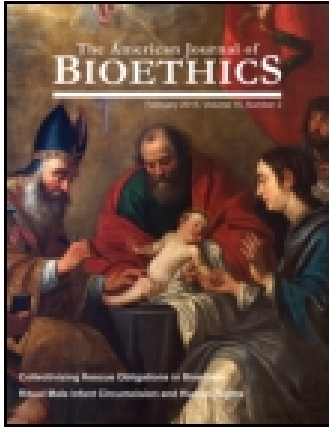


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Ritual Male Infant Circumcision: The Consequences and the Principles Say Yes

Johan Christiaan Bester, University of Calgary

Jacobs and Arora (2015) build a strong argument for the ethical permissibility of ritual male infant circumcision (RMIC) based on two approaches: a consequentialist-type argument with a parallel principlist argument in favor of RMIC, and the refutation of human rights claims often used by opponents of RMIC. The consequentialist argument is a simple one: The good achieved by RMIC outweighs the potential harms, and therefore RMIC is ethically sound. Taken together with the refutation of misplaced human rights claims, the consequentialist and principlist considerations are compelling.

The consequentialist argument can be further strengthened in a number of ways, making the case in favor of ritual male circumcision even more compelling: first by considering RMIC as a sound medical choice, second by viewing RMIC as a harm reduction strategy, and third by considering the best interests of the infant with regard to family and culture.

INFANT MALE CIRCUMCISION AS A MEDICAL PROCEDURE

A number of recent review articles have appeared that underline the medical benefits of infant male circumcision. We now have good evidence that there are considerable benefits to infant circumcision while the risk for harm is minute.

Infant circumcision confers the following benefits:

- Decreases the heterosexual transmission of HIV by at least 50–60%, and in some trials even up to 76% (Hayashi and Kohri 2013; Rosario, Kasabwala, and Sadeghi-Nejad 2013; Tobian, Kacker, and Quinn 2014).
- Provides protection against sexually transmitted infections (STI) other than HIV (Hayashi, and Kohri 2013; Tobian, Kacker, and Quinn 2014).
- Decreases the risk of carcinoma of the penis by at least 10-fold (Hayashi and Kohri 2013).
- Decreases the risk of urinary-tract infection (UTI) substantially (Hayashi and Kohri 2013; Morris and Wiswell 2013). This is particularly important in infancy, when the kidney is more susceptible to injury and scarring,

which can lead to serious complications later in life (Morris and Wiswell 2013). Lack of circumcision in males confers a 9.9 times higher risk for UTI in infancy and a lifetime risk of UTI of 23%. (Morris and Wiswell 2013).

- Benefits future female sexual contacts by decreasing a variety of STI and cervical cancer (Tobian et al. 2014). Men who were circumcised as infants showed decreased HIV transmission to female partners, but this was not translated to HIV-positive men who were circumcised as adults (Tobian et al. 2014).

The harms of infant circumcision when performed by a trained provider in hospital are minimal. The median frequency of complications is 1.5%, with the median for serious complications 0% (Weiss et al. 2010). Circumcisions at later ages are known to have a higher complication rate (Weiss et al. 2010). For example, adult and adolescent circumcisions have complications in 2–8% in one study and 18% in another, and these complications are generally more serious (Weiss et al. 2010).

Claims regarding loss of sexual pleasure and function with RMIC are unfounded in the light of the best available evidence. High-quality evidence shows that there is no negative effect on sexual function or satisfaction due to male circumcision; this was demonstrated in a recent meta-analysis (Morris and Krieger 2013).

The combined benefits of male infant circumcision are said to outweigh risks by more than 100 to 1 (Morris and Wiswell 2013). The risk/benefit ratio is so favorable that infant male circumcision can be seen as a “surgical vaccine” (Morris and Wiswell 2013). Furthermore, infant circumcision is cost-effective, with each circumcision in the United States saving \$313 for the medical system (Tobian et al. 2014).

The case for viewing infant male circumcision as a preventive medical procedure is quite strong: The benefits are substantial, and the risks are minimal. Further, the risk/benefit ratio is optimal in infancy: Many of the benefits do not translate fully to older children and adult men, and the risk of circumcision complications is lowest in infants. From a medical perspective, infant male circumcision should be offered to all parents in view of its impressive risk/benefit ratio.

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Of course, those who request RMIC do not do so on medical grounds, but rather on cultural or religious grounds. This should not prevent practitioners from providing a medically sound preventive procedure. If a person requested vaccination purely for cultural reasons, it would not be seen as a barrier to providing vaccination. The onus is on the practitioner, however, to discuss benefits and risks with the parents.

RMIC AS A HARM REDUCTION STRATEGY

There are many cultural groups in which circumcision plays an important role, including Jews, where circumcision rates exceed 98%, and Muslims (Tobian et al. 2014). Circumcision is so central to these groups that it is unthinkable that males who identify with these groups would not choose circumcision. Thus, if circumcision is deferred to the age of consent, it is highly likely that men in these groups will choose circumcision. The risks of circumcision in infancy are low. At the age of consent the risks are higher: Complications are more frequent and generally more serious. Also, many of the medical benefits ascribed to infant circumcision do not translate well to adult circumcision. Thus, RMIC is a harm reduction strategy, performing circumcision when the risks are low and the risk/benefit ratio is optimal.

There are much higher complication rates for nonmedical and nonsterile circumcisions. Performing RMIC in medical settings will decrease the amount of circumcisions done in nonmedical settings, which will decrease harm. Given the central role that infant circumcision plays in some cultures and faiths, it is also likely that some will simply not heed bans on infant circumcision, and this will lead to an increase in circumcisions performed by nonmedical providers. This is similar to one of the considerations in the debate to legalize abortion: Restricting access to medical abortions led to back street abortions and to substantial harm. In the same way, it seems likely that preventing RMIC in medical settings will lead to harm.

Therefore, RMIC provided in a medical setting can be seen as a harm reduction strategy: Harm is reduced by not waiting till the age of consent, and harm is reduced by limiting the number of nonmedical circumcisions.

THE BEST INTERESTS OF THE INFANT AND ITS PLACE IN THE FAMILY AND COMMUNITY

When decisions are made on behalf of infants, the correct guiding ethical principle is the best interest principle, meaning that choices should be made in the light of the best interests of the child (Buchanan and Brock 1990, 246 Elliott 1998). Considerations of medical benefit and harm reduction show RMIC to be in the best interests of the infant. However, there is another compelling set of interests we should consider as well.

Narrowly focusing on the interests of the infant as individual may overlook the interests of the infant as

part of a family (Elliott 1998). The interests of the infant are closely intertwined with the interests of the family (Elliott 1998). Harming the family harms the infant, and harming the infant harms the family. Of course, this applies to healthy parent-child relationships, not abusive relationships.

The infant has vested interests in the cultural, religious, and relational practices of the family. If a child is excluded from these, a schism is introduced between child and family, harming both. The interests of the child are best served in promoting bonding and unity with his parents and his culture. There may be cultural practices in some groups where the harm from the practice exceeds any benefit from the practice; in such cases an argument can be made for banning of these harmful cultural practices. However, RMIC is not a harmful practice.

If a child is not allowed into the cultural practices of the community, it distances him from his community. Those who are not circumcised are sure to feel a measure of exclusion from their cultural group. This places strain on the family and on the community, which affects the interests of the child. These are minority communities, dependent on mutual cultural and religious expression for their cohesion. Banning circumcision will affect the cohesion and vitality of the minority community negatively. In turn, this will create instability in the cultural heritage of the child who is supposedly protected through banning circumcision.

Furthermore, the banning of nonharmful cultural practices may be considered invidious discrimination. Thus, banning RMIC will introduce unjust institutionalized discrimination against the culture and the family, which will undoubtedly harm the individuals within the culture and family.

CONCLUSION

Consequentialism seeks the greatest good for the greatest number. With regard to RMIC, the consequentialist argument is compelling. RMIC provides medical benefits to infants, preventive benefits to future female partners, and societal benefits through reducing burden of disease. RMIC is a harm reduction strategy in certain communities. Suppression of RMIC would frustrate the best interests of the child, his family, and the community, and would introduce institutionalized discrimination against these groups. The greatest good for the greatest number is achieved by allowing RMIC.

The principlist argument is equally compelling: RMIC provides medical benefit and is a harm reduction strategy, satisfying beneficence and nonmaleficence. Benefit to female sexual partners and decreased medical burden to society are considerations of justice. Autonomy is respected through allowing parents to decide in the best interests of their child.

The case for RMIC is ethically sound: The consequences and principles in unison say yes. ■

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