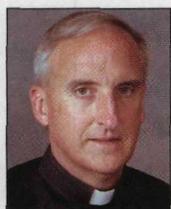


TO CIRCUMCISE OR NOT TO CIRCUMCISE?

A Catholic Ethicist Argues That the Practice Is Not in the Best Interest of Male Infants

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Routine neonatal male circumcision is the most frequent surgical operation performed on males in the United States. In recent years, however, there has been a widespread debate in the medical, ethical and, most recently, the legal communities concerning the surgery's appropriateness.¹ At first glance, the issue appears to be solely medical. But, after further analysis, one can see that it has religious, cultural, and even socioeconomic implications. A comprehensive review of the medical literature reveals arguments both for and against this routine procedure. One writer notes that "of the at least 16 national and international medical organizations that have spoken on routine neonatal circumcision, not a single group has recommended it. This includes five leading American organizations, including the American Medical Association and the American Academy of Pediatrics."²

Is neonatal male circumcision a prophylactic measure with significant health benefits? Or is it, rather, a form of bodily mutilation and child abuse? Formidable questions are being posed to medical, legal, and ethical authorities about the procedure's purpose. Can parents give consent to perform circumcision on a minor if it is for nontherapeutic purposes? Are parents knowledgeable enough about this procedure to give informed consent? Do the benefits of such a procedure outweigh the risks? Can cultural and religious considerations justify the procedure when the medical evidence might not warrant it?

The controversy extends to Catholic health care. In particular, some staff members in Catholic hospitals have challenged the practice of male circumcision as a violation of the moral law. The *Catechism of the Catholic Church* states that, "except when performed for strictly thera-

peutic medical reasons, directly intended amputations, mutilations, and sterilizations performed on innocent persons are against the moral law."³ This implies that nontherapeutic mutilations violate the physical integrity of the human person and are, therefore, morally wrong.

In this article, I intend, first, to examine the medical and legal issue of neonatal male circumcision; second, to give an ethical analysis of the current controversy surrounding the issue; and, third, to determine if it is ethical for Catholic hospitals to permit it.

MEDICAL AND LEGAL ANALYSIS

Neonatal male circumcision is a relatively uncomplicated medical procedure.* As the American Medical Association (AMA) describes it:

The normal uncircumcised penis consists of a cylindrical shaft and rounded tip (glans) that are separated by a tissue groove (coronal sulcus). The fold of the skin (foreskin) covering the glans is removed during the circumcision procedure to a point near the coronal sulcus. At birth, separation of the foreskin from the glans is incomplete. The

*The relative simplicity and painlessness of male circumcision contrasts sharply with female circumcision—sometimes called female genital mutilation. The latter practice entails amputating some or all of the external genitalia—the clitoris, the small genital lips, and the large ones—thereby diminishing a woman's ability to experience sexual pleasure. Female circumcision is performed in 28 African countries, some Middle Eastern countries, and immigrant communities in other parts of the world. See Celia Dugger, "African Ritual Pain: Genital Cutting," *New York Times*, October 5, 1996, pp. 1A, 6A.

separation process continues through childhood via desquamation and epidermal keratinization of the shaft. Keratinization does not occur on the mucosal surface of the foreskin, which may contain specialized sensory cells. Eventually, unforced and complete retraction of the foreskin can be accomplished.⁴

Some medical scholars believe that circumcision may be the oldest form of surgery. One writer notes that “the Egyptians, who probably acquired the practice from African tribes, practiced circumcision as early as 4000 B.C. In the Jewish religion, the origin of circumcision is attributed to Abraham, who established the ‘blood covenant’ with God through circumcision. This practice is also of pre-Islamic Arabic tradition and became a near prerequisite to becoming a Moslem. The practice is very widespread and is unknown only to Indo-Germanic people, the Mongols, and non-Moslem Finno-Ugrian races.”⁵

In modern times, male circumcision has been performed in Western societies mainly for medical reasons, primarily to prevent phimosis, an inability to retract the foreskin. Three methods of circumcision are commonly used on newborn males: the Gomco clamp, the Plastibell device, and the Mogen clamp (or variations derived from the same principle on which each of these devices is based). In each of the three methods, the surgeon:

- Estimates the amount of external skin to be removed
- Dilates the preputial orifice so that the glans can be visualized, allowing the surgeon to ensure that it is normal
- Frees the inner preputial epithelium from the epithelium of the glans
- Places the device (which sometimes requires the surgeon to make a dorsal slit)
- Leaves the device in situ long enough to produce hemostasis and amputation of the foreskin⁶

Males have traditionally undergone circumcision for a variety of reasons, besides the prevention of phimosis. The procedure has been performed to:

- Enhance the man’s sexual performance
- Give him societal prestige
- Sacrifice a piece of his flesh to fertility gods
- Demonstrate his membership in a particular tribe

- Demonstrate his ability to withstand pain
- Enable him to become like his circumcised father
- Allow him to conform to social practice
- Protect him from infant urinary tract infections (UTIs)
- Protect him from sexually transmitted diseases (STDs), AIDS, and cancer of the penis

Except among Jews, for whom male circumcision has long been a religious ritual, the practice does not appear to have been widespread in the United States before the 1940s.⁷ The customary reason for the acceptance of neonatal circumcision is that it promotes genital hygiene and prevents genital diseases. Acceptance was also grounded in the anti-masturbation hysteria of the late 1800s. It was feared that a young boy who had to pull his foreskin back to wash his penis might, by doing so, learn to masturbate—a practice then widely believed to lead to insanity and numerous other illnesses.⁸

Although researchers cannot know the exact number, they estimate that about a sixth of the world’s current male population can be considered circumcised, mostly for religious reasons.⁹ The American Academy of Pediatrics (AAP) estimates that 1.2 million newborn males are circumcised annually in the United States, at a cost ranging from \$150 million to \$270 million.¹⁰ Circumcision rates vary widely, both in this country (80 percent of Midwestern male babies are circumcised, versus less than 40 percent of those born in the West) and in other parts of the English-speaking world (17 percent of Canadian male babies are circumcised, versus only 5 percent of those born in Britain). Elsewhere in Europe, in South America, and in non-Muslim Asia, the procedure is rare.¹¹

In 2003, Arizona, Missouri, Montana, and North Carolina joined six other states—California, Mississippi, Nevada, North Dakota, Oregon, and Washington—in refusing to offer Medicaid reimbursement for circumcision for any reasons, including religious belief.¹² Legislators in those states apparently believe that if people have to pay for the procedure out of their own pockets, few will opt for it. And, indeed, research indicates that neonatal male circumcision is emerging as a cultural ritual in the United States rather than a medical necessity. Today the decision to have circumcision performed is likely to be more emotional than rational. Esthetics, cultural attitudes, social pressures, and tradition seem to be the impetus for the procedure. What was formerly thought of as a medical act has now become a cultural one.¹³

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Medically speaking, the foreskin has three main functions: protective, immunological, and erogenous.¹⁴ The foreskin is not just penile skin necessary for a natural erection; it is specialized tissue that is richly supplied with blood vessels, highly innervated, and uniquely endowed with stretch receptors. The foreskin contributes significantly to the sexual response of the intact male. It also provides a natural lubricant that, among other things, prevents the entry of STDs, viral and bacterial. In incontinent infants, the foreskin fulfills an essential function of protecting the glans.¹⁵

The development of the foreskin (or prepuce, as it is also known) is incomplete in the newborn male child; separation from the glans, rendering it intractable, does not usually occur until sometime between nine months and three years of age. Neonatal male circumcision traumatically interrupts the natural separation of the foreskin from the glans. Because physicians must tear skin from sensitive glans, the procedure interferes with penile development.¹⁶

According to the medical literature, complications from this surgery normally occur in no more than 5 percent of cases, although they can be so severe as to result in loss of the penis or even death.¹⁷ Unfortunately, such complications are often overlooked and underreported. They include lacerations, skin loss, skin bridges, chordee, meatitis, stenosis, urinary retention, glans necrosis hemorrhage, sepsis, gangrene, and meningitis.¹⁸ One medical ethicist notes that, "although precise estimates are difficult to give due to, among other factors, concealment of the event when it occurs, responsible commentators nevertheless place the number of circumcision-caused deaths in the United States annually at well over 200."¹⁹ Other writers estimate that between 2 percent and 10 percent of circumcisions result in that morbidity and death.²⁰

Long-term adverse outcomes are often not recognized until years later, often not until the start of sexual activity. Circumcision typically involves the removal of one-third of the entire penile skin, resulting in a significant loss of erogenous tissue. The loss of erogenous tissue can alter sexual functioning. In a study of 313 circumcised males, nearly 50 percent said they had a sense of having been violated, 62 percent felt they had been mutilated, and 84 percent reported some degree of sexual harm (progressive loss of glans sensitivity, excess stimulation needed to reach orgasm, painful coitus, and impotence).²¹ Opponents of neonatal male circumcision argue that the procedure is unnecessary and that "greater awareness

of the incidence and scope of associated complications will encourage a more carefully considered decision on whether or not to circumcise."²²

Is Circumcision Mutilation?

Circumcision proponents argue that it is not a form of mutilation but, rather, a procedure similar to breast reduction, liposuction, and rhinoplasty—that is, essentially cosmetic surgery.²³ To determine whether the procedure constitutes mutilation, one must review the potential harms and benefits. Two bioethicists, Michael and David Benatar surveyed the medical literature and came to the conclusion that neonatal circumcision has both harms and benefits, with the benefits slightly outweighing the harms.²⁴ They conclude that the procedure is a suitable matter for parental discretion.

On the other hand, the Benatars found that circumcision is often practiced without anesthesia or with inadequate analgesia—even though well-documented studies have shown that neonates are capable of feeling pain.²⁵ According to the AMA, "based on recent survey data, 54% of pediatricians, family practitioners, and obstetricians perform at least 1 circumcision per month. Of physicians performing circumcision, 45% use anesthesia, most commonly dorsal penile block with lidocaine (71% of pediatricians, 56% of family practitioners, 25% of obstetricians). Those physicians who reported not using anesthesia cited concern about adverse effects and a belief that circumcision does not warrant anesthesia."²⁶

The Benatars recommend the use of topical analgesia with a eutectic mixture of local anesthetic cream (containing small amounts of lidocaine and prilocaine), dorsal penile nerve block, and ring block (another form of anesthesia).²⁷ The AAP suggests that placing the baby in a comfortably padded bed and rubbing sucrose on his pacifier may reduce distress (and crying) during circumcision; acetaminophen, the academy says, may provide analgesia after the immediate postoperative period.²⁸ One could criticize the Benatars for failing to cite recent medical literature indicating that neonates not only experience pain; they may also, as they grow older, suffer from a reduced sensitivity to pain as a result of inadequately controlled pain in infancy.²⁹ In any case, all medical authorities recommend the use of analgesia both during the procedure and postoperatively in reducing the associated pain and distress.

As for complications resulting from circumcision, the Benatars argue that the "consensus, even among those reporting high complication rates, is

that the incidence of clinically significant complications is very low. It is commonly believed to be around 0.19% to 1.55%. It is also believed that even where there are complications, the majority of these either resolve spontaneously or are easily resolved by simple medical intervention."³⁰

One of the benefits attributed to neonatal circumcision involves penile cancer. Proponents of routine circumcision cite the extremely low incidence of penile cancer in Israel (0.1 per 100,000 males), where the procedure is even more prevalent than in the United States (which has a penile cancer rate of 0.9 to 1 per 100,000), the vast majority of whose males are circumcised.³¹ Cancer of the penis is admittedly a rare disease, and the literature shows the relationship between circumcision and penile cancer to be difficult to evaluate. Nevertheless, circumcision opponents note that the incidence of penile cancer is higher in the United States than in Denmark (0.82 per 100,000 males), where circumcision is extremely uncommon. Studies indicate that, although neonatal circumcision offers some protection from penile cancer, circumcision at a later stage does not seem to confer the same level of protection. None of these studies can be considered definitive, however, and it is difficult to estimate the risk based on them. The AAP has concluded that "in a developed country such as in the United States, penile cancer is a rare disease and the risk of penile cancer in an uncircumcised man, although increased compared with a circumcised man, is low."³²

The medical literature does indicate a relationship between UTI and circumcision, the consensus being that circumcision is associated with a lower incidence of UTI. (The studies do not, however, agree about the magnitude of the increased risk for uncircumcised boys; indeed, their estimates of the risk range from 3.7-fold, on one hand, to 12-fold, on the other.³³) According to the AAP:

All studies that have examined the association between UTI and circumcision status show an increased rate of UTI in uncircumcised males, with the greatest risk in infants younger than 1 year of age. The magnitude of the effect varies among studies. Using numbers from the literature, one can estimate that 7 to 14 of 1000 uncircumcised male infants will develop a UTI during the first year of life, compared with 1 to 2 of 1000 circumcised male infants. Although the relative risk of UTI in uncircumcised male infants compared with cir-

cumcised male infants is increased from 4- to as much as 10-fold during the first year of life, the absolute risk of developing a UTI in an uncircumcised male infant is low (at most, 1%).³⁴

It appears that circumcision may slightly reduce the risk of developing UTIs.

Finally, some research indicates that uncircumcised males are at higher risk for both STDs and human immunodeficiency virus (HIV) infection. There are other studies that suggest that uncircumcised males have a reduced risk for STDs, especially for syphilis, genital ulcer disease (GUD), gonorrhea, and herpes. And still other studies have found that it makes no difference in this regard whether one is circumcised or not.³⁵ However, R. S. Van Howe, an opponent of male circumcision, argues that "no solid epidemiological evidence has been found to support the theory that circumcision prevents STDs. . . . The only consistent trend is that uncircumcised males may be more susceptible to GUD, while circumcised men are more prone to urethritis."³⁶ Given the available data, the best one can say is that circumcision will give a male some protection from STDs.

A substantial amount of medical data concerns the association of circumcision and HIV infection. One team of researchers reviewed 30 studies, finding that 22 of them (including two prospective studies) documented a statistically significant association between the uncircumcised state and HIV infection, with those who are circumcised being less likely to become HIV infected.³⁷ A study led by Bertran Auvert, PhD, Universite Versailles Saint-Quentin, France, and presented at the July 2005 3rd International AIDS Society Conference on HIV Pathogenesis and Treatment, discovered that "adult male circumcision has been found to provide a 65% protective effect against infection for HIV in a randomized trial of more than 3,035 sexually active, heterosexual men in South Africa." The Joint United Nations Programme on HIV/AIDS immediately issued a statement saying that "UNAIDS emphasizes that more research is needed to confirm the reproducibility of the findings of this trial and whether or not the findings have more general application."³⁸

According to the AAP, "There does appear to be a plausible biologic explanation for this association in that the mucous surface of the uncircumcised penis allows for viral attachment to lymphoid cells at or near the surface of the mucous

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membrane, as well as an increased likelihood of minor abrasions resulting in increased HIV access to target tissues.³⁹ Both the AAP and the Benatars conclude that behavioral factors appear to be more important factors in the disease's development than whether one is circumcised or not. In most of the data reviewed for this article, an increased chance of HIV infection was present only in groups that were already at high risk for HIV infection for other reasons.

A review of the medical data regarding the benefits and risks of neonatal circumcision yields no definitive answer to whether it is or is not medically indicated. In recent years, however, neonatal circumcision has become a *legal* issue. On December 19, 2000, William G. Stowell, an 18-year-old man filed suit in U.S. district court in New York against the physician who had circumcised him as a newborn and against the hospital in which the procedure occurred.⁴⁰ The issue involved informed consent. A nurse had obtained consent for the circumcision from the plaintiff's mother. The plaintiff argued that, because his mother was then debilitated by the effects of a cesarean section and painkillers, the consent was invalid.

The suit also questioned whether a physician could legally and ethically remove healthy, normal tissue from a non-consenting minor for non-therapeutic reasons. In April 2003, Stowell settled with the physician and the hospital in what had by then become a landmark case. The terms of the settlement have not been publicly disclosed. Even so, the case has moved the discussion of neonatal male circumcision into the nation's courtrooms, guaranteeing that more such cases will be filed in the future.

If we are to determine whether neonatal male circumcision should continue to be a routine procedure in the United States, we must ask what is best for the newborn, whether parents have a legal right to consent to a procedure that appears largely nontherapeutic, and whether the procedure violates the ethical requirement of minimizing the risks to the patient.

ETHICAL ANALYSIS

The medical evidence concerning whether neonatal circumcision is beneficial or harmful to newborn males is equivocal. The legal issue regarding the potential liability of physicians and hospitals is unresolved. Nevertheless, because people seek moral clarity, the ethical dimension of the controversy has taken on a new urgency.

Proponents of circumcision argue that since it

is not (as they believe) a form of mutilation, but merely an alteration of the person's appearance, and since it can be said to yield neither medical gains nor losses, the procedure should be left to the discretion of parents, who will act in the best interest of their child. Opponents argue that (as they believe) since the procedure is nontherapeutic and unsupported by clear medical evidence, it should be deferred until the child reaches adulthood and can make his own informed decision. To determine whether the procedure is ethical, I will use the principles of *respect for persons*, *beneficence* (including *nonmaleficence*), and *justice* to examine both sides of the issue.

RESPECT FOR PERSONS

This principle incorporates two ethical convictions—first, that individuals should be treated as autonomous agents; second, that persons with diminished autonomy are entitled to protection. Seen in this way, the principle implies two further moral requirements—a requirement to acknowledge autonomy and a requirement to protect those with diminished autonomy.⁴¹

Since children are minors and lack decisional capacity, parents are given a legal right to grant informed permission for diagnosis and treatment on the child's behalf. These decisions are understood to be based on the child's "best interest."

Opponents argue that the procedure should be delayed until the individual can give informed consent for himself. Opponents believe that parents are entitled to give consent to surgical procedures for their children only when medical necessity is immediate and clear.⁴² Some such critics go so far as to call neonatal circumcision an "assault" and equivalent to child abuse. "Male neonatal circumcision is neither a diagnostic procedure nor a treatment of a disease," one organization says. "Thus nontherapeutic circumcision is, in effect, an act of battery. No parent can grant consent for an act of battery. By this reasoning, 'parental consent' for a nontherapeutic, nondiagnostic circumcision on a child appears to be invalid."⁴³

Proponents, on the other hand, argue that parents have the right to give appropriate permission for medical procedures that they believe are in the best interest of the child. The Benatars argue that prophylactic immunizations of children are acceptable, even when no clear and immediate medical necessity is apparent; they suggest that the same reasoning supports neonatal circumcision.⁴⁴ The Benatars agree that parents' right to give permission for medical procedures is not unlimited; parents should not, for example, be

allowed to grant permission for procedures that are unequivocally harmful to the child. However, circumcision is not harmful, and, in fact, postponing the procedure until the child becomes an adult can result in psychological unpleasantness and increased risks; and any benefits obtained from a delayed procedure would be significantly reduced.

In disputing the point, J. Steven Svoboda, a legal expert, cites studies indicating that infants probably suffer more greatly from the pain of male circumcision than adults do.⁴⁵ Moreover, researchers have documented the serious lifelong psychological damage inflicted by the procedure, which can include post-traumatic stress disorder, depression, and a host of other sequelae.⁴⁶

The issue of informed consent comes into play here. The evidence clearly shows that that most parents are not told of the procedure's benefits and risks and that few, if any, are given the option of no treatment. Non-circumcision is a viable alternative, as is delaying the procedure until adulthood. Failure to give parents this valuable information—including the fact that more than 200 circumcision-caused deaths occur annually in the United States—is a direct violation of the principle of informed consent. Physicians can never place parental desires over the needs of the child. The physician's responsibility is to provide parents with the objective information they need to make a well-reasoned decision that is in the child's best interest.⁴⁷

It is important that physicians not coerce or bias parents in their decision making. In this case, being noncoercive would include reassuring parents that deciding to circumcise is medically acceptable—as is deciding *not* to circumcise, or to delay making the decision. In addition, the physician should, first, make sure the parents are making their decision with accurate information, and, second, give them a step-by-step explanation of the procedure.⁴⁸ Besides determining what constitutes informed consent, the physician should also confirm the validity of the consent. As noted above, even though William Stowell's mother was debilitated by the effects of a cesarean section and painkillers, a nurse obtained consent from her to circumcise William. How many other cases like this have occurred? Lack of education, false information, questionable legal validity, and even bias can result in a failure of genuinely *informed* consent. Any one of these factors will undermine patient autonomy; collectively, they clearly violate the basic principle of respect for persons.

BENEFICENCE

This principle obliges one to prevent and remove harm to another person and to promote his or her good by minimizing possible harms and maximizing possible benefits. Beneficence includes *nonmaleficence*, which prohibits the infliction of harm, injury, and death on others. In medical ethics, the principle is closely associated with the maxim *Primum non nocere*: "Above all, do no harm."

Medical research shows that neonatal male circumcision protects against the development of phimosis, balanitis (inflammation of the glans), and paraphimosis (a problem, seen in elderly men, requiring intermittent or chronic bladder catheterization).⁴⁹ Other medical benefits from male circumcision include reduced incidence of penile cancer, reduced incidence of UTIs, possible reduced susceptibility to certain STDs, and (in high risk groups) a possible reduced risk of HIV.

On the other hand, circumcision can lead to the problems discussed above: lacerations, skin loss, skin bridges, chordee, meatitis, stenosis, urinary retention, glans necrosis, penile loss, hemorrhage, sepsis, gangrene, meningitis, and even death. Given the possible medical complications that are possible and the fact that the procedure is nontherapeutic, it seems advisable for parents to defer the decision to circumcise until the child can give assent or legal consent. "It might be an indication of the procedure's long-term lack of viability that only one out of every 200 intact American men opts for circumcision in adulthood."⁵⁰

Evidence suggests that North American men who have been circumcised are becoming more aware of the mutilation and harm that has been done to them and, as a result, are seeking methods of replacing the lost prepuce.⁵¹ The root of this reaction seems to be a realization that a perfectly normal, healthy, sexually responsive part of their penis was surgically amputated when these men were too young to consent, refuse, or resist.⁵² In addition, research has shown that neonatal circumcision is usually performed without anesthesia and that postoperative pain is rarely addressed. The pain and stress caused by circumcision can contribute to breast-feeding failure, which can in turn have an effect on neonatal development.⁵³

Neonatal male circumcision fails the test of beneficence because the minor benefits that might result from the procedure do not outweigh its potential harms and risks. Indeed, recent policy statements issued by professional societies repre-

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senting Australian, Canadian, and American pediatricians do not recommend routine circumcision.⁵⁴ The procedure also fails the test of nonmaleficence because the removal of functioning, healthy body tissue in the name of tradition, custom, or a non-disease-related cause intentionally inflicts bodily harm, injury, and, in rare cases, even death on vulnerable minors. This is clearly contrary to the basic tenet of medical ethics: "First do no harm."

JUSTICE

This principle recognizes that each person should be treated fairly and equitably and be given his or her due. It can be applied to neonatal circumcision in two ways.

First, questions of justice have been raised about the legal right to bodily integrity of these vulnerable patients. One problem with circumcision, besides pain and possible complications, is the loss by the infant of the inherent value of an intact penis. To circumcise a person is to violate his bodily integrity, which is a direct violation of the principle of justice. Many people see male circumcision as cruel and degrading because it detracts from the appearance and function of the male sex organ by removing large amounts of healthy, functional, protective erogenous tissue. To mutilate and degrade any individual is a violation of the principle of justice.

Second, circumcision specifically involves the issue of distributive justice, which concerns the fair and equitable allocation of medical resources. As noted, more than a million U.S. males are circumcised each year, at a cost estimated to be as high as \$270 million. A cost-benefit analysis of neonatal male circumcision has found it not to be cost effective; indeed, in contrast to most medical interventions, which cost money but preserve or restore health, neonatal male circumcision costs money and may reduce health.⁵⁵ Today the United States has 46 million uninsured people and countless others who are underinsured. Spending hundreds of millions of dollars a year on a nontherapeutic surgery that has, at best, debatable benefits for the child is a direct violation of the principle of distributive justice. The primary beneficiary of male circumcision seems to be the medical community. As an organization opposed to the procedure notes, "Physicians receive an estimated \$200 million in fees for 1,100,000 circumcisions performed annually in the United States, while hospitals receive an estimated \$500 million due to longer stays for both mother and infant when circumcision is performed."⁵⁶

Medical resources in this country and worldwide are limited and must be conserved. Proper stewardship of these resources entails not wasting them on treatments that have questionable outcomes and can be deemed inappropriate. These resources must be rationally allocated; to waste them is ethically irresponsible and morally objectionable.

THE CATHOLIC PERSPECTIVE

In the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)*, Directive 29 states clearly that "bodily integrity" must always be respected:

"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."⁵⁷ Directive 33 states that any therapeutic procedure that causes harm to a patient can be justified only if the benefits outweigh the burdens: "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."⁵⁸ The *Catechism of the Catholic Church* states that "except when performed for strictly therapeutic reasons, directly intended amputations, mutilations, and sterilizations performed on innocent persons are against the moral law."⁵⁹

Examining neonatal male circumcision in light of these moral directives, one can conclude that the amputation of normal, healthy foreskin for nontherapeutic purposes not only violates the child's bodily integrity but also is a medical procedure whose benefits do not clearly outweigh the risks. The *ERDs* state clearly that such procedures can be justified if there is a proportionate benefit to the patient. But neonatal male circumcision fails the test of proportionality because the questionable therapeutic benefit is overbalanced by the certainty of permanent injury to the penis; the loss of protective, immunological, mechanical, sensory, erogenous, and sexual functions; as well as the risk to health and life inherent in every circumcision.⁶⁰ Neonatal male circumcision may be appropriate for religious reasons, but after one makes a thorough examination of the medical literature and a comprehensive ethical analysis, one sees quite clearly that it should not be a routine medical procedure.

Some ethicists have tried to justify circumcision under the Catholic moral principle of totality. As one writer notes, the principle of totality "is merely the fact that the parts of a physical entity, as parts, are ordained to the good of the physical whole. Since the good of the whole is the fundamental meaning of, and reason for, the existence of the parts, there is no violation of the right order in the destruction of the parts, when this is necessary for the good of the whole."⁶¹ What this principle states is that the parts exist and function for the good of the whole and are thus naturally subordinated to the good of the whole body. Thus when one body part—such as a gangrenous arm—becomes detrimental to the good of the whole body, it can be medically amputated. But there are limitations to amputations and mutilations, in that they must be necessary for the good of the whole body. Pope Pius XI clarified this when he said, "Furthermore, 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."⁶²

The principle of totality was further clarified by Pope Pius XII, on the occasion of his address to the First International Congress on the Histopathology of the Nervous System. He said:

Considered as a whole, the physical organism of living beings, of plants, animals, or man has a unity subsisting in itself. Each of the members, for example, the hand, the foot, the heart, the eye, is an integral part destined by all its being to be inserted into the whole of the organism. Outside the organism it has not, by its very nature, any sense, any finality. . . . What results as far as the physical organism is concerned? The master and user of this organism, which possesses a subsisting unity, can dispose directly and immediately of the integral parts, members, and organs, within the scope of their natural finality. He can also intervene, as often as, and to the extent that, the good of the whole demands, to paralyze, destroy, mutilate, and separate the members.⁶³

The Catholic Church teaches that God created us in God's image and likeness (Gn 1:27-28). It

follows then that God created males with normal, healthy foreskins for the purpose of protecting the glans, providing natural lubrication to prevent dryness, and contributing significantly to the sexual response of the intact male. To surgically remove the foreskin for hygienic reasons, and/or to obtain other questionable benefits that absorb medical resources costing over \$200 million a year is not only ethically unjustifiable but morally irresponsible, especially when such procedures can lead to serious injury and even death. Besides the possible harm the procedure can inflict on a child—which violates the basic tenet of Catholic health care of treating every person with dignity and respect—it also violates Catholic health care's mandate to be responsible stewards of medical resources. When millions of people in the United States and around the world lack basic health care, the provision of a nontherapeutic procedure—especially one that is unnecessary, costly, and in some cases fatal—is irresponsible and a violation of the moral law. Therefore, it is unethical and immoral for Catholic health care institutions to continue to allow neonatal male circumcisions, except out of respect for religious practices of other faith traditions. Respecting the religious beliefs and practices of other faiths is confirmed in the *ERDs*.

CULTURE IS NO EXCUSE

Some ethicists have tried to justify neonatal male circumcision under the principle of totality for cultural reasons. The practice may have a powerful cultural value for many people. But the fact that something is culturally valued does not mean that it is also morally acceptable. History is full of examples of cultural traditions that run the gamut from the detrimental to the morally reprehensible—foot binding and widow burning are but two examples. As the Benatars have noted, "It is all too easy (and common) to privilege those cultural ways to which one is accustomed on account of their familiarity. There is value in stepping back from one's cultural assumptions. When one views male circumcision from another cultural perspective, one can only wonder what possessed ancient people to first think of removing the foreskin."⁶⁴

To justify male circumcision for cultural reasons could be seen as a precedent that supports the justification of female circumcision for cultural reasons. To justify one of these practices because of its cultural acceptance is to start down the slippery slope toward justifying the other as socially acceptable.

Barring religious obligation, there is little to

recommend routine neonatal male circumcision. If promoting the dignity and respect of every human person is a priority for the United States and for Catholic health care, then it is time to better educate the public about this issue and protect those who are the most vulnerable in our society. Doing so is not only a social responsibility; it is a moral imperative as well. ■

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