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# **Non-therapeutic male genital cutting & harm: Law, policy, & evidence from UK hospitals**

## **ABSTRACT**

Female genital cutting (FGC) is generally understood as a gendered harm, abusive cultural practice, and human rights violation. By contrast male genital cutting (MGC) is held to be minimally invasive, an expression of religious identity and a legitimate parental choice. Yet scholars increasingly problematise this dichotomy, arguing that male and female genital cutting can occasion comparable levels of harm. In 2015 this academic critique received judicial endorsement, with Sir James Munby's acknowledgement that all genital cutting can cause 'significant harm'. This article investigates the harm occasioned by MGC. It is informed by a Freedom of Information study which provides some empirical evidence of the nature and frequency of physical harm caused by MGC in UK hospitals. While acknowledging the challenges and limitations of FoI research, we outline important lessons that this preliminary study contains for medical ethics, law, and policy. It provides some empirical evidence to support claims regarding the risks which accompany the procedure and the obligation of health professionals to disclose them, and reveals the paucity of measures in place to ensure that harms are recorded, disclosed and monitored.

**Key Words:** Harm, genital cutting, circumcision, consent, Freedom of information, hospital records, children.

## INTRODUCTION

Male and female genital cutting procedures are commonly conceptualized and legally treated as ‘entirely different, even oppositional, practices’.<sup>1</sup> Thus, in the UK, in common with other jurisdictions, male genital cutting (MGC) is legally tolerated while female genital cutting (FGC) is met with increasingly punitive criminal law responses.<sup>2</sup> This asymmetrical legal treatment is typically justified on the basis that FGC is an abusive cultural practice which violates human rights, whereas MGC is understood as minimally invasive and an expression of religious identity that may have prophylactic advantages.<sup>3</sup> Such justifications rely on a variety of (gendered and raced) understandings of harm.<sup>4</sup> Thus, for instance, it is argued that FGC occasions direct bodily harm, as well as reflecting and perpetuating the wider harm that follows abusive gender relations. In stark contrast, any harm associated with MGC is reduced to rare instances of surgical complication.<sup>5</sup> Further, it is contended that harm is also occasioned by failure to circumcise: the boy may face being ostracised by his peers and the wider religious community,<sup>6</sup> as well as missing out on any putative health benefits.<sup>3 5</sup>

These binary understandings of the harms and benefits occasioned by the genital cutting of children have recently been challenged in English and Welsh law by Sir James Munby LJ,

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<sup>1</sup> Bennett, T. (2015). *Cuts and Criminality: Body Alteration in Legal Discourse*. Surrey: Ashgate Publishing, 68. The language employed in debates around the genital cutting of male and female children is contested and controversial (e.g. Davis DS. (2001). *Male and Female Genital Alteration: A Collision Course with the Law?* *Health Matrix*. 11, 487-570). In this article, we acknowledge these debates and refer to male and female genital cutting which we believe is the most neutral and least problematic formulation.

<sup>2</sup> Fox M., Thomson M. (2017). *Bodily Integrity, Embodiment and the Regulation of Parental Choice*. *Journal of Law & Society*. 44, 501-33.

<sup>3</sup> Earp BD., Hendry J., Thomson M. (2017). *Reason and paradox in medical and family law: Shaping children’s bodies*. *Medical Law Review*. 25(4), 604-27.

<sup>4</sup> Shahvisi, A., & Earp, B. D. (in press). *The law and ethics of female genital cutting*. In S. Creighton & L.-M. Liao (Eds.) *Female Genital Cosmetic Surgery: Interdisciplinary Analysis & Solution*. Cambridge: Cambridge University Press. Available at

[https://www.researchgate.net/publication/322287554\\_The\\_law\\_and\\_ethics\\_of\\_female\\_genital\\_cutting](https://www.researchgate.net/publication/322287554_The_law_and_ethics_of_female_genital_cutting)

Earp, B. D., & Darby, R. (2017). *Circumcision, sexual experience, and harm*. *University of Pennsylvania Journal of International Law*, 37(2 – online), 1-56. Available at

[https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2986449](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2986449)

<sup>5</sup> Robert Darby has problematised the tendency to reduced harm to surgical complications - see Darby R. (2016). *Moral Hypocrisy or Intellectual Inconsistency?* *Kennedy Institute of Ethics Journal*. 26(2), 155-163; Darby, R. (2015). *Risks, benefits, complications and harms: neglected factors in the current debate on non-therapeutic circumcision*. *Kennedy Institute of Ethics Journal*, 25(1), 1-34. Furthermore, casting the harm resulting from MGC as ‘rare’ depends upon the standard one uses to define ‘rare’, and the type of MGC in question, since less skilled practitioners will be more prone to causing harm - see Frisch, M. & Earp, B. D. (2018). *Circumcision of male infants and children as a public health measure in developed countries: a critical assessment of recent evidence*. *Global Public Health*, 13(5), 626-641.

<sup>6</sup> In the context of the religious and cultural significance of MGC, Michael Freeman has argued that a child has a right to circumcision. See, Freeman MDA., (1999). *A Child’s Right to Circumcision*. *BJU*. 83(S1), 74-78.

President of the Family Division. In the case of *B and G*<sup>7</sup> Munby LJ stated that, for the purposes of the Children's Act 1989, both female and male genital cutting can constitute 'significant harm' (p 69).<sup>8</sup> While he ultimately concluded that, in 2015, society was 'still prepared to tolerate' MGC (p 64), and his comments have yet to be taken up in other cases, we suggest that his statement regarding harm could mark a shift in judicial thinking. We suggest that such a shift would be particularly pertinent in the context of a wider judicial endorsement of patient autonomy, coupled with recognition of patients' and parents' rights to know the risks involved in procedures.

In this article, we interrogate the ethical question of harm, locating it within recent scholarship and professional guidance which challenge dominant polarised conceptions of harm in the context of genital cutting. We report on wider developments in law and policy where the courts have adopted the position that material risks of harm must be disclosed in order for consent to be legally valid.<sup>9</sup> Most significantly, in 2015 the UK Supreme Court stated in *Montgomery v Lanarkshire Health Board* that practitioners must disclose risks which would be significant to the reasonable person in the position of the person - patient or parent - giving consent. In this regard the Supreme Court emphasised the importance of respecting patients' rights and bodily integrity.<sup>10</sup> Applied to genital cutting, we argue that such dicta underline the importance of health professionals being informed about the material risks of the procedure. Drawing on results from a Freedom of Information (FoI) exercise that we conducted with the objective of empirically ascertaining the harm that male children suffer as a result of genital cutting in England and Wales, we suggest that better evidence is needed about the risks of this practice. While we acknowledge the significant limitations of FoI exercises in general, which are also reflected to this exercise, our study does reveal a record of bodily harm resulting from MGC. We argue that this reinforces calls for FGC and MGC to be debated within a common framework that recognises the value of a child's bodily integrity and his/her right to determine what is done to his or her body,<sup>2 3 11 12</sup> and also that it

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<sup>7</sup> *Re B and G* (children) (care proceedings) [2015] EWFC 3.

<sup>8</sup> 'Significant harm' is the threshold test for care proceedings by virtue of s.31. If such harm exists, the question is whether it resulted from parental care that fell below what it would be 'reasonable to expect'.

<sup>9</sup> For an overview of the issue with respect to neonatal circumcision, see Svoboda, J. S., Van Howe, R. S., & Dwyer, J. G. (2000). Informed Consent for Neonatal Circumcision: An Ethical and Legal Conundrum. *Journal of Contemporary Health Law & Policy* (1985-2015), 17(1), 61-134.

<sup>10</sup> *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. See also, Heywood R. (2015) R.I.P. Sidaway: Patient Orientated Disclosure – A Standard Worth Waiting For?. *Medical Law Review*. 23(3), 455-66.

<sup>11</sup> Earp BD. (2015). Female Genital Mutilation and Male Circumcision: Toward an Autonomy-based Ethical Framework. *Medicolegal and Bioethics*. 5(1), 89-104.

points to the need for a more comprehensive empirical investigation of these risks and how hospitals respond to them. We conclude by considering the implications of an approach grounded in harm prevention and the protection of bodily integrity, for law and policy.

## DEBATING HARM

As noted above, in England and Wales, there has recently been some judicial recognition of the harm occasioned by male genital cutting. In *B and G Munby LJ* considered the ‘curious’ (p 62) legal position of MGC vis-à-vis FGC, relying on the World Health Organisation’s (WHO) typology of FGC.<sup>13</sup> Having stated that a number of FGC practices are ‘more invasive than male circumcision’ (p 60), Munby observed that some practices falling under Type IV (defined as ‘all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization’) are ‘on any view much less invasive than male circumcision’ (p 60).<sup>14</sup> Further, he acknowledged that Type Ia, (that is, cutting or removal of the clitoral hood or prepuce), ‘is physiologically somewhat analogous to male circumcision’ (n.1). Following this assessment of the invasiveness of the different practices, and his acceptance that Type IV would constitute ‘significant harm’ for the purposes of the Children’s Act, he concluded:

Given the comparison between what is involved in male circumcision and FGM Type IV, to dispute that the more invasive procedure involves the significant harm involved in the less invasive procedure would seem almost irrational. In my judgement, if Type IV amounts to significant harm... then the same must be so of male circumcision (p 67).

This dicta marks a distinct departure from previous case law,<sup>2</sup> and in our view has the potential to align judicial thinking with the growing academic literature challenging common

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<sup>12</sup> Van Howe RS., Svoboda JS., Dwyer JG., Price CP. (1999) Involuntary circumcision: The legal issues. *BJU*. 83(S1), 63-73.

<sup>13</sup> WHO. (2017) Fact Sheet. Retrieved 2 October, 2017, from <http://www.who.int/mediacentre/factsheets/fs241/en/>

<sup>14</sup> In Denmark, doctors have declared circumcision of healthy boys ‘ethically unacceptable’, ([https://www.huffingtonpost.com/entry/denmarks-29000-doctors-declare-circumcision-of-healthy-us\\_58753ec1e4b08052400ee6b3](https://www.huffingtonpost.com/entry/denmarks-29000-doctors-declare-circumcision-of-healthy-us_58753ec1e4b08052400ee6b3)) and in Iceland the Nordic Ombudsman for Children made waves in saying that it ‘violates fundamental medical-ethical principles’ <https://www.crin.org/en/docs/English-statement-pdf>

sense and legal understandings of female and male genital cutting as categorically different.<sup>15</sup> Such scholarship has stressed the comparability of harm and risk when genital cutting of male, female and intersex infants are understood as involving a diverse range of practices of varying degrees of invasiveness.<sup>16</sup> Focusing on the actual corporeal harm occasioned by the cutting of children reveals a commonality between cutting practices that is generally obscured by the different cultural understandings of their meanings. As Earp, Hendry and Thomson (2017) have argued, polarisation of the practices:

... is in tension... with the fact that both the degree of invasiveness of the interventions themselves, as well as the underlying motivations, root causes, rationales, and associated symbolic meanings are at times quite similar, the same, or even reversed, when comparing like cases.<sup>17</sup>

A focus on bodily harm has also emerged beyond the academic literature, particularly in northern European jurisdictions.<sup>18</sup> For example, the Royal Dutch Medical Association's (KNMG) 2010 position paper highlighted potential harms, including:

infections, bleeding, sepsis, necrosis, fibrosis of the skin, urinary tract infections, meningitis, herpes infections, meatitis, meatal stenosis, necrosis and necrotising complications, all of which have led to the complete amputation of the penis. Deaths have also been reported (p 8).

Having detailed the range of complications associated with the procedure, the Association concluded that a 'powerful policy of deterrence should be established.' (p 3). Importantly, it stated that MGC may infringe a child's right to bodily integrity: 'The child is not only protected by the right to religious freedom, but also by the right to physical integrity. This right... is one of the most important basic rights' (p 13). Such a right was also accepted in a controversial ruling by the Cologne District Court in 2013. It found that cutting a boy for

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<sup>15</sup> For a discussion of the need to address the various forms of genital cutting within the same paradigm see Fox M, Thomson M. [2005] Cutting it: surgical interventions and the sexing of children" *Cardozo Journal of Law & Gender* 12: 82-97 Earp, B. D., & Steinfeld, R. [2018]. Genital autonomy and sexual well-being. *Current Sexual Health Reports*, 10(1), 7-17; Garland F, Travis MJ. (2018) Legislating Intersex Equality: Building the Resilience of Intersex People through Law. *Legal Studies* (forthcoming)

<sup>16</sup> Fox M., Thomson M. (2005) Short Changed? The Law and Ethics of Male Circumcision. *International Journal of Children's Rights*. 13, 161-181.

<sup>17</sup> Earp et al, *op. cit.* note 3, p6

<sup>18</sup> See, e.g., Child Rights International Network. (2013) Let the Boys Decide on Circumcision: Joint Statement from the Nordic Ombudsmen for Children and Paediatric Experts. Retrieved 2 October, 2016, from <http://www.crin.org/docs/English-statement-.pdf>; Nordic Association of Clinical Sexology. (2013). Nordic Association of Clinical Sexology statement on non-therapeutic circumcision of boys. Retrieved 2 October, 2017, from [http://nacs.eu/data/press\\_release001.pdf](http://nacs.eu/data/press_release001.pdf)

religious reasons caused impermissible bodily injury thus breaching his right to both physical integrity and self-determination. It was clear that neither parental rights nor freedom of religion could justify circumcision which ‘changes the child's body permanently and irreparably’.<sup>19</sup> Leave to appeal the decision was denied,<sup>2</sup> although the ruling prompted legislation which lessened its impact. The ethical importance of the child’s right to bodily integrity, self-determination, and an ‘open future’ has also been advocated in recent academic literature.<sup>2</sup> Such claims also chime with a trend for bodily integrity to be positioned in UK health law as the foundation or ‘cornerstone’ of all human rights and as a prerequisite for individuals to act equally in the public sphere.<sup>20</sup> Protecting children’s bodily integrity is therefore essential to guaranteeing future rights and freedoms.<sup>2</sup> While such scholarly trends are important in articulating children’s rights, their practical significance is heightened when endorsed by a prominent judicial voice such as Munby’s.

Yet, within the emerging literature which has focused attention on the question of harm, there continues to be limited consideration of the qualitative or quantitative nature of such harms.<sup>21</sup> In taking up this issue, it is worth emphasising at the outset that non-therapeutic MGC is the removal without therapeutic justification of healthy erogenous tissue that has a clear physiological function.<sup>22</sup> In the case of FGC the loss of directly analogous tissue is accepted to be harmful in and of itself, and we contend that no logical justification for distinguishing between removal of healthy female and male tissue exists.<sup>3</sup> <sup>23</sup> Should the risk of *further* harm

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<sup>19</sup> Landgericht Köln (Cologne District Court), Judgment on May 7 (2012) No. 151 Ns 169/11. See English translation available at Ambler A. (2012) News – District Court of Cologne Judgement of 7 May 2012 on Male Circumcision for Religious Reasons. Retrieved 1 October, 2017, from <https://www.dur.ac.uk/ilm/news/?itemno=14984> p.3. For an in depth analysis of this case, see Merkel, R., & Putzke, H. (2013). After Cologne: male circumcision and the law. Parental right, religious liberty or criminal assault? *Journal of Medical Ethics*, 39(7), 444-449.

<sup>20</sup> Elsewhere, we have traced how the right to bodily integrity has become increasingly significant in UK and European Court of Human Rights jurisprudence in seminal cases including *Montgomery* – see n x and *Glass v. UK* [2004] 1 FLR 1019 - which cast it as underpinning a right to autonomy or family life, see Fox and Thomson, note 2. See also Herring J, and Wall J, [2017] The Nature and Significance of the Right to Bodily Integrity. *Cambridge Law Journal* 76:566-88. For an ethical analysis of the content of this right in the context of genital cutting of children see J. Mazor [2018, forthcoming] On the Child’s Right to Bodily Integrity: When is the Right Infringed? *Journal of Applied Philosophy*

<sup>21</sup> Although, see Gerharz EW., Haarmann C. (2000) The First Cut is the Deepest? Medicolegal Aspects of Male Circumcision. *BJU*. 86, 332-338, 334; Earp, B. D., & Darby, R. (2017). Circumcision, sexual experience, and harm. *University of Pennsylvania Journal of International Law*, 37(2), 1-56. Available at [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2986449](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2986449)

<sup>22</sup> Cold, C. J., & Taylor, J. R. (1999). The prepuce. *BJU International*, 83(S1), 34-44; for an alternate view that suggests that it has little physiological function, see Cox, G., Krieger, J. N., & Morris, B. J. (2015). Histological correlates of penile sexual sensation: does circumcision make a difference? *Sexual Medicine*, 3(2), 76-85.

<sup>23</sup> A number of commentators have also drawn attention to the potential for pain and trauma from the event itself. See Van Howe RS., Svoboda JS., Dwyer JG., Price CP. (1999) Involuntary Circumcision: The Legal Issues. *BJU*. 83(S1), 63-73, 67.

from MGC manifest it can range from the relatively minor to the catastrophic.<sup>24</sup> We argue that interrogating such harm is important for four related reasons. First, as already noted, the harms and risks of MGC have been ignored historically.<sup>25 26</sup> In this regard, law, policy and practice have lagged behind the (already slow) transition in our understanding of infants from passive objects to persons who experience pain and have interests.<sup>27</sup> Secondly, this has at times impacted on cost benefit analyses of MGC, since harms have not been weighed against putative benefits.<sup>10</sup> Thirdly, harm has a specific ethical valence when non-therapeutic interventions are being considered, and in analogous contexts it defines the legitimate parameters of both parental action and religious observance.<sup>28</sup> Finally, recognising documented and quantifiable harms is particularly important in the evaluation of claimed medical or health benefits. The assertion of such benefits has a long and dubious history, closely tied to Victorian preoccupations with masturbation, purity and hygiene that have been recast by subsequent generations.<sup>29 30</sup> At times, these claimed benefits have surfaced with a distinctly racial hue.<sup>31</sup> This history, at least in respect to neonatal circumcision, has been subject to sustained criticism,<sup>12 28</sup> and contemporary health claims are increasingly understood as heavily influenced by cultural preoccupations.<sup>32 33</sup> Yet, since medical or health claims continue to carry particular resonance it is crucial in evaluating the procedure to weigh speculative claims of medical benefit against quantifiable harms and risks.

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<sup>24</sup> As detailed by the KMNG – see n 44. Moreover, such harms may be psycho-social or psychological – see e.g., Johnsdotter, S. [2013]. Discourses on sexual pleasure after genital modifications: the fallacy of genital determinism - a response to J. Steven Svoboda. *Global Discourse*, 3(2), 256-265; Earp, B. D. (2015). Sex and circumcision. *American Journal of Bioethics*, 15(2), 43-45

<sup>25</sup> Darby R. (2015). Risks, Benefits, Complications and Harms: Neglected Factors in the Current Debate on Non-Therapeutic Circumcision. *Kennedy Institute of Ethics Journal*. 25(1), 1-34.

<sup>26</sup> Fox M, Thomson M. (2005). A Covenant with the Status Quo? Male Circumcision and the New BMA Guidance to Doctors. *J Med Ethics*. 31, 463-469.

<sup>27</sup> Cunningham Butler N. (1989). Infants, Pain and what Health Care Professionals Should want to know now – an issue of epistemology and ethics. 3(3) *Bioethics* 181

<sup>28</sup> Plant R. (2011). Religion, Identity and Freedom of Expression. *Res Publica*. 17(1), 7-20.

<sup>29</sup> Darby R. (2005). *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain*. Chicago: Chicago University Press.

<sup>30</sup> Fox M, Thomson M. (2012). The New Politics of Male Circumcision: HIV/AIDS, Health Law and Social Justice. *Legal Studies*. 32(2), 255-281.

<sup>31</sup> Fox M, Thomson M. (2013). HIV/AIDS and Male Circumcision: Discourses of Race and Masculinity. In Fineman M. Thomson M (eds). *Masculinity, Feminism and Law*. (pp97-113) Aldershot: Ashgate.

<sup>32</sup> Frisch M et al. (2013). Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision. *Pediatrics*. 131(4), 796-800; see also the response by the AAP - AAP (2013). Cultural bias and circumcision: the AAP task force on circumcision responds. *Pediatrics*, 131(4), 801-804; and also the response to this rebuttal, Earp, B. D. & Shaw, D. M. (2017). Cultural bias in American medicine: the case of infant male circumcision. *Journal of Pediatric Ethics*, 1(1), 8-26.

<sup>33</sup> Van Howe R. (2017) Response to Vogelstein: How the 2012 AAP Task Force on circumcision went wrong. *Bioethics* 1

## EVIDENCING MEDICAL HARM

Some concrete evidence of the medical harm occasioned by MGC in England and Wales does exist, although it remains under-reported. For instance, NHS reporting of ‘Admitted Patient Care, Outpatients and Accident and Emergency Data’ discloses that between 1998 and 2014, 21,965 patients were admitted to NHS hospitals due to problems concerning ‘circumcision’.<sup>34</sup> This yearly recording of statistics details the incidence of complications, as a primary diagnosis, ranging from 872 to 2,009 per complete year, which suggests that the harms occasioned by male genital cutting are under reported. In an attempt to unpack what appears to be a significant record of harm, in November 2016 we sent a Freedom of Information (FoI) request to 51 NHS Trusts and 11 NHS CCGs. The exercise secured a response rate of 82.3% (n=51). Each authority was asked to provide information about the number of patients admitted for post-circumcision problems between January 2008 and January 2016, as well as details of age and the diagnosis. Responding to anecdotal reports regarding the severity of problems encountered at certain hospitals, we also requested information on how many admissions could be considered life threatening. Finally, the authorities were asked whether any procedures for monitoring short and long-term complications of infant circumcision were in place. At the outset, we would acknowledge that this exercise generated data with significant limitations, reflecting the inherent limitations of using the FoI mechanism to assess the practices of public bodies. These limitations are especially apparent in a study such as ours which surveyed a range of hospitals with variable recording practices. Due to budgetary constraints on FoI requests, which are likely to be an issue in most studies, certain authorities were unable to comply with the request in whole or in part. The total cost of work that can be requested is capped at £450. In practice, with retrieval time charged at £25 per hour, a maximum of 18 hours work can be required from each authority; while the authority may exceed this limit, there is no incentive for it to do so.

Of the responses received, six hospitals claimed that it would be too much work to generate the requested information, with a number citing the reason as being the large number of patients circumcised during that time (e.g. North Tees recording 1,618). Conversely, and

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<sup>34</sup> NHS Digital. (2014). Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data: April 2014 – August 2014. Retrieved 1 October, 2017, from <http://content.digital.nhs.uk/searchcatalogue?productid=16574&q=surgical+deaths&topics=0%2fillnesses+and+conditions&sort=Relevance&size=10&page=1#top>

highlighting very directly the problems of a multi-site survey, a nearby NHS Trust (South Tyneside PCT) stated that they did not conduct circumcisions and so reported no post-circumcision problems. Such variation highlights problems around record keeping, interpretation of the data requested, and consistency of response. In total, five hospitals claimed not to hold this information, or to be unable to access it due to insufficient coding to provide the necessary detail. Others declined to provide information because the small number of cases might render individuals identifiable, thereby breaching confidentiality and data protection rules.<sup>35</sup> When information was forthcoming, the amount of data provided was inconsistent, seemingly reflecting the approach of individual trusts either to FoI requirements or to MGC, or both. Wide variation also existed in how accurately Trusts interpreted the questions posed. Where data was not fully recorded by the trusts, on occasions we were provided with speculative responses that could not be adequately utilized. For example, one hospital commented:

Paediatrics at the Trust do not keep a record of patients who have been admitted with post-circumcision problems (**we think** we have seen between 2 and 5 patients during that period of time (emphasis added)).

Finally, the data regarding age could not be provided in a significant number of cases, and consequently we are not able to report on age distribution of complications.

In the first place then we would suggest that the value of this study lies in how it supports a wider critique of the difficulties in using FoI exercises to generate a comprehensive dataset, at least in a health context.<sup>36</sup> Differences in data collection methodologies deployed by various hospitals can produce or exacerbate variation in results and the FoI process does not allow for external corroboration of accuracy. As we have highlighted, this issue was compounded by the number of hospitals that held no data in response to particular questions, or which declined to respond at all. Some respondents themselves cast doubt on the diagnostic information they supplied. For instance, Belfast Health and Social Care Trust acknowledged that 'Data quality issues also exist with some of the diagnostic information'. It is therefore possible that some of the data remains unreported, even at those hospitals which responded to the requests. Given the variations which this study and others have revealed, it is highly questionable whether the FoI process is fulfilling its potential to facilitate research

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<sup>35</sup> s7 Data Protection Act 1998.

<sup>36</sup> See Farrukh A., Mayberry JF. (2015). Ethnic Variations in the Provision of Biologic Therapy for Crohn's Disease: a Freedom of Information Study. *Medico-Legal Journal*. 83(2), 104-108, 107.

which effectively investigates the actions of public institutions and bodies. At the very least such exercises need to be supplemented by further empirical research.<sup>37</sup> The limitations of the FoI process were widely recognised during the enactment of the FoI legislation, with Members of the House of Commons and House of Lords<sup>38</sup> acknowledging the large number of exemptions. However, it was argued that a balance had to be struck between access to information and the effective functioning of public authorities.<sup>39</sup> Yet in practice this compromise has resulted in too few requests being acceded to: ‘Of the 10,564 FOI requests received [between July 2016 and September 2016], 7,882 were resolvable. Of these 44% were granted in full, and 33% were withheld in full’.<sup>40</sup> As in our study, a significant proportion of withheld information was justified by exemptions based on potential costs. This priority accorded to the functioning of public authorities means that ‘[e]xceptions remain far too common. And the available information is too often placed behind tedious bureaucratic hurdles.’<sup>41</sup>

## RESULTS OF THE FOI EXERCISE

In total, over this eight-year period, 1,266 post-circumcision problems<sup>42</sup> were reported by the NHS authorities.<sup>43</sup> 1,026 of these could be assigned to specific years and these are

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<sup>37</sup> Savage A., Hyde R. (2014). Using FOI Requests to Facilitate Research. *Journal of Social Research*. 17, 303-317.

<sup>38</sup> Sir Nicholas Lyell: ‘The defect of the Bill is that it is too restrictive and has too many exemptions. There must be a significant number of exemptions.’ HC Deb 7 December 1999, vol 340, cols714-98, [763]; Lord Goodhart ‘(...) 23 categories of exemption are too many. Do the Government accept that when we have had a few more months' experience of the Freedom of Information Act, it will be necessary to set up an independent review to reconsider whether further access to information will be necessary?’ HL Deb 8 March 2005, vol 670, cols 620-3, [620].

<sup>39</sup> The Minister of State, Cabinet Office (Lord Falconer of Thornton): ‘Openness does not have a monopoly on righteousness. Privacy and confidentiality have their proper place, and the right of the public to know must not place an unnecessary burden on business or undermine the proper and efficient running of government in the public interest’ HL Deb 17 October 2000, vol 617, cols886-912, [899].

<sup>40</sup> Wallace J. (2016). Freedom of Information Statistics – Implementation in Central Government (July to September 2016). Retrieved 24 January, 2018, from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/577781/foi-statistics-q3-2016-bulletin\\_1\\_.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577781/foi-statistics-q3-2016-bulletin_1_.pdf), p1

<sup>41</sup> Nick Clegg. (2011). Restoring British Liberties speech, - January 2011. Retrieved 24 January, 2018, From <https://www.gov.uk/government/speeches/civil-liberties-speech-deputy-prime-minister>

<sup>42</sup> It must be noted that it would not be possible to deduce with certainty that all problems ‘post’-circumcision were caused by circumcision, so we may only use data that the hospitals respond to as being a ‘post-circumcision complication’.

<sup>43</sup> It is difficult to give a precise number of individuals that are circumcised each year to give full context to this number, but research suggests that the number of boys being circumcised is around 3.1% Rickwood AMK, Kenny SE, Donnell SC. (2000) Towards evidence based circumcision of English boys: survey trends in practice *BMJ* 321, 792-794. Cathcart P, Nuttall M, van der Meulen J, Emberton M, Kenny SE. (2006) Trends in paediatric circumcision and its complications in England between 1997 and 2003. *British Journal of Surgery* 93, 885-890,

represented in **Figure 1**. The number of problems has remained fairly steady, with a small drop in 2014, and a further drop in 2016 (an incomplete year at the time of the request). It should also be noted that the earlier years (2008-2010) have artificially low levels, due to reorganisations within the NHS. Indeed, owing to changes in their systems, some hospitals could not provide data for the full period requested. Several were unable to provide information before 2010, others were unable to do so prior to 2013.

NHS authorities reported the following 52 different post-circumcision complications or problems that resulted in follow-up care (see **Table 1**). Many of these complications are relatively minor, although again it is worth recalling that they typically result from a non-therapeutic intervention. Other harms are significantly more serious; for example, amputation (recorded as either ‘Removal of other organ (partial) (total)’ or ‘Acquired absence of genital organ(s)’).<sup>44</sup> As regards the more serious complications, three are worthy of note on the basis of frequency: moderate bleeding, haemorrhage and haematoma, and infection. As regards the first, bleeding is believed to occur in approximately 1% of all circumcisions,<sup>45</sup> but rates for this complication can be higher where MGC is performed by those without medical training.<sup>46</sup> Of course, bleeding can be exacerbated by pre-existing conditions, and for those with coagulation disorders can be lethal. Moderate bleeding can result in the loss of a potentially fatal amount of blood.<sup>47</sup> In our study this occurred at NHS Greater Glasgow and Clyde, where a patient needed a blood transfusion. This was the only response that acknowledged a complication that could be regarded as life threatening. Other authorities, such as Barking and Dagenham, reported that they ‘do not have the level of detail to answer whether any of the admissions were considered life threatening’. With haemorrhage or

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888. It is possible to estimate the number of yearly circumcisions based on this number, but we acknowledge the significant limitations of this estimate. ONS Statistics (<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths>) for births suggest 696,000 children are born each year in the UK and Wales, and if we assume approximately half of these are boys, we have 348,000 births a year. This would lead to an estimate of around 10,788 boys per year, and thus 86,304 over an 8 year period.

<sup>44</sup> As noted, the KNMG also noted the risk of amputation. This is also recorded in Gerharz EW., Haarmann C. (2000). The First Cut is the Deepest? Medicolegal aspects of male circumcision. *BJU*. 86, 332-338, 335.

<sup>45</sup> Krill AJ., Palmer LS., Palmer JS. (2011). Complications of Circumcision. *Scientific World Journal*. 11, 2458-2468, 2463.

<sup>46</sup> Özdemir E. (1997). Significantly increased complication risks with mass circumcisions. *BJU*. 80, 136-139, 137; Atikeler MK., Onur R., Gecit I., Senol FA., Cobanoglu B. (2001). Increased Morbidity after Circumcision from a Hidden Complication. *BJU*. 88, 938-940, 938.

<sup>47</sup> Evidence of coagulation disorders significantly increasing the risk of death associated with circumcision was presented in: Earp, B. D., Allareddy, V., Allareddy, V., & Rotta, A. T. (2017, September). Factors associated with early deaths following neonatal circumcision. Presented at the American Academy of Pediatrics National Conference, Chicago.

haematoma, swelling of blood clots can potentially cause severe harm. Finally, infection, if left untreated, may cause severe damage, but on its own, it is usually treatable. Infections can vary greatly in terms of seriousness, but no hospital cited any complication as serious as necrosis, which has been noted by the KMNG and others as a potential outcome of circumcision. It is also worth noting that some post-circumcision problems are recorded with a different primary diagnosis (e.g. vomiting), but diagnostic descriptions show that it is a result of a circumcision.

Within the authorities surveyed, procedures for monitoring short and long-term complications of infant circumcision were rare, and the majority could provide no information on any such process. Some hospitals gave reasons for this absence of procedures, such as not performing circumcisions on children; others offered no such justification. For hospitals that performed circumcisions on the basis of ‘medical necessity’<sup>48</sup> the need for monitoring procedures for infant circumcision was downplayed. For example, the Isle of Wight stated:

We have not identified any monitoring systems for following up on infant circumcision. It should be noted that the majority of circumcision procedures undertaken were of adult patients (354/453, 78%) with only 22% (100/453) aged under 16.

The implication here seems to be that since children are a minority of those circumcised, a monitoring procedure for children would be unwarranted. Only Alder Hey and University Hospital Southampton provided detail about their monitoring procedures. Alder Hey ensures that a Paediatric Urologist or Nephrologist provides long term management and follow ups, whereas Southampton uses follow up clinics with the surgical team, or with the general practitioners, depending on the reason for the circumcision.

## CONCLUSIONS

The growing acknowledgement that MGC may entail harm (from the removal of healthy tissue per se through to subsequent complications)<sup>49</sup> raises troubling questions for law,

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<sup>48</sup> Phimosis is often recorded as a clinical justification for MGC, however it has been argued that this problem is routinely over-diagnosed, see Shankar KR., Rickwood AMK. (1999). The Incidence of Phimosis in Boys. *BJU*. 84, 101-102, 101.

<sup>49</sup> The loss of healthy tissue per se is beginning to be acknowledged as a harm. See, for example, Svoboda, J. S. (2017). Nontherapeutic circumcision of minors as an ethically problematic form of iatrogenic injury. *AMA*

policy, and medical practice. Specifically, judicial recognition that the procedure is harmful, coupled with increasing evidence of the harms occasioned, will increase pressure on medical regulators and the legislature to consider whether the current ‘curious’ legal and policy position identified by Munby LJ is sustainable. In addition, we would argue that the results of our FoI exercise suggest the need for further empirical research to inform the practices of the medical profession, individual practitioners and Trusts. Specifically, it is important that better data is kept, including details regarding the incidence of harm. In turn these should inform the process of consent to individual procedures, especially given the emphasis in the Supreme Court ruling in *Montgomery* on the importance of disclosing risks that a reasonable patient or parent would wish to know. Risk disclosure is particularly important where the procedure is performed for non-therapeutic reasons. In the Netherlands the KNMG statement summarised the ethical and professional obligations on practitioners, emphasising the duty to share information that is entailed by the twin facts that the procedure is not medically indicated and carries these clear risks of harm:

Doctors who perform circumcisions must... follow all applicable scientific guidelines. This entails, amongst other matters, that circumcisions can only be carried out under local or general anaesthetic, after thorough and precise advice and information has been given to the child’s parents. The fact that this practice is not medically necessary and entails a genuine risk of complications means that extra-stringent requirements must be established with regard to this type of information and advice (p 1).

We would argue that this summary is equally applicable to the United Kingdom, especially following the *Montgomery* decision, since such risks of harm would surely be considered material by a reasonable parent considering this intervention. Yet from our FoI results it seems doubtful that healthcare professionals have the necessary awareness of risks, since it is evident that Trusts approach the recording of complications in different ways, with a significant number failing to record at all. This variance raises concerns about the level of knowledge amongst hospital staff, as well as the accuracy of statistics generated to inform public health planning. Moreover, the fact that only a minority of authorities reported that they provided post-circumcision monitoring poses questions concerning whether patients are offered or receive adequate follow-up care. The potential for post-circumcision problems to

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*Journal of Ethics*, 19(8), 815-824. See also Earp, B. D. (2017). Gender, genital alteration, and beliefs about bodily harm. *Journal of Sexual Medicine*. 14(5 - Supp. 4), e225.

go undiagnosed is further cause for concern and points to the need for a more unified approach to recording complications and caring for patients' post-circumcision.

In sum, valuable information has been gleaned about incidence and types of harms by our preliminary study, which should inform the advice given by health professionals. Yet, our experience of the FoI process reinforces questions about its utility in health research. This is due to the lack of consistency in record keeping, the widespread use of exemptions, and the variable degree of engagement with requests. To realise the potential of the FoI Act, action needs to be taken to ensure that public bodies possess the technical and organisational expertise to effectively and consistently answer FoI requests. In 2004 the House of Commons Constitutional Affairs Committee commented that 'there is little evidence that the DCA [Department of Constitutional Affairs] has been sufficiently active in providing the necessary leadership to ensure that many of the organisational and technical problems have been addressed in time in [the health] sector.'<sup>50</sup> Although these issues have been clearly flagged as concerns, in 2016 the FoI process was deemed fit for purpose by a Cabinet Office review of its operation.<sup>51</sup> Widespread relief that the Act was not repealed may have deflected attention from the issue of whether the process has been adequately implemented or resourced. In our view it is now imperative that the system is adequately funded and enforced in order to realise the research potential of the FoI legislation.

Our data provides some empirical evidence to support the growing academic and judicial concern with the physical harms caused by MGC and how these are recorded by public bodies.<sup>52</sup> As we have demonstrated, in addition to the direct harm occasioned by MGC, further harms can range from the relatively minor to the catastrophic. They often go unreported and generally enter public discourse only in the most extreme cases, where death occurs, or where there is a clustering of harm.<sup>53</sup> These documented harms also need to be

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<sup>50</sup> Parliament. (2005). House of Commons Constitutional Affairs Committee, Freedom of Information Act 2000 – progress towards implementation: First Report of Session 2004-2005 Volume I [20]. Retrieved 22 January, 2018, from <https://www.publications.parliament.uk/pa/cm200405/cmselect/cmconst/79/79i.pdf>

<sup>51</sup> Gov.uk. (2016). Independent Commission on Freedom of Information Report 2016. Retrieved 22 January, 2018, from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/504139/Independent\\_Freedom\\_of\\_Information\\_Commission\\_Report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/504139/Independent_Freedom_of_Information_Commission_Report.pdf)

<sup>52</sup> Also see Frisch, M. & Earp, B. D. (2018). Circumcision of male infants and children as a public health measure in developed countries: a critical assessment of recent evidence. *Global Public Health*, 13(5), 626-641.

<sup>53</sup> Such clustering was seen in a widely reported mass circumcision in a School library in Oxford. Of this group 44.8% developed complications. See Paranthaman K., Bagaria J., O'Moore E. (2010). The Need for Commissioning Circumcision Services for Non-Therapeutic Indications in the NHS: Lessons from an Incident Investigation in Oxford. *Journal of Public Health*. 33(2), 280-283.

read in the context of other scientifically robust studies, which indicate, for example, that MGC results in a higher incidence of sexual dysfunction in later life.<sup>54</sup> Further, such harms exist alongside other less direct harms that are increasingly acknowledged, such as violations of the child's rights to bodily integrity, self-determination, and an open future.<sup>2</sup>

There are signs that law is finally beginning to engage with these direct and indirect harms of MGC. In a series of recent cases courts have had to adjudicate in parental disputes over cutting male children.<sup>55</sup> Arguably, a consensus has emerged that in these circumstances an order permitting the intervention will be refused, deferring the decision until the child is competent to make it. This aligns with academic work that questions the role of 'family interests' in best interests deliberations.<sup>56</sup> Given the harms we have identified, however, it must be questioned why a child's bodily integrity and self-determination is afforded protection only in families riven by dispute.<sup>3</sup> As case law increasingly stresses the importance of bodily integrity as a platform for autonomous and informed decision-making, it is difficult to defend the current legal position, which subjects decision-making to scrutiny only in cases where parents disagree. Rather we would argue that there is a need for a comprehensive re-thinking of the limits of parental choice where irreversible bodily harm is occasioned to a child for non-therapeutic reasons.

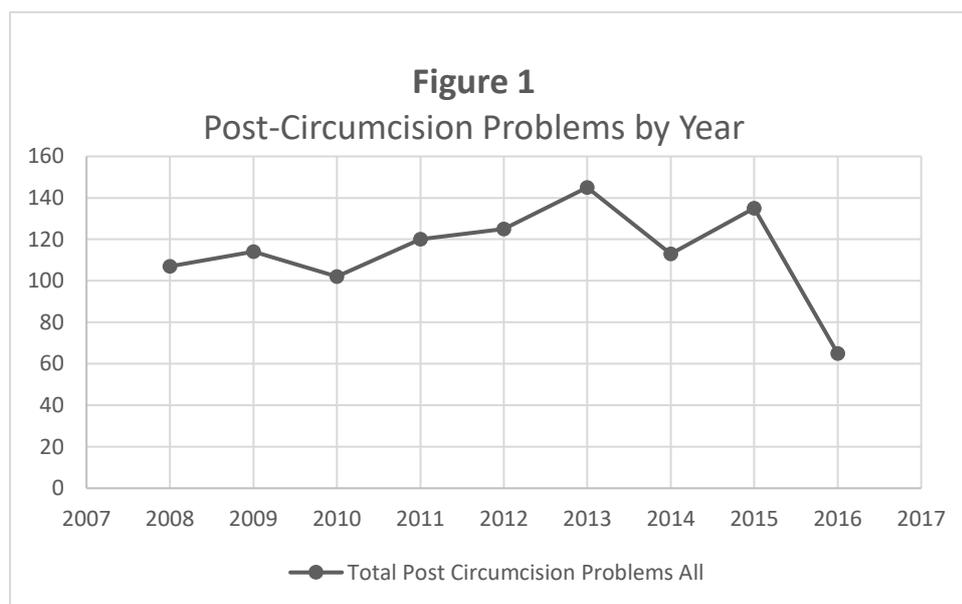
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<sup>54</sup> Frisch, M., Lindholm, M., & Grønbaek, M. (2011). Male circumcision and sexual function in men and women: a survey-based, cross-sectional study in Denmark. *International journal of epidemiology*, 40(5), 1367-1381; but compare with Morris et al. who claim circumcision makes no difference to sexual pleasure and function (albeit that their study relies adult circumcision rather than infant circumcision): Morris, B. J., & Krieger, J. N. (2013). Does male circumcision affect sexual function, sensitivity, or satisfaction?—a systematic review. *Journal of Sexual Medicine*, 10(11), 2644-2657

<sup>55</sup> *Re J (child's religious upbringing and circumcision)* [1999] 2 FLR 678; *Re S (Specific Issue Order: Religion: Circumcision)* [2004] EWHC 1282 (Fam); *Re L and B (children) (Specific Issues: Temporary Leave to Remove from the Jurisdiction; Circumcision)* [2016] EWHC 849 (Fam).

<sup>56</sup> P. Baines. (2017). Family interests and medical decisions for children. 31 *Bioethics* 599

**TABLES/FIGURES**



**Table 1 – List of post-circumcision complications or problems that resulted in follow up care, as obtained by Freedom of Information Requests.**

Pulmonary stenosis
Pain
Pyrexia
Sepsis unspecified
Escherichia coli as cause of dis classified to other chaps
Hypo-osmolality and hyponatraemia
Residual foreign body in soft tissue – Other
Other and unspecified hydronephrosis
Vesicoureteral-reflux-associated uropathy
Urinary tract infection, site not specified
Redundant prepuce, phimosis and paraphimosis
Leukoplakia of penis
Other specified disorders of penis
Disorder of penis, unspecified
Other congenital malformations of penis
Congenital hydronephrosis
Retention of urine
Other difficulties with micturition
Fever, unspecified
Syncope and collapse
Haemorrhage, not elsewhere classified
Contusion of external genital organs

Traumatic secondary and recurrent haemorrhage
Post-traumatic wound infection, not elsewhere classified
Other early complications of trauma
Unspecified early complications of trauma
Haemorrhage and haematoma complicating a procedure NEC
Disruption of operation wound, not elsewhere classified
Infection following a procedure, not elsewhere classified
Other complications of procedures, not elsewhere classified
Unspecified complication of a procedure
Other specified complications of surgical and medical care NEC
Contact with other sharp object(s) Home
Contact with other sharp object(s) School, other institution and public administrative area
Contact with other sharp object(s) Other specified places
Contact with other sharp object(s) Unspecified place
Surgical instruments materials and devices (inc sutures)
Surgical operation with implant of artificial internal dev
Other reconstructive surgery
Removal of other organ (partial) (total)
Other surgical procedures
Surgical procedure, unspecified
Observation for other suspected diseases and conditions
Sterilization
Attention to surgical dressings and sutures
Other specified surgical follow-up care
Acquired absence of genital organ(s)
Soft tissue infection
Balanoposthitis
Polyuria
Post op swelling circumcision
Unilateral or unspecified inguinal hernia, with obstruction, without gangrene

## FIGURE LEGENDS

Figure 1: A graphical representation of the number of post-circumcision problems by year, found through our Freedom of Information request.

Table 1: A list of post-circumcision complications or problems that resulted in follow up care, as obtained by our Freedom of Information request.