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### Legislation on male infant circumcision in Europe: a call to avoid paternalism and to promote evidence-based, patient-centred care

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## SYMPOSIUM ON GERMAN COURT RULING ON CIRCUMCISION

### Legislation on male infant circumcision in Europe: a call to avoid paternalism and to promote evidence-based, patient-centred care

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Male infant circumcision is a controversial and debated topic in both scientific and public discourses in parts of Western Europe. Debates are heated and it is not always entirely clear what is in the best interest of the male infant. In this article, we discuss the importance of returning to core principles of evidence-based, patient-centred care that may help move the discussion away from the current, increasingly polarised positions. According to principles of evidence-based medicine, systematic retrieval and critical appraisal of the best evidence available should be a core consideration in all decisions regarding healthcare policy and practice. Applying this principle to male infant circumcision, we need a careful, dispassionate critique of the evidence in relation to the benefits and risks associated with the procedure and an assessment of the potential health gains and adverse effects of any interventions (such as legislation) that may be introduced. Currently, the more robust evidence-base has tended to focus on biomedical aspects of male infant circumcision and this shows consistent evidence of important benefits of this practice, but also some risks. However, health is multi-dimensional and when considering male infant circumcision, there is therefore a need to broaden the perspective to also include psycho-social considerations. It is also imperative that those striving to deliver patient-centred care keep the best interests of the patient/family at the heart of their decision-making, promote autonomy and do not inadvertently exceed the fine line between beneficence and medical paternalism. In summary, we argue that a more comprehensive and robust evidence-base is needed to enable evidence-based policy-making and that these uncertainties are communicated to patients/families so they can in the light of this evidence make an informed choice.

**Keywords:** male circumcision; evidence-based care; public health

Male infant circumcision continues to invoke considerable controversy and debate in parts of Western Europe, not least since the German court ruling deemed male circumcision equivalent to grievous bodily harm in June 2012 (Landesgericht Köln 2012). There are many reasons why it provokes such strong emotions: circumcision is a practice that relates to children who are typically unable to, or in some cases not invited to, provide their informed consent; it involves surgical operations performed for non-therapeutic reasons; and it is a practice that in many cases stems from deeply held religious beliefs, which are for many difficult to grapple with in a now predominantly secular Western Europe (Gatrad and Sheikh 2001). This is however anything but a simple debate between secular and

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religious perspectives. The complexity of this issue is exemplified by the fact that although a number of medical bodies have criticised the practice on the above grounds and because of concerns related to health risks associated with the procedure, other powerful advocacy and professional bodies such as the World Health Organization (WHO) and the American Academy of Pediatrics (AAP) have strongly argued for the preventive and public health benefits associated with male circumcision (e.g. in reducing heterosexually transmitted HIV infections). This has in the US led to calls for reimbursement of the procedure and promotion of the practice among groups who have no tradition for this specific practice (Baker 2012; Siegfried et al. 2009; Singh-Grewal, Macdessi, and Craig 2005; Task Force on Circumcision 2012). Within this overall highly charged professional and public discourse, it is not always clear what is in the best interests of the child and his family and whether these interests are centre-stage in the minds of the various protagonists.

In this article, we draw on some core principles that should underpin decision-making when seeking to protect and promote public health (Institute of Medicine 2002; International Conference on Primary Health Care 1978; Public Health Leadership Society 2002). In particular, we point to the inherent dangers of medical paternalism, the need for a sufficient evidence-base encompassing not only the biomedical dimensions of male infant circumcision but also the psycho-social considerations, and in libertarian societies the need to ensure that this is then combined with respect for patient perspectives, preferences and autonomy (Illich 1976; Locke 2009; Mill 1859; Skrabanek 1994). Adherence to these core principles is we argue all the more important when considering deeply contested issues in order to ensure sound public policy-making.

Evidence-based medicine is one of the central pillars underpinning modern medicine. It has been defined as 'a systematic approach to clinical problem solving which allows the integration of the best available research evidence with clinical expertise and patient values' (Sackett, Strauss, and Richardson 2000). Systematic retrieval of the best evidence available and a critical appraisal of this evidence should be the basis of all decisions regarding health care policy and practice, although this scenario undeniably remains an ideal rather than a reality (Heneghan and Godlee 2013). At least in principle, promoting or discouraging certain practices should build on both scientific evidence and a principle of proportionality (Lee 2012; Rose 1994). When considering intervening against male infant religious circumcision, we therefore need strong evidence for the health risks associated with the procedure; these risks should then be balanced carefully against the benefits of this practice and the risks of interventions inadvertently resulting in harm. In relation to the health risks and benefits of male circumcision, the more robust evidence-base suggests important benefits, but also some risks. Studies have tended to focus on biomedical considerations including the physiological, prophylactic and to a lesser extent sexual effects of male infant and adult circumcision (Hayashi and Kohri 2013; Pinto 2012; Weiss et al. 2006; Wheeler and Malone 2013). Recently published reviews and the review performed by the AAP Task Force on Circumcision show preventive effects of male circumcision in relation to urinary tract infections, transmission of some sexually transmitted infections (HIV, human papillomavirus and herpes simplex virus type 2) and penile cancer (Hayashi and Kohri 2013; Larke et al. 2011; Task Force on Circumcision 2012). Randomised controlled trials conducted in developing countries have documented benefits of male circumcision on rates of sexually transmitted infections and sexual satisfaction (Kigozi et al. 2008; Krieger et al. 2008; Siegfried et al. 2009; Wawer et al. 2011). The risks associated with the procedure are mainly surgical complications and concerns about

psychosexual function, but the key question here is the trade-off between potential benefits and risks (Perera et al. 2010; Siegfried et al. 2009; Task Force on Circumcision 2012; Wheeler and Malone 2013).

According to Sackett's definition of evidence-based medicine, scientific evidence and clinical expertise need to be integrated with patient values if we wish to achieve the goal of providing high-quality health care services that reflect the interests, values and choices of patients (Sackett, Strauss, and Richardson 2000). Patient-centred care is therefore central to evidence-based medicine and so is a multidimensional concept of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organization 1948). This multidimensional concept of health emphasises that health is about more than just physical functioning. When considering male infant circumcision, we therefore need to broaden our gaze beyond just biomedical issues and also include the psycho-social dimensions of it. Parallel with the biomedical research, there is a need to understand the psychological and social effects of male infant religious circumcision including the possible meanings attributed to being circumcised in relation to masculinity, identity and belonging to religious communities, but this remains a very under-developed field of enquiry (Yavuz, Demir, and Dogangün 2012). A narrow focus on possible health risks based on relatively few cases of short or long-term physical complications following male circumcision fail to encompass the diversity of religious, cultural and social factors that influence decision-making surrounding male infant circumcision. In keeping with the WHO concept of health, we therefore need a much broader evidence-base that also investigates the impact of male circumcision on psychological and social well-being among larger populations than is most often the case in current studies. An unbiased summary of this broader evidence base will help families contemplating having their son circumcised for religious or health reasons in deciding what is in the best interest of their child.

Male infant circumcision is a contentious issue and there is a real danger of exceeding the fine line between beneficence and unwarranted medical paternalism. Acting in the best interest of the male infant must be the key concern for both opponents and proponents of male infant circumcision. In the absence of a broad evidence-base, we risk acting on behalf of these children without fully considering whether our understanding of the best interest of the child is adequate or whether our actions build on too narrow understandings of health which have been fashioned on possibly normative grounds. Holding on to standard principles underpinning evidence-based medicine and patient-centred care is therefore important, not least in the current situation with charged 'ugly, messy and nasty' debates surrounding male infant religious circumcision (Collier 2012). We need carefully to balance respect for individual values, interests and autonomy with obligations to prevent harm and protect health. This is even more important when male infant religious circumcision is concerned, since this topic is simultaneously sensitive, concerned with minors, and practised by religious minority groups who may be at particular risk of marginalisation and social exclusion in response to actions on part of majority groups (Grove and Zwi 2005; Inhorn and Serour 2011; Johnson et al. 2004; Sheikh 2007). If we fail to acknowledge the multiple dimensions of male circumcision both on a discursive level and in clinical encounters with families from Jewish or Muslim backgrounds, we risk alienating these families which may negatively affect their trust in and use of health care services in relation to circumcision and perhaps also when other health needs arise (Inhorn and Serour 2011).

Legislation against male circumcision should be a last resort, and in view of the emerging evidence of health benefits and the real risk that prohibition would drive the

practice underground, we believe prohibiting male infant religious circumcision to be counter-productive as it is likely to result in net harm. It is unlikely – not least given the considerable controversy on the health aspects of the procedure and the deep-held religious beliefs from which it arise – that male infant religious circumcision will be easily abandoned by Muslim and Jewish communities. Practices that are perceived to be important – even constitutive – for identity, that are normalised and reinforced in interactions within immediate and extended relationships and build on deeply personal beliefs about the existential meaning with the human condition are not changed nor eradicated by simple information or even legislation (Gatrad, Sheikh, and Jacks 2002). The heated discourse on religious circumcision with arguments feeding into debates on multiculturalism and religious diversity in the West only makes the debate even less likely to influence the everyday decisions and practices in families (Laird, de Marrais, and Barnes 2007). It is much more likely that legislation ruling the procedure illegal will drive the practice underground resulting in potentially more harm to the children undergoing this ritual. Even if legal action is not taken, the current discourses on religious circumcision may hinder the trust and mutual understanding that is needed in clinical encounters between parents considering having their child circumcised and health care professionals who still for the most part do not share the religious beliefs of their patients. Also, heated debates may lead to over-sensitivity or reluctance to take up any reasonable concern that could be important and relevant to discuss in these encounters, e.g. in relation to the question of pain or prevention of bleeding and infection. Acknowledging both the importance attached to male circumcision for individual families and the risks associated with this practice will enable the engagement of families that is necessary if poorly performed male circumcision and its negative effects on children are to be prevented. A more balanced, person-centred approach based on a broader evidence-base is therefore needed.

In conclusion, debates on male infant religious circumcision are often heated and resting on a narrow evidence-base pertaining to the effects on the overall well-being of the child. From a medical point of view, adhering to the core principles underpinning evidence-based medicine is of paramount importance for the delivery of high-quality, patient-centred care. For this to happen, we need a more substantial, broader evidence-base that encompasses both biomedical and psycho-social dimensions of male circumcision. This insight should be translated into recommendations thereby ensuring that families considering male infant circumcision are offered impartial, informed choice. In the meantime, sensitive, accessible care should be available for those who choose to have their child circumcised.

We do not call for an anything-goes attitude to this practice, but we do suggest that the current discourses on circumcision – with their at times quite charged perspectives on the practice – risk contributing to a climate that is not conducive to tackling the potential adverse health effects of the practice. Given the charged nature of the debate and the wider religious connotations of it, it is important that legislators, policy-makers and health care professionals avoid turning to unwarranted medical paternalism and instead remain true to the principles that have helped secure Europe's position as a bastion of rationality, liberalism and person-centred care.

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