Article:
Fox, M. and Thomson, M. orcid.org/0000-0002-1570-2481 (2024) Judging children's best interests: Centring bodily integrity. Clinical Ethics, 19 (4). pp. 341-348. ISSN 1477-7509

https://doi.org/10.1177/14777509241291708

Clinical Ethics

Judging children's best interests: Centring bodily integrity

Journal:	*Clinical Ethics*
Manuscript ID	CE-24-058.R1
Manuscript Type:	Papers
Keywords:	Bodily integrity, Embodied integrity, Children, Best interests, Genital cutting, Law

Abstract: This article addresses how bodily integrity has been mobilised in the context of genital cutting of male infants and the extent to which the concept is taken into account in legal decision making in the UK. While bioethicists have debated whether interventions on children's bodies are more appropriately determined on the basis of hypothetical consent or in the child's best interest, it is clear that in law the relevant test is whether interventions are in the child's best interest. As the issue of non-consensual genital cutting of infants has become more contested, courts have been asked to adjudicate on the best interests of infants in situations where their caregivers disagree about procedures. Although this body of jurisprudence remains (surprisingly) small, in this article we argue that while there are now discernible trends in such cases (for example, deferring decision-making until the child has the requisite capacity to decide, engaging with certain human rights norms), too often judicial reasoning about a child's best interests remains largely empty of reasoned content, and in certain respects is regressing. Using the recent case of Re P to exemplify this logic, and drawing on our previous work advocating the value of embodied integrity, we argue that judges should adopt a more substantive framework of values in judging the child's corporeal and other interests in such cases. This would move best interests assessments beyond a mere formalistic exercise and lead to better reasoned legal judgments.

Judging children's best interests: Centering bodily integrity

Introduction:

Twenty years ago the British Medical Association (BMA) issued revised guidance to its members on how they should respond to requests for non-therapeutic male circumcision.[1] The 2004 guidance provoked our interest in the issue of male genital cutting and how it is professionally and legally regulated. In a critique of the guidance, we argued that the BMA wrongly assumed that the practice was lawful and also drew a deeply problematic dichotomy between the practices of male and female genital cutting.[2] More broadly, we criticised UK law's failure to confront the risks that male genital cutting poses to the infant body. Reflecting back on this early intervention, it is striking both that the BMA guidance failed to refer to the bodily integrity of the child subject and that we failed to criticise it for this omission.

In a roughly contemporaneous article, which addressed legal regulation of the practice in more depth,[3] we suggested that law's failure to satisfactorily address the procedure is grounded in a wider cultural reluctance to recognise the pain and harm that the practice causes to infant male bodies. Here we noted Jo Bridgeman's suggestion that in part this may reflect a wider cultural unwillingness to recognise young children as possessors of bodily integrity.[4(p111)] This reluctance persisted notwithstanding the foundational position of bodily integrity as a key jurisprudential value.[5-7] Over the subsequent two decades much has changed both in our own position and in the wider ethico-legal context.[8] For instance, following our initial attempt to reframe male genital cutting as a matter deserving of ethico-legal attention, a growing body of scholarship has criticised how law has responded to the practice.[9-14] In our contributions to this literature, which have largely focused on the legal

position governing children who are too young to consent, we have argued that it is crucial to cast non-consensual genital cutting as an unwarranted interference with bodily integrity, which should usually be deferred until the child can make the decision for himself.[15] In addressing bodily integrity we have sought to develop how this fundamental value is understood, to better explain what we seek to protect when bodily integrity is invoked. To this end, we have sought to articulate the concept of embodied integrity. This concept engages our lived experience of the body as the means by which we experience and become ourselves in the world. In our view it offers a more complex understanding of corporeality than the prevalent 'invasion narrative'[16] which underpins most ethico-legal accounts of bodily integrity and seeks purely to protect bodily boundaries. In contrast, embodied integrity recognises that the body is inseparable from the social and institutional contexts in which it exists and acknowledges that our bodies enable us to pursue key dimensions of our humanity, such as our wellbeing, flourishing and our relationships. Finally, within this understanding, the body is recognised as a site at which we experience and enact our subjectivity.[15, 17] Non-consensual and non-therapeutic bodily interventions might acordingly best be understood not as one off interventions, but as biographical. They have the potential to shape our life course and later embodied freedoms. As such, we argue that any best interests assessment – the framework within which decisions regarding the care of children and young people are required to be made in UK domestic and international law - must begin with an accounting of possible bodily risks and harms.

As we have pursued this work it is notable that bodily integrity has attracted considerable attention in ethico-legal scholarship which has often been critical of male genital cutting.[18, 19] Further, in other jurisdictions professional bodies have promulgated guidance that is more

overtly critical of male genital cutting, and in some cases this questioning of the practice has been grounded in the value of bodily integrity.[20] More generally in English law, criticism of the vagueness inherent in best interests approaches and how they have been applied,[21, 22] has prompted judges in a range of contexts to flesh out the content of these approaches, thereby making them more meaningful.[13] Yet, as Stalford has argued, best interests assessments remain 'highly contingent on the subjective assessment and value framework of the decision-maker.'[23] In practice, moreover, parental views are typically upheld in the courts,[21] unless they are deemed to very adversely affect their children's best interests.

While we would argue then that much has changed in the past two decades, it is also true that too much remains the same. For instance, although the BMA has updated its guidance in the form of a 2019 tool kit for doctors, this document reiterates its refusal to adopt a position on male genital cutting. Thus, the guidance notes that the 'BMA has never taken a position in the debate about the acceptability or otherwise of the procedure and continues to sharply differentiate it from the crime of female genital cutting, which is the subject of separate guidance condemining the practice.[24(p3)] Arguably, this refusal on the part of a key medical regulator to take a position on the ethics of neonatal male genital cutting tacitly positions the BMA as a supporter of the status quo, since its unwillingness to question or challenge the parental or medical choice to circumcise an infant implicitly endorses the legitimacy of the practice. Secondly, on the supranational level, and as Sandland has argued, little has changed and it remains the case that the 'approach of the international community has not been to defend the practice of MGM, but to neglect it, and treat it as a non-issue in human rights terms.'[13] Within the UK, and notwithstanding a growing legal academic literature, there remain few decided legal cases addressing male genital cutting. While there

are some positive features of these rulings, they follow a regrettably similar narrative (largely) eschewing any fundamental questioning of the practice.

Back in 2004 only one case - the 1999 Court of Appeal decision in *Re J* – had been reported that directly considered male genital cutting.[25, 26] Subsequently there have been 4 reported cases.[27-30] Like *Re J* they typically involve instances where there was a disagreement between the parents about whether the procedure should be performed on a young child. In some respects, this paucity of legal cases is surprising given that the BMA's 2019 guidance is clear that:

> where people, and/or agencies, with parental responsibility for a child disagree about whether he should be circumcised, doctors should not circumcise the child without the leave of a court.[24(p6)]

In this article we assess how adequately courts carry out this responsibility, focusing on *Re P (Child in Care: Circumcision)*[31] the most recently decided case, heard in the High Court in 2021. We adopt this singular focus to highlight how little judicial reasoning has advanced in the more than 20 years the issue has been before the courts. This is true notwithstanding the significant changes beyond the courts that we have noted.[32] While agreeing with the outcome in this case, where Cobb J held that the decision should be deferred until the child could decide for himself, we suggest that much of the reasoning and assumptions in the judgment is highly problematic. In particular, we assess how best interests calculations work in practice in these cases. While we are mindful of the dangers in placing too much emphasis on a single lower court ruling, we argue that *Re P* exemplifies how judges approach these

cases more generally, and that judicial reasoning is a matter that should concern bioethcists. We would also assert that the case carries particular significance in having been decided by an influential senior judge well versed in applying best interests tests in a range of contexts. We return to this point in our conclusions.

Although bioethicists have frequently debated whether interventions on children's bodies are more appropriately determined on the basis of the child's hypothetical consent,[33] in the child's best interests,[18, 34, 35] or within a best interests framework that is qualified by a 'significant harm' threshold,[36] it is clear that in law the relevant test - enshrined in s. 1(1) Children Act 1989 - is whether interventions are in the child's best interests.[37, 38] Thus, as Cobb J notes in *Re P,* the 'welfare of the child, both in the immediate and long term, is the paramount consideration in reaching a decision about circumcision for a male child… this is uncontroversial in the instant case, and has been the starting point of all previous decisions' (at para 27). We argue that in applying this test in cases where the genital cutting of male infants is proposed, English judges have ignored bodily integrity arguments in reaching their decisions about the child's welfare. This leaves judicial reasoning in these cases somewhat superficial and marked by a failure to disentangle the interests of the child from those of the adults involved - a process exemplified by *Re P*.

The facts in Re P

Re P is the latest in the series of cases where male genital cutting is contested, but the first case in which the child was in interim care. It concerned P - a 21-month-old boy - born to Muslim parents, who had subsequently separated. The court noted that P's father was

Muslim by birth and heritage, while his mother had converted to Islam several years prior to P's birth. P was subject to an interim care order under the Children Act 1989 and had been placed in the care of maternal relatives - Mr and Mrs R - under a special guardianship order. His older sibling and half sibling were also in the care of (different) relatives following concerns about domestic abuse in the familial home. It was accepted that Mr and Mrs R were likely to become P's permanent carers. They had indicated that they would respect his Muslim heritage. For instance, they were committed to educating him about the Muslim faith and heritage, to celebrating Eid and to ensuring that he followed a largely halal diet. However, they did not support P being circumcised in the short term. This prompted P's mother, with the support of his father, to seek the court's authorisation under the inherent jurisdiction for P to be circumcised within a few months. The mother indicated her concern that if the procedure was not performed before P's second birthday it was unlikely that he would choose to be circumcised in later life. The Local Authority and the Children's Guardian opposed the application, contending that the decision ought to be deferred until the point at which P could know the necessary medical and cultural facts and make his own choice. His social worker suggested that contact with his birth parents and the provision of cultural and religious books for P would more meaningfully promote his identity and cultural heritage than circumcising him.

The Ruling in *Re P*

Surprisingly, Cobb J's ruling scarcely engages with earlier rulings in this area, and largely ignores subsequent developments in how best interests have been addressed in other health

contexts. In assessing P's best interests Cobb J determined that only four matters were relevant:

i) the child's religious upbringing;

ii) the 'medical issues', specifically the irreversibility of the procedure and the balancing of risks and benefits;

iii) the view of the parents and carers of the child; and

iv) the environment in which the child is brought up.

It is noteworthy that having opened the ruling by referring to best interests as the 'paramount consideration in reaching a decision about circumcision for a male child', Cobb J immediately turns to the 'religious upbringing of the child'. Rather than placing the child at the centre of his ruling, this starting point means attention is immediately diverted to the parents. Cobb J states that religious upbringing 'may be a matter of great importance' and highlights the value of religious beliefs to the *parents*, noting that 'how significant the religious upbringing is will vary from case to case depending on the strength of the religious beliefs and observance of the child's parents' (para 27). As we have argued elsewhere, this highlights the difficulties judges face in disentangling the interests of parents and children.[15]

Having started with this consideration of the importance of parental religious views, Cobb J offers only a cursory assessment of the medical risks and benefits when he turns to this factor. The court had heard expert testimony from the agreed medical expert - Mr Mangera - a Consultant Urologist and Muslim, who was invited to provide both medical and religious evidence. Mr Mangera indicated that at P's age the likely method of circumcision would be a

'ring' technique, such as a Plastibel, with the procedure performed under local anaesthetic by a doctor. Regarding the risks of the procedures, Mr Mangera categorised these as being: likely pain from the anaesthetic injection and during the healing process ('mild to moderate … manageable with paracetamol'); the possibility of bleeding (occurring in 1% of cases, usually in the first 12 hours); risk of infection (occurring in less than 1% of cases); and of cosmetic issues (arising in 2% of cases). He also referred to other unspecified 'more minor risks' (para 11). As we shall address below, his assessment of the medical risks differs in significant respects from expert testimony accepted by other courts.

The third consideration pertains to the views of the parents and the current carers regarding the desirability of circumcision. This is the first reported case in which the birth parents have been in agreement that circumcision should be performed, in order for P to connect with his Muslim heritage. In familiar rhetoric from child law jurisprudence, Cobb J states that the parental views are 'of considerable importance, and I attach significant weight to them' before effectively overiding them (para 34). He does emphasise that both parents are practicing Muslims to whom their faith is important – which distinguishes the facts from earlier cases such as *Re J* and *Re S*. However, Cobb J explicitly acknowledges that his decision is 'influenced by the fact that presently neither parent chooses to see P, and neither parent has (contrary to their offer to do so) provided P with age-appropriate books and/or learning materials about Islam' (para 34). Thus, it seems that in future parents applying for circumcision to be authorised by a court need to demonstrate clearly both their own commitment to the faith and also that they are taking active steps to bring their child up consistent with these beliefs. In this case, the birth parents had both failed to turn up for contact arrangements with P and had failed to provide religious materials, which perhaps lent

greater weight to the fact that while Mr and Mrs R were not parties to the proceedings they were not in favour of the procedure. Cobb J indicated that the views of Mr and Mrs R 'carried significant weight' given that it was 'a strong thing to impose a medically unnecessary surgical intervention on a residential carer/parent who was opposed to it' (para 27).

This consideration is closely linked to the fourth feature of the best interests calculation he outlined, which is the environment in which the child will be raised. Cobb J notes that it is a relevant factor, if within this environment 'circumcision was not a part of family life' or 'not in conformity with the religion practised by the primary carer' (para 27). Again, the idea of the familial environment in which P is to be raised is addressed in a cursory manner and Cobb J pays scant attention to how this environment will promote the child's 'social and cultural interests' which - as the BMA guidance indicates - is a necessary part of the best interests test.[24(pp6,13-15)] Rather, this consideration seems oriented to ensuring 'family integrity' is protected rather than directly promoting the best interests of the child. A notion of family integrity has been discernible in the earlier male genital cutting cases where the court's focus has been on maintaining the family unit and making a child 'fit' with the values of their parents, even where this entails harmful and irreversible interventions on his body. Emphasising family integrity has obscured the need for a full account of the risks and harms involved in male genital cutting and other practices.[15(p523)]

Evaluating the Ruling

There are, certainly, some positive features of *Re P*. Ultimately, the decision to reject the parents' application reinforces the clear trend in English law of deferring the decision until

the child is competent to deciding for himself. While the ruling does not couch it in these terms, this is an important component in recognising a child's bodily autonomy and preserving his right to an open future.[15, 39] The ruling also reinforces the BMA guidance that 'Parental preference alone does not constitute sufficient grounds for performing' male genital cutting.[24(p6)] Additionally, there is a welcome stress in both the medical testimony and the judge's ruling on the irreversible nature of the intervention. Furthermore, the decision that it is in P's best interest for the procedure to be deferred, notwithstanding that at 2-years P was significantly younger than the children in any of the prior cases, and hence significantly removed from the point at which he would gain *Gillick*-competence, is also notable. Finally, the fact that the decision was reached notwithstanding the fact that both biological parents supported the application to circumcise, suggests a downplaying of parental interests and a tentative more towards a re-centering of the child in the best interests assessments, even if this was not apparent in much of the reasoning.

However, against this, some aspects of this case are more troubling than the earlier jurisprudence. Our essential criticism of the judgment is that this non-consensual procedure raises a wider and more complex range of issues than Cobb J allows, and even the four matters which he articulates as relevant to the best interests assessments are not interrogated in adequate depth. The narrow scope of the assessment is particularly disappointing given that he stresses on two occasions that the question of religious upbringing needed to be considered within a 'wider welfare perspective' (para 12) or 'wider welfare review' (para 27). Yet his own welfare review seems unduly narrow.

Our most significant concern about the reasoning is that, while the case fits the trajectory of earlier jurisprudence in many respects, it devotes even less attention to the embodied risks which genital cutting poses to the child. The minimal account of risks provided by Mr Mangera and accepted by Cobb J contrasts quite starkly to the expert testimony accepted by the court in the 2017 case of *In re L and B (Children).* There, Mr Muir, a consultant urologist at King's College Hospital, London indicated in his testimony that 'about five per cent of boys will suffer a significant complication after circumcision, with about one in fifty needing emergency treatment for bleeding'. He testified that by 'significant' he meant anything over and above mild pain, and added that at the extreme end of the spectrum major, although rare, complications such as glans amputation, penile necrosis and even the child's death could occur. Significantly, given the method proposed in the current case, Mr Muir noted that he had personally treated five boys who had suffered partial or complete amputation of the glans with the Plastibell device and that it was a form of circumcision which he would never recommend. He also indicated that where these major complications did result they required complex multiple plastic surgical operations with often unsatisfactory outcomes (at para 69).

In *Re P* these major risks are simply not mentioned. It is also unclear what the other 'minor risks' Mr Mangera referred to are. Further, and surprisingly, there is no reference in either the expert testimony or the judgement to psychological risks. This appears to be at odds with earlier appellate authority. Thus, in the Court of Appeal in *Re J* Thorpe LJ had reiterated the view of the first instance judge that procedure 'carried small but definable physical and psychological risks' such that for it to be ordered 'there would accordingly have to be clear benefits to J which would demonstrate that circumcision was in his interests notwithstanding the risks' (at p 574). Yet Cobb J simply opines that the proposed ring method 'would be painful

and distressing to P for a number of days or weeks, but no more' (para 36). Significantly, not only is there a failure to comment on the infliction of pain on an unconsenting child,[40] but neither are any benefits articulated to weigh in the balance against this. Rather, the judge simply notes that deferring the procedure until P is older means that the procedure would at that point be more complex and have a longer recovery period. Nevertheless, he adds - without having commented on the orders of risk - that he 'does not regard it as an inherently risky procedure', while bearing in mind that it is irreversible (para 35). This conclusion, with no reference to either the psychological risks of the procedure or any countervailing benefits, makes Cobb J's position difficult to reconcile with the dicta of Sir James Munby, President of the Family Division in a 2015 case that male genital cutting amounts to significant harm for the purposes of s.31 of the Children Act. It is arguable that in *In re B and G* Munby LJ provided the most developed judicial reasoning on the issue to date,[12, 41] which makes it perplexing that Cobb J fails to engage with it.

We have criticised judges in earlier cases for not properly articulating the precise nature of the physical and psychological risks of male genital cutting.[3(p166)] *Re P* is more problematic because psychological risks are completely ignored, while the pain caused and the risks of the procedure are trivialised. As we have noted of earlier decisions, this seems at odds with the general tendency of contemporary judges to require ever more detailed quantifications of risks prior to authorising medical interventions.[3] It suggests that the male genital cutting cases are at odds with approaches to assessing risks in the case of other medical interventions and that in this specific line of cases judges are systematically failing the standards they impose elsewhere. Moreover, as we have shown estimations of the risks appear to vary across the reported case law. The failure to be more attentive to risks in nenotatal male

genital cutting cases is particulary hard to countenance given the existence of an extensive literature detailing the inherent risks of the procedure and experiences of harm.[40]

Finally, there is a failure, as suggested above, to fully engage with earlier authorities. Where Cobb J does turn to earlier cases he quotes selectively from them. Thus, there is no mention of the fact that in *In re B and G,* Sir James Munby deemed male circumcision to constitute serious harm equivalent to the least serious type of female genital cutting. Nevertheless, Cobb J cites his later dicta that 'Society and the law, including family law, are prepared to tolerate non-therapeutic male circumcision performed for religious or even for purely cultural or conventional reasons, while no longer being willing to tolerate FGM in any of its forms' (para 72). We would argue that here he relies upon - and reinscribes - a dichotomy between different forms of genital cutting that has been problematised in the ethico-legal scholarship.[8] Over time this work has moved towards a consensus that non-therapeutic interventions on the body of any child should be deliberated within a framework that centres the child's autonomy and right to bodily integrity.[15, 32] In failing to engage with these arguments, Cobb J is then able to accept rather than interrogate a number of problematic opinions. He does not question, for example, Mr Mangera's view that if P were to be raised as a Muslim child 'his parents should be given the same rights as all other Muslim families; which is to have a circumcision at a young age provided both his parents understand the risks and benefits' (para 12). This replicates reluctance in earlier judgments to confront the presumption that the decision to circumcise can legitimately be entrusted to parents in the absence of any dispute. Yet, until this series of cases, this was not an articulated 'right' that could supersede a child's right to bodily integrity. Similarly, other comments are not interrogated. The mother's concern about deferring the procedure was because P was unlikely to choose to be

circumcised in later life 'since he would probably be deterred by the likely pain and discomfort which the procedure would then cause him' (para 14).[18] Had Cobb J engaged with the value of bodily integrity it is more likely that this point would have required a considered response addressing the pain and the invasion of P's bodily integrity at stake in this decision, regardless of the time at which it was performed. Further, we would argue that engaging with embodied integrity would require acknowledgment that bodily interventions are not one off events; rather they are biographical, shaping future embodied choices practices and freedoms. In this regard, the mother's wish to prevent a future choice by P not to be cut acutely illustrates this point.

Conclusion

Mr Justice Cobb is an experienced judge who was a specialist family law barrister for over 20 years prior to being appointed as a High Court Judge assigned to the Family Division in 2013. Earlier this year he was appointed as a Lord Justice of Appeal. In other cases his judgments have offered nuanced and well-reasoned assessments of best interests. For instance, in a 2013 case he refused an application to perform a non-therapeutic sterilisation on a 21 year woman with Downs Syndrome, having had regard to 'the method of achieving the sterilisation (involving the necessary hospitalisation of K), the likely permanence of the procedure, and the interference with K's physical integrity.[42(para 27)] He offered a similarly nuanced assessment in a later case where the sterilisation of a 36 year old woman with autism and borderline learning disability was authorised, stressing that best interests were not limited to best medical interests, and noting that '[t]he ethical, legal and medical issues arising here are self-evidently of the utmost gravity, engaging, and profoundly impacting upon DD's personal

autonomy, privacy, bodily integrity, and reproductive rights'. He also took into account the 'bodily violation' that insertion of an IUD entailed.[43(paras 5, 116)] The different outcomes in these cases suggest to us that, despite the lip service that judges sometimes play to the concept of bodily integrity as a foundational legal value, and the wider acknowledgment of it as the cornerstone of all other rights,[15, 17, 40] it is imperfectly protected or valued in practice.[15]

Nevertheless, while recognising that bodily integrity arguments may not ultimately determine the outcome of cases given their open texture, it is striking that there is simply no reference to the concept in Cobb J's judgment in *Re P.* As with the judges in the earlier cases, bodily integrity seems to constitute a blind spot when the genital cutting of a male child too young to consent is proposed. This myopia means that only limited consideration is given to the seemingly obvious fact that what the court is considering is the painful excision of healthy tissue from a child unable to give his consent and for no demonstrable medical benefit. To counter this, we would reiterate the importance of starting any analysis of the best interests of the child with a robust analysis of the embodied risks and harms of male genital cutting and any other embodied practice.[44] In so doing, judges could usefully draw on sophisticated recent legal analyses of bodily integrity.[45-49] Explicitly starting best interests assessments with a consideration of bodily or embodied integrity would lead to a more robust assessment of a child's welfare and rights. This would make it less likely that their interests would be subsumed by other concerns or interests - such as a notion of family integrity - and better protect the child's body from unnecessary encroachment.

While it is clear that family integrity is given significant weight in deliberations, courts may wish to acknowledge that a non-consensual procedure may come to be regretted by an

individual. This has the potential to disrupt family integrity, directly counter to the outcome that is desired. As such, we endorse Mazor's view that the likelihood that a child may come to regret his parent's decision in the future is an important factor to take into account in judging where a child's best interests lie. Acknowledging the potential that the child will come to regret decisions made by others about their bodies reinforces the importance of bodily integrity and could help to further ground a presumption against non-consensual and non-therapeutic interventions in children's bodies. In similar vein to our proposal that best interests assessments by courts would be more meaningful if they explicitly took the child's embodied integrity as a starting point, we would suggest that the possibility of the child regretting his parents' choice about his body is a factor which should be explicity considered when applying best interests tests. In this way, we suggest that legal and bioethical scholars can usefully engage with evidence-based accounts which would encourage decision-makers to address rather than downplay or ignore embodied harms and risks including psychological harm.

Centring embodied integrity in legal analyses surfaces the importance of the body as the means through which we experience the world, as well as one means by which we express our place in that world. It can also provoke consideration of the biographical nature of the interventions under consideration, and how such decisions potentially shape the life course and preclude later embodied freedoms. As such, bodily - or embodied - integrity is an essential starting point in any best interests assessment where an intervention on a body of a child or young person is proposed.

References

1. British Medical Association. The Law and Ethics of Male Circumcision: Guidance for Doctors. *J Med Ethics* 2004; **30**: 259–263.
2. Fox M and Thomson M. A Covenant with the Status Quo? Male Circumcision and the new BMA Guidance to Doctors. *J Med Ethics* 2005; **31**: 463–469.
3. Fox M and Thomson M. Short Changed? The Law and Ethics of Male Circumcision. *Int J Child Rights* 2005; **13**: 161–181.
4. Bridgeman J. The Child's Body. In: Evans M and Lee E (eds) *Real Bodies: A Sociological Introduction*. Basingstoke: Palgrave Macmillan, 2002, pp.96–114.
5. Neff CF. Woman, Womb, and Bodily Integrity. *Yale J Law Fem* 1990; **3**: 327–353.
6. Ludbrook R. The Child's Right to Bodily Integrity. *Curr Issues Crim Justice* 1995; **7**: 123–132.
7. Brazier M. Introduction – Being Human: Of Liberty and Privilege. In: Smith S and Deazley R. (eds) *The Legal, Medical and Cultural Regulation of the Body: Transformation and Transgression*. London: Routledge, 2009, pp.1–12.
8. One notable change in terms of our own approach is the move early in our work from using 'circumcision' to the more open 'male genital cutting'.
9. Fox M and Thomson M. Older minors and circumcision: Questioning the limits of religious actions. *Med Law Int* 2008; **9**: 283–311.
10. DeLaet DL. Genital Autonomy, Children's Rights, and Competing Rights Claims in International Human Rights Law. *Int J Child Rights* 2012; **20**: 554–583.
11. Fox M and Thomson M. The new politics of male circumcision: HIV/AIDS, health law and social justice. *Leg Stud (Soc Leg Scholars)* 2012; **32**: 255-281.
12. Earp B, Hendry J and Thomson M. Reason and Paradox in Medical and Family Law: Shaping Children's Bodies. *Med Law Rev* 2017; **25**: 604–627.
13. Sandland R. The Construction of Gender and Sexuality in the Approach of Key International Law Actors to the Circumcision of Children. *Hum Rights Law Rev* 2019; **19**: 617–647.
14. Möller K. Male and Female Genital Cutting: Between the Best Interest of the Child and Genital Mutilation. *Oxf J Leg Stud* 2020; **40**: 508–532.
15. Fox M and Thomson M. Bodily integrity, embodiment, and the regulation of parental choice. *J Law Soc* 2017; **44**: 501–531.
16. See: Savell K. Sex and the Sacred: Sterilization and Bodily Integrity in English and Canadian Law. *McGill Law J* 2004; **49**: 1093-1141.
17. Fox M, Thomson M and Warburton J. Embodied Integrity, Shaping Surgeries, and the Profoundly Disabled Child. In: Dietz C, Travis M and Thomson M (eds) *A Jurisprudence of the Body*. Palgrave Macmillan, 2020; pp.281-314.
18. Mazor J. On the child's right to bodily integrity: when is the right infringed? *J Med Philos* 2021; **46**: 451–465.
19. See also the special issue: The ethics of male circumcision. *J Med Ethics* 2013; **39(7)**. https://jme.bmj.com/content/39/7.
20. See, for example, the position of the Royal Dutch Medical Association: KNMG. Non-therapeutic circumcision of male minors. Report, KNMG, The Netherlands, May 2010. See also: Van Dijk G. Non-Therapeutic Circumcision: The Ethical Position of the Royal Dutch Medical Association. *J of Sex Med* 2017; **14**: e225.
21. Heywood R. Parents and medical professionals: conflict, cooperation, and best interests. *Med Law Rev* 2012; **20**: 29-44.
22. Thomson M. A capabilities approach to best interests assessments. *Leg Stud (Soc Leg Scholars)* 2021; **41**: 276-293.
23. Stalford H. The broader relevance of features of children's rights law: the "best interests of the child" principle. In: Brems E, Desmet W and Vandenhole W (eds) *Children's Rights Law in the Global Human Rights Landscape: Isolation, Inspiration, Integration?* Oxford: Routledge, 2017, pp.37–51.

24. British Medical Association. Non-therapeutic male circumcision (NTMC) of children – practical guidance for doctors. Guidance Note, UK, 2019.
25. *In re J (Specific Issue Orders: Muslim Upbringing and Circumcision)* [1999] 2 FLR 678.
26. *In re J (Specific Issue Orders: Child's Religious Upbringing and Circumcision)* [2000] 1 FLR 571.
27. *In re S (Specific Issue Order: Religion: Circumcision)* [2005] 1 FLR 236.
28. *T v S (Wardship)* [2012] 1 FLR 230.
29. *In re B and G (Children)* [2015] 1 FLR 905.
30. *In re L and B (Children) (Specific Issues: Temporary Leave to Remove from the Jurisdiction: Circumcision)* [2017] 1 FLR 1316.
31. *In re P (Circumcision: Child in Care)* [2021] EWHC 1616 (Fam).
32. Many of these developments are acknowledged and addressed in the two important publications by The Brussels Collaboration on Bodily Integrity, see:
The Brussels Collaboration on Bodily Integrity. Medically unnecessary genital cutting and the rights of the child: Moving towards consensus. *Am J Bioeth* 2019; **19**: 17-28;
The Brussels Collaboration on Bodily Integrity. Genital Modifications in Prepubescent Minors: When may Clinicians Ethically Proceed? *Am J Bioeth*. Epub ahead of print 17 July 2024. DOI: 10.1080/15265161.2024.2353823.
33. Earp BD. The child's right to bodily integrity. In: Edmonds D. (ed) *Ethics and the Contemporary World*. London: Routledge, 2019, pp.217–235.
34. Vallentyne P. The rights and duties of childrearing. *William Mary Bill Rights J* 2003; **11**: 991–1010.
35. Pugh J. The child's right to bodily integrity and autonomy: A conceptual analysis. *Clin Ethics*. Epub ahead of print 25 July 2023. DOI: 10.1177/14777509231188817.
36. For example: Diekema DS. Parental refusals of medical treatment: The harm principle as threshold for state intervention. *Theor Med and Bioeth* 2004; **25**: 243-264.
37. Archard D, Cave E and Brierley J. How should we decide how to treat the child: harm versus best interests in cases of disagreement. *Med Law Rev* 2024; **32**: 158–177.
38. Cave E and Nottingham E, Who knows best (interests)? The case of Charlie Gard. *Med Law Rev* 2017; **26**: 500-513.
39. Darby R. The child's right to an open future: is the principle applicable to non-therapeutic circumcision? *J Med Ethics* 2013 **39**: 463-468.
40. For discussion of the tendency to downplay and pain of the procedure see Fox M, Thomson M and Warburton J. Non-therapeutic male genital cutting & harm: Law, policy and evidence from UK hospitals. *Bioethics* 2019; **33**: 467-474.
41. *In re B and G (Children)* [2015] 1 FLR 905.
42. *A Local Authority v K, Mrs K and Mr K A NHS Trust* [2013] EWHC 242.
43. *Re DD (No 4) (Sterilisation)* (2015) EWCOP 4.
44. Alderson P. Bodily integrity and autonomy of the youngest children and consent to their healthcare. *Clin Ethics*. Epub ahead of print 27 July 2023. DOI: 10.1177/14777509231188006.
45. Herring J and Wall J. The nature and significance of the right to bodily integrity. *Camb Law J* 2017; **76**: 566–588;
46. Ammaturo F. Intersexuality and the 'Right to Bodily Integrity': Critical Reflections on Female Genital Cutting, Circumcision and Intersex 'Normalising Surgeries' in Europe. *Soc Leg Stud* 2016; **25**: 591-610.
47. Garland F and Travis M. *Intersex Embodiment: Beyond Identity and Disorder*. Bristol: Bristol University Press, 2022.
48. Dietz C. Governing Legal Embodiment: On the limits of self-declaration. *Fem Leg Stud* 2018; **26**: 185-204.
49. Thomson M. Foetal subject: Law, gender, and embodiment. In Vauchez SH and Rubio-Marín R (eds) *The Cambridge Companion to Gender and the Law*. Cambridge: Cambridge University Press, 2023, pp.61-97.

Statements and Declarations

Ethical considerations

Not applicable.

Consent to participate

Not applicable.

Consent for publication

Not applicable.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article

Funding Statement

Not applicable.

Data availability

Not applicable.