants for nonreligious reasons. Even Israel, the only other country to practice RMIC, waits until a week has passed before enacting the cutting and peeling of ritual *periah*.

In a deep and fascinating essay, Hugh Young propounds the theory that RMIC is propagated and maintained as a nonrational “memplex,” which is “a cluster of related and interconnecting cultural units that are transmitted by imitation (memes), as well as by language.”⁸⁶ (Perhaps one could say that the urge to circumcise children is socially contagious, caught by cultural osmosis or instilled through mass subliminal hypnosis.) One of his many insightful points is that “the memes of Jewish

⁸¹Quoted in Fleiss and Hodges, *What Your Doctor May NOT Tell You*, 100.

⁸²Morgan, “Penile Plunder,” 1103.

⁸³Morgan, “Rape of Phallus,” 123.

⁸⁴Ibid. See also Morgan, “Penile Plunder,” 1103.

⁸⁵Edward Wallerstein, “Circumcision: The Uniquely American Medical Enigma,” *Urologic Clinics of North America* 12.1 (February 1985): 123–132.

⁸⁶Hugh Young, “Circumcision as a Memplex,” in *Bodily Integrity and the Politics of Circumcision: Culture, Controversy, and Change*, ed. George Denniston et al. (New York: Springer, 2006), 1–16.

circumcision and routine infant circumcision in the US are like the two members of a double star orbiting each other, influencing each other while keeping their distance.”⁸⁷ As if to confirm Young’s thesis of cultural mimesis, Douglas Rooks condemns the tendency of too many American fathers to perpetuate the custom by inflicting on their sons a procedure that was done to them. This “matching” obsession seems to him to be one of the main reasons why the operation continues to be performed, even against the better judgment of physicians who comply with parental requests.⁸⁸

Robert Van Howe furnishes several reasons in answer to the question posed in the title of his article, “Why Does Neonatal Circumcision Persist in the United States?”: a tendency to assign a low rank to children’s rights, emotional denial by physicians of infant distress during circumcision, publication bias in American medical literature, physicians’ fears of offending Muslims or Jews (especially fear of the label “anti-Semite”), the failure of ordinary medical protocols to be applied to EMIC (for example, lack of enforcement of the requirement to account for removal of normal tissue, violations of informed consent, solicitation by physicians of unnecessary surgery each time they take the unilateral initiative to ask parents whether they want their son circumcised, and failure to test this surgery for efficacy against established therapies), and lastly the financial stake of income padding through insurance payments.⁸⁹ One could add, in connection with Van Howe’s allegation of a monetary inducement for physicians, the incentive of lucrative gains reaped by biotech firms in producing commodities derived from human foreskins, as mentioned earlier.

Thomas Ritter and George Denniston concatenate a series of oddities about EMIC that together constitute an impressive indictment:

The operation of routine, infant circumcision of males involves a paradox of absurdities completely at variance with sound medical–surgical–legal practice; a normal structure is operated upon; no anesthesia is used [formerly]; the patient does not give his consent; he is forcibly restrained while a normal segment of his body is removed; the parental consent is of quasi-legality since the part removed is a healthy, nondiseased appendage; there are no legitimate surgical–medical indications for the operation; the patient and the part operated upon are subject to a host of possible complications, including death; the genitalia are now irrevocably diminished in appearance, function and sensitivity.⁹⁰

⁸⁷Ibid., 7.

⁸⁸Douglas J. Rooks, “Just Like Dad,” *Maine Times* 29.9 (January 2–8, 1997): <http://www.cirp.org/news/1997-01-02MaineTimes/editorial.html>: “Parents, apparently led by fathers who want their sons to look like them, are insisting on a surgery which has no demonstrated medical value and clearly imposes pain on the newborn and possible negative consequences afterwards. Bluntly put, this is narcissism at its worst.” See also Sharon Bass, “Circumcision Persists Despite Doctors’ Disapproval,” *Maine Times* 29.9 (January 1997): <http://www.cirp.org/news/1997-01-02MaineTimes>: “The number one reason, according to both doctors and parents, is so son will look like father and his male peers.”

⁸⁹Van Howe, “Why Does Neonatal Circumcision Persist in the United States?” in Denniston and Milos, *Sexual Mutilations*, 111–119.

⁹⁰Denniston and Ritter, *Doctors Re-examine Circumcision*, 1–2.

Among the various plausible theories for the prevalence and persistence of RMIC in the United States, two of the most cogent ones are offered by Lawrence Dritsas and Leonard Glick. Dritsas concludes his article on the circumcision controversy in Gentile America with the following retrospective diagnosis of the conduct of the medical profession:

All the reviews of literature performed by medical organizations in many countries, including our own, concerning routine male circumcision show that there was never sufficient cause, according to contemporary standards, to routinely amputate the foreskins of baby boys. For a physician to cease performing circumcisions now represents a condemnation of past practices and an admittance of error. The error is most serious because it is committed upon the genitalia. The decline in tonsillectomies in recent decades is a famous example of changes in medical opinion, but the foreskin is somewhat different, more hidden and taboo. Furthermore, the tonsils were removed in an overactive response to a pathological condition; circumcision is purely preventative and a response to possible future pathologies. To call into question the received knowledge of the medical profession, passed from doctor to resident, is a revolution of sorts, for progress typically means new and better procedures to replace the old, not the cessation of a common practice.⁹¹

Having summarized the history of the AAP in failing to apply to the EMIC debate the guidelines of its own bioethics committee regarding proxy consent,⁹² Dritsas continues,

I believe this is why we see such tentative statements coming from [the] American Academy of Pediatrics. By purposely avoiding its own Committee on Bioethics, the American Academy of Pediatrics Task Force on Circumcision was able to equivocate the issue before our eyes. What the task force is saying in effect is, “As scientific doctors, we find ourselves unable to recommend or deny this procedure; therefore, you will decide and we shall be your scalpels. This is no longer a medical question.” In one dramatic sweep, the task force decided not to make a decision and absolved itself of all guilt while continuing to perform a questionable procedure. There is no other medical procedure performed on minors, male or female, that follows this policy or has this history.⁹³

In a similar vein, Glick explains that in 1971 the AAP stirred up a controversy among some physicians with their verdict that there exist “no valid medical indica-

⁹¹Lawrence S. Dritsas, “Below the Belt: Doctors, Debate, and the Ongoing American Discussion of Routine Neonatal Male Circumcision,” *Bulletin of Science, Technology and Society* 21. 4 (August 2001): 297–311.

⁹²“Thus ‘proxy consent’ poses serious problems for pediatric health care providers. Such providers have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses. Although impasses regarding the interests of minors and the expressed wishes of their parents or guardians are rare, the pediatrician’s responsibilities to his or her patient exist independent of parental desires.” Committee on Bioethics (1993 to 1994), “Informed Consent, Parental Permission, and Assent in Pediatric Practice,” *Pediatrics* 95. 2 (February 1995): 314–317.

⁹³Dritsas, “Below the Belt.”

tions” for RMIC. After convening a task force to study the matter further, in 1975 they reaffirmed the 1971 conclusion that there is “no absolute medical indication for routine circumcision of the newborn.” But this time they tacked on a disclaimer: “Nevertheless, traditional, cultural, and religious factors play a role in the decision made by parents, pediatrician, obstetrician, or family practitioner on behalf of a son. . . . The final decision is theirs [the parents], and should be based on true informed consent.” Aghast at the audacity of this proposition, Glick (like Dritsas) comments on its extraordinarily unique character “in the history of American medicine” (and probably the annals of any civilized medicine up to that time): “The pediatricians declared that their colleagues should be willing to perform a surgical procedure lacking adequate *medical* rationale, provided only that *parents* (actually, a parent) request or agree to it. . . . In short, *a group of well-qualified pediatricians accorded to parents exclusive right to authorize physicians to perform surgery on infants for explicitly nonmedical reasons.*”⁹⁴ He levels the charge that “by acceding to parental wishes, rather than relying first and foremost on their own medical judgment, . . . many physicians have abdicated responsibility for deciding whether to perform circumcisions.” Hence, “they have accepted the fact that circumcision has become a *custom* without medical justification.”⁹⁵

Denniston makes the point that one measure of the validity of surrogate consent is the probability that the patient himself would elect the procedure. Given that, out of a group of five-hundred normal men, hardly a single one would choose non-therapeutic genital surgery, it is extremely unlikely that any infant boy would consent to the deprivation of his prepuce if granted the opportunity to voice his preference.⁹⁶

Although she does not apply her reasoning to EMIC, Helen Watt defends general propositions on “bodily invasions” that seem pertinent here:

Respect for a person as a living bodily being encompasses respect for that person’s bodily borders, of a kind which goes well beyond avoidance of *deliberate* harm to life or health. An innocent person who is not intending unjust harm to others must surely have a right to bodily integrity: his or her body should not be deliberately invaded in a way foreseen (though not intended) to cause death or serious permanent injury.⁹⁷

Although the risk of death from *periah* is remote, an earlier section of this article established that it always inflicts permanent disabilities in terms of protective and sexual functions for males (as boys and men). Regarding whether these are actually “serious” injuries, we can appeal to the dictum that the only minor surgery is an operation done on someone else, despite the fact that physicians and parents have treated this matter lightly for over a century in the United States.

⁹⁴Glick, *Marked in Your Flesh*, 210, original emphasis.

⁹⁵*Ibid.*, 276, original emphasis.

⁹⁶George Denniston, “Does Being Born a Healthy Male Require Surgical Correction?” leaflet, 2003, http://www.doctorsopposingcircumcision.org/pdf/DOC_trifold_brochure.pdf.

⁹⁷Helen Watt, “Bodily Invasions: When Side Effects Are Morally Conclusive,” *National Catholic Bioethics Quarterly* 11.1 (Spring 2011): 51.

The mentality that married couples (on account of their procreative faculties and activities) are the ultimate arbiters of the origin and fate of their offspring is pernicious, underlying both the so-called right to have a child (via any reproductive technology whatsoever) and the right to choose to terminate a pregnancy.⁹⁸ The same mindset (though admittedly far more benign than in procured abortion) is operating in the exaggerated deference of social institutions to a so-called parental right to circumcise a son (i.e., commit elective posthectomy on him).⁹⁹ The natural moral law, as interpreted by the magisterium of the Catholic Church, does elevate parental prerogatives in the rearing of their children to a superior status, one greater than the dominion of the state. Therefore, parents must make many choices on behalf of their immature children, including health decisions concerning food, medicine, and curative surgery.¹⁰⁰ But rule by parents is not a totalitarian dictatorship. They have the right and duty to form character but no jurisdiction to deform natural anatomy and physiology, no license to have a surgeon take from their son a normal part of his masculine equipment as though it were *their* property to dispose of.¹⁰¹ Parental monarchical power ends where a child's integral God-given constitution

⁹⁸ See Benedict M. Guevin, "Reproductive Technologies in Light of *Dignitas personae*," *National Catholic Bioethics Quarterly* 10.1 (Spring 2010): 57.

⁹⁹ M. Fox and M. Thomson say that they "challenge the assumptions . . . which construe this procedure as a matter of parental choice," showing that it is "problematic" to "tolerate the non-therapeutic, non-consensual excision of healthy tissue," arguing that "both professional guidance and law are uncharacteristically tolerant of risks inflicted on young children, given the absence of clear medical benefits." They also assert, as other authors have said over the years, that "non-consensual male circumcision . . . has long existed as a procedure in need of a justification." They "conclude that it is ethically inappropriate to subject children—male or female—to the acknowledged risks of circumcision and contend that there is no compelling legal authority for the common view that male circumcision is lawful," "A Covenant with the Status Quo? Male Circumcision and the New BMA Guidance to Doctors," *Journal of Medical Ethics* 31.8 (August 2005): 463–469.

¹⁰⁰ Although William E. May defends the ethical liceity of a certain limited parental consent to elective experimentation on their "voiceless" post-natal offspring, he stresses the severe qualification that such a procedure must not pose any significant threats to the child worse than ordinary quotidian risks, "Proxy Consent for Non-Therapeutic Experimentation," *National Catholic Bioethics Quarterly* 7.2 (Summer 2007): 239–248. See also his *Catholic Bioethics and the Gift of Human Life*, 2nd ed. (Huntington, IN: Our Sunday Visitor, 2008), 221–229. As the present paper has striven to demonstrate, though, EMIC exposes a young son to serious, unnecessary risks and in fact inherent damage (without meaningful benefits to anyone else) that exceed whatever alleged "drawbacks" there may have been in leaving his genital integrity intact.

¹⁰¹ In a similar vein, Kevin D. O'Rourke writes that "parents have no right to control the talents and careers of their children" and "the teaching of the Church . . . calls on parents to realize that infants are not possessions to be controlled but human beings with the intrinsic potential to become fully functioning adults like themselves." "Catholic Principles and In Vitro Fertilization," *National Catholic Bioethics Quarterly* 10.4 (Winter 2010): 722. *A fortiori*, parents have no right to resculpt the anatomy and change the physiology of their sons. Indeed, circumcision of male infants blocks one of the avenues toward becoming "fully functioning adults."

begins, thereby excluding from the arena of ethical legitimacy the option to permit nontherapeutic operations, such as EMIC, on their children.

It is conceded that EMIC is legal everywhere on earth. In some lands that legality is irrelevant because there is no inertial cultural tradition maintaining it (for example, it never had a place in the old Catholic countries of Europe and Latin America). In other locales, mainly the United States, there is now an entrenched social prejudice favoring the retention of a parental option, though not a tenacious obligation as in the Muslim–Jewish realm (and a few countries influenced by Islam and Judaism, whether directly or indirectly, such as the Philippines and South Korea). Nevertheless, if EMIC is unethical, then there is no reason *a priori* why it cannot someday be banned, just as female genital mutilation is prohibited in many countries. Some (for example, the authors of the UN World Health Organization report) argue that male circumcision is not the same thing (female genital mutilation being more brutal), and that authoritative world bodies “consider FGM [female genital mutilation] to be universally unacceptable, as it is an infringement on the physical and psychosexual integrity of women and girls and is a form of violence against them.”¹⁰² Yes, female genital mutilation does indeed perpetrate violence against girls, especially when it entails acts of clitoridectomy, infibulation, or vulvectomy, but depending on the severity of the cutting, female circumcision need be no more invasive than male circumcision: simple removal of the clitoral hood would correspond to the skinning of *periah*, just as nicking of the clitoral hood would parallel the blunting of *milah*. Thus, if the WHO deems *all* female genital cutting a trespass against the bodily and psychosexual integrity of girls, then by a consistent extension the excision of the prepuce in posthectomy should likewise be regarded as “an infringement on the physical and psychosexual integrity” of boys, being “a form of violence against them.”

The real difficulty in securing a legal ban of male genital mutilation (*periah*, not *milah* for religious purposes) lies in the fact that there is a more widespread tradition of circumcising males among societies feeling the compulsion to cut their children’s genitals, making the task seem daunting. After all, even banning abortion (infinitely worse than male genital mutilation) appears to be a practical impossibility from a human perspective. As with any social change, efforts must begin by breaking down the wall of embarrassed silence that shrouds this topic and maintains the inertia of what can be shown to be a senseless custom. The initiation of a new cultural norm antithetical to EMIC would require a concerted effort on the part of medical associations to convey to their members the necessity of educating the public (especially new parents) about the deleterious nature of the modern form of this surgery. Wallerstein offers some concrete steps that could be undertaken:

To resolve the problem, the positions of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists should become definitive statements that circumcision is unnecessary surgery, not to be undertaken except in rare medical circumstances. Endorsements of this position should be obtained from all relevant medical groups. This information

¹⁰²WHO, “Male Circumcision,” 27–28.

should be disseminated to the entire medical profession, to all hospitals, nurses and nursing associations, childbirth educators, and most certainly to parents via the popular press. Meetings of professional and lay persons should be called on local, state and national levels to discuss circumcision. With such an approach, routine newborn nonreligious circumcision will soon pass from the scene to join blood-letting and cupping in medical history.¹⁰³

¹⁰³ Wallerstein, "Circumcision: The Uniquely American Medical Enigma." On the other hand, Geoffrey Miller concludes his comprehensive article with the prognosis that, because of the embedding of RMIC in American culture, "It is inconceivable, at least at present, that the United States will prohibit male circumcision as it has done with female genital mutilation, even if religious ceremonies are exempted from such a ban" ("Circumcision: Cultural-Legal Analysis," 585).