CIRCUMCISION OF MALE INFANTS

RESEARCH PAPER

Queensland Law Reform Commission
December 1993

The short citation for this Research Paper is Q.L.R.C. R.P.
Published by the Queensland Law Reform Commission, December 1993.

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1. INTRODUCTION

(a) Terms of Reference

This reference is part of a wider reference given to the Commission by the Attorney-General in its Fourth Programme of work.[1] The full terms of the reference are set out in item 4 of the Programme, namely:

> **"Examine the rights relating to consent to medical procedures by:-**
>
> **(a) children;**
>
> **(b) intellectually disabled adults (including consent to sterilisation)."**

The Commission has divided the terms of reference into two major parts. The first part concerns consent by young people to medical procedures. The second part concerns consent to medical procedures on intellectually disabled adults.[2]

The first part of the reference has also been divided into distinct research projects to enable the Commission to deal with particular issues in detail and to avoid confusion between seemingly disparate matters. The research projects currently being undertaken include:

(i) consent to medical examinations in child abuse cases;

(ii) female genital mutilation;

(iii) male circumcision;

(iv) general legislation on consent to medical treatment of young people;

(v) sterilisation of young people.

(vi) treatment of severely defective neonates.

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1 Fourth Programme dated September 1990.

2 The latter part is being dealt with by the Commission in its forthcoming Report on *Assisted and Substituted Decision-Making.*

This Research Paper concerns item (iii) above.

(b) Consultation

In May and June 1993 advertisements were placed in the Courier-Mail calling for public submissions on Consent by Young People to Medical Treatment. An Information Paper outlining a wide range of issues was available to assist anyone interested in making a written or oral submission. Also, a number of media interviews were given by a member of the Commission to elicit public interest in the matters being dealt with.

Approximately 300 copies of the Information Paper have been distributed and, to date, approximately 160 oral and written submissions have been received. 24 of those submissions relate specifically to consent to circumcision of male infants.

In addition, a number of individuals and organisations with a particular interest in male circumcision have been approached for information and opinions on relevant matters raised by this reference. The assistance of those who have made submissions and others who provided information and comments to the Commission in the preparation of this paper is greatly appreciated.

(c) The Need for Reform and the Commission's Approach

From the Commission's research to date, it is apparent that there are two quite vocal sides of the debate on routine infant male circumcision. One side advocates the practice, primarily on a preventative health basis or on religious grounds. The other side opposes the practice, primarily on human rights and preservation of bodily integrity grounds. Both sides rely on medical evidence and opinion to support their respective views.

This Research Paper has been produced to assist the Commission in understanding the issues and arguments on the topic of routine infant male circumcision. It is being circulated to individuals and organisations with an interest or expertise in the issues raised, to verify the accuracy and significance of the information contained in the Research Paper, and to seek suggestions as to the most appropriate approach to adopt.

There will be wider community consultation on routine infant male circumcision and other matters to be dealt with during the course of this reference, at a later date.

2. THE HISTORY OF MALE CIRCUMCISION

(a) Origins

The practice of circumcising[3] male infants dates at least back to 2340-2180 BC. Egyptian representations of Pharaonic times show the circumcised penis. It is apparent that male circumcision had been practised in Egypt for many thousands of years.[4] Because of the uniqueness of Egyptian records, it is not possible to make any conclusive statements either about the origins of male circumcision or about its spread.

In Genesis 17 of the Old Testament God is said to have directed Abraham to circumcise himself, his son and all other males in his house:[5]

> 10 This *is* my covenant, which ye shall keep, between me and you and thy seed after thee; Every man child among you shall be circumcised.
>
> 11 And ye shall circumcise the flesh of your foreskin; and it shall be a token of the covenant betwixt me and you.
>
> 12 And he that is eight days old shall be circumcised among you, every man child in your generations, he that is born in the house, or bought with money of any stranger, which *is* not of thy seed.
>
> 13 He that is born in thy house, and he that is bought with thy money, must needs be circumcised: and my covenant shall be in your flesh for an everlasting covenant.

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3 Circumcision, also referred to as prepucectomy, is the removal of the prepuce (foreskin) from the penis. See pp 11, 12 below.

4 Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* 1982 at 51. There is speculation that female circumcision started in the same area as a parallel to the male operation or at puberty, although it is probably true to say that male circumcision is performed in many more societies than female circumcision, both in the past as well as the present. See Queensland Law Reform Commission *Female Genital Mutilation* Research Paper December 1993.

5 The Holy Bible, The British and Foreign Bible Society. Historians have dated the covenant back to 1713 BC. But **note** *The Epistle of Paul the Apostle to the Galatians*, The Holy Bible, The British and Foreign Bible Society, Chapter 6 Verses 12-16:

> 12 As many as desire to make a fair shew in the flesh, they constrain you to be circumcised; only lest they should suffer persecution for the cross of Christ.
> 13 For neither they themselves who are circumcised keep the law; but desire to have you circumcised, that they may glory in your flesh.
> 14 But God forbid that I should glory, save in the cross of our Lord Jesus Christ, by whom the world is crucified unto me, and I unto the world.
> 15 For in Christ Jesus neither circumcision availeth anything, nor uncircumcision, but a new creature.
> 16 And as many as walk according to this rule, peace *be* on them, and mercy, and upon the Israel of God.

> 14 And the uncircumcised man child whose flesh of his foreskin is not circumcised, that soul shall be cut off from his people; he hath broken my covenant ....
>
> 23 And Abraham took Ishmael his son, and all that were born in his house, and all that were bought with his money, every male among the men of Abraham's house; and circumcised the flesh of their foreskin in the selfsame day, as God had said unto him.
>
> 24 And Abraham *was* ninety years old and nine, when he was circumcised in the flesh of his foreskin.
>
> 25 And Ishmael his son *was* thirteen years old, when he was circumcised in the flesh of his foreskin.
>
> 26 In the selfsame day was Abraham circumcised, and Ishmael his son.
>
> 27 And all the men of his house, born in the house, and bought with money of the stranger, were circumcised with him.

In the Islamic religion, Abraham was the first Prophet to be circumcised.[6] Dr S N Khan states:[7]

> Circumcision, encouraged in Islam and widely practised by Muslims, is a tradition of the Prophet and an important ritual. It is recommended that it be performed on the newborn but, in some communities, it is done just before puberty.

In a submission to the Commission, it was stated:[8]

> We wish to emphasise that Muslim parents or guardians throughout the world enjoy the right to consent to circumcision of young boys on the ground of authentic religious reasons, although some doctors may support it on purely medical grounds.

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6 Pridie ED, Lorenzen AE, Cruckshank Dr A, Hovell JS, and MacDonald DR *Female Circumcision in the Anglo-Egyptian Sudan* 1945 from the Foreward by Skeikh Ahmed-El-Taher (The Mufti of the Sudan) referred to in Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* 1982 at 5.

7 Khan SN *The Islamic Viewpoint* Australian Family Physician Vol 15 No 2 February 1986 179.

8 Islamic Council of Queensland.

Rabbi John Levi has summarised the mainstream Jewish attitude to circumcision as:[9]

> Jewish male children must be circumcised on the eighth day of life unless there is a danger to the child's life because of the operation, in which case it may be delayed. (The traditional 'eight days' are counted by including the first day of life: a child born on a Sunday is circumcised the following Sunday). Circumcision in Jewish life is a religious ceremony and should, if possible, be performed by a Jewish doctor who has been trained to do it and will read the appropriate religious service and name the child.

Both Jews and Muslims circumcise in accordance with Abraham's covenant with God. Most of the major religions in Australia do not promote routine circumcision or consider it to be a mandated religious practice.[10]

Non-religious theories of the origin of male circumcision suggest that it was practised as a punitive measure, as a puberty or pre-marital rite, as an absolution against the feared toxic influences of vaginal (hymeneal) blood, for other health reasons, as a mark of slavery or for cosmetic reasons.

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9 Levi JS *Religion and Medicine: Jewish Medical Ethics* Australian Family Physician Vol 15 No 1 January 1986 17 at 18.

10 For example:

Read H *The Salvation Army Viewpoint* Australian Family Physician Vol 15 No 3 May 1986 at 574:

> Circumcision is neither required nor prohibited by The Salvation Army; it is a matter for parents to decide. Circumcision is not undertaken as a religious ritual ....

Manning KM *A Catholic Viewpoint* Australian Family Physician Vol 15 No 4 April 1986 493 at 496:

> No great importance is attached to this in the Christian tradition. Reasons such as hygiene justify its use.

McLean D *Jehovah's Witnesses* Australian Family Physician Vol 15 No 6 June 1986 772:

> While circumcision was mandatory for Israelite males, it is not seen as applying to Christians but couples may have their child circumcised if they wish.

Baliozian A *Armenian Church* Australian Family Physician Vol 15 No 8 August 1986 1024:

> Generally [circumcision] is opposed by the Church but accepted if a medical practitioner decides it is for the patient's benefit.

Ewers GA *Churches of Christ* Australian Family Physician Vol 15 No 8 August 1986 1024:

> Few members, if any, would have objection to ... circumcision although there is no stated policy on these things.

Archbishop Stylianos *Greek Orthodox* Australian Family Physician Vol 15 No 8 August 1986 1024-1025:

> Circumcision and the like constitute individual issues in Christian ethics and cannot be answered *a priori*, that is to say, without bearing in mind the person they relate to.

Some claim it was a diminution of human sacrifice.[11]

Hosken observes:[12]

> Some anthropologists also speculate how or if the tradition of male circumcision, the removal of the prepuce, is related to cutting off the entire penis which was offered as a sacrifice to the gods. This is said to have been practiced in ancient Egypt. The custom to use the male genitals as war trophies was also widespread as reported in Middle Eastern history, and has also been recorded by the ancient Egyptians.
>
> The Gallas, Somalis and the Abyssinians, it is related, cut the complete genital apparatus off their enemies. Some warriors offered the genitalia of their enemies as trophies to the girls they chose to marry. To use male genitalia as war trophies continues to the present in some parts of Africa; for instance it was reported in the two recent upheavals in Zaire (Biafra and Shaba Province). It was also reported in Vietnam.
>
> Circumcision of both boys and girls came into fashion long before Islam, and was practiced in many different areas in Africa. The practice was unknown to the Romans until they conquered Egypt and the Middle East. The Copts in Egypt, and the Abyssinians (Ethiopians) have practiced circumcision of boys and girls (at a much younger age than the typical puberty rites of Sub-saharan Africans) from prehistoric times.
>
> It is stated that both the Jews and the Arabs learned circumcision in Egypt, rather than vice versa. The rule in the Middle East, as well as in Sub-saharan Africa, is that a boy cannot get married unless he is circumcised. The same rule applies to excision [in females], which has acquired much the same rhetoric and similar, though less important, rituals as the male operation. All rituals connected with men are more important in the Middle East, as well as in most of Africa because of the dominant position of men. The purpose and the result of excision and infibulation [in females] are quite the opposite of the male operation, though they are often correlated, a fact which was and is not at all unknown to the practitioners.
>
> ... excision [in females] ... is practiced to affirm the sex of the individual, because it is believed that the clitoris represents a male element in a female, and that the prepuce of the penis represents femininity in a boy. Hence, the girls are excised and the boys circumcised in order to establish their sex in society.

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11 See Milos MF and Macris D *Circumcision: A Medical or a Human Rights Issue*? Journal of Nurse-Midwifery Vol 37 No 2 1992 at 875.

12 Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* 1982 at 55.

(b) Western Cultures

In a number of Western countries such as the United States of America and Australia, the practice of male circumcision for non-religious reasons became prevalent by the beginning of the twentieth century.

> Within the miasma of myth and ignorance [when the aetiology of most diseases was unknown], a theory emerged that masturbation caused many and varied ills. It seemed logical to some physicians to perform genital surgery on both sexes to stop masturbation.[13]

In 1891 P C Romondino, MD, advocated circumcision to prevent or cure alcoholism, epilepsy, asthma, hernia, gout, rheumatism, curvature of the spine and headaches.[14]

During the First World War circumcision was promoted for hygiene reasons and for prevention of venereal diseases.[15]

In the 1930's it was considered that circumcision prevents cancer of the penis.[16] In the 1950's it was claimed that cervical cancer occurs in women because their sexual partners are not circumcised.[17]

In World War II male troops were encouraged to be circumcised, given limited personal hygiene facilities in overseas combat zones. Circumcision is not now encouraged at recruitment or during service unless the person presents with a medical condition indicating a need for circumcision.[18]

By the 1960's the majority of Australian and virtually all United States and

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13 Wallerstein E *Circumcision: the Uniquely American Medical Enigma* Urological Clinics of North America 12(1) [1985]: 123-32 referred to in Milos MF and Macros D *Circumcision: A Medical or a Human Rights Issue*? Vol 37 No 2 1992 Journal of Nurse-Midwifery at 875.

14 Romondino PC *History of Circumcision from the earliest times to the present.* Philadelphia: Davis, 1891 [Re-published New York: AMS Press, 1974] 161-82.

15 Surgeon-General's Office, Canberra. Also, Milos MF *Body Ownership Rights of Children: the Circumcision Question* 1992 American Atheist 50 at 53.

16 Wolbarst AL *Circumcision and Penile Cancer* Lancet Vol 1 1932 at 150-153.

17 Wynder EL et al *A study of environmental factors in carcinoma of the cervix* American Journal of Obstet. Gynecol. Vol 68(84) 1954 1016-1046 referred to in Milos MF, Macris D *Circumcision: A Medical or a Human Rights Issue*? Journal of Nurse-Midwifery Vol 37 No 2 March/April 1992 875 at 885.

18 Surgeon-General's Office, Canberra.

Canadian male infants were circumcised.[19]

(c) Aboriginal and Islander Culture

Circumcision of boys and adolescents is also a part of Australian Aboriginal culture, at least in certain areas. John Cawte notes:[20]

> Circumcision in adolescence will probably remain a feature of Aboriginal cultural life in the Centre. It provides an occasion for social integration, personal identity, and a holiday. But changes must be expected with growing westernisation. For example, requests are being heard for the operative procedure to be carried out with proper surgical and aseptic precautions ... with retention of the elaborate tribal ritual before, during and after the surgical ceremony.
>
> Many educated Aborigines who have grown up without undergoing the circumcision ceremony, because of Mission affiliations at the time, express an uncomfortable sense of incomplete tribal responsibility and status. They are asking for the operation, even at mature ages. The European doctor who offers his service finds himself questioning whether his own culture does not circumcise at the wrong time, when the little boys are too young to appreciate the psychological and social implications of the kind that Aborigines understand very well. Certainly he will have no wish to interfere with the Aboriginal view of the procedure's proper timing.[21]

Money et al have described the circumcision practices of the Yolngu Aboriginal community in Arnhemland. At the age of 8 or 9 boys go through an initiation ceremony of circumcision or 'dhapi':[22]

> The ceremonial initiates among the elders carry the boy off, safe from the view of girls and women, encircling him in close formation. One of them lies on his back on the ground, the boy lying face upward upon him and pinioned in a locked embrace. Another man holds down the boy's legs. A

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19 Leitch IOW *Circumcision - A Continuing Enigma* Australian Paediatric Journal Vol 6 1970 59 at 63.

20 Cawte J *Social Medicine in Central Australia: The Opportunities of Pitjantjara Aborigines* The Medical Journal of Australia February 3 1977 221 at 227.

21 Cawte also refers to the practice of subincision (described at p.10 below). Id at 227:

> Subincision is another matter; this is going a little too far for European tastes; a subincised man makes a mess by spraying rather than squirting in toilets and urinals.

22 Money J, Cawte JE, Bianchi GN, Nurcombe B *Sex Training and Traditions in Arnhemland* British Journal Med. Psychol. Vol 43 1970 383. See also Gray D *A Revival of the Law : The Probable Spread of Initiation Circumcision* in *Religion in Aboriginal Australia : An Anthology* 1986 at 419.

> third does the actual cutting. In ancient times a stone knife was used. Today the instrument is a razor blade. The cutting is more likely to be a series of dissection movements than swift incision. The boy may cry out with the pain. Immediately the foreskin is removed, the men in charge carry the boy into the bush nearby where he is passed through the smoke of a fire for spiritual cleansing. The bleeding of his penis is stopped by cauterizing with a piece of hot charcoal and the application of hot, wet leaves. He returns to his home camp-fire and there rests and recuperates for about a week.
>
> The meaning of the ceremony is, like the origin of circumcision itself, lost in the unrecorded annals of prehistory. My own theoretical guess is that it represents a substitute for, and attenuation of, a still earlier practice of human sacrifice. One may see a similarity with the way in which the symbol of the Crucifixion became a substitute for, and attenuation of, the animal sacrifice of Old Testament times.

Similarly, Meggit refers to the rite of circumcision for boys between 11 and 13 in the Walbiri people of Central Australia:[23]

> The rite of circumcision and its attendant ceremonies firmly and unequivocally establish a youth's status in Walbiri society. Should he fail to pass through these rites, he may not enter into his father's lodge, he may not participate in religious ceremonies, he cannot acquire a marriage line, he cannot legitimately obtain a wife; in short, he cannot become a social person.

Meggit also notes that:[24]

> The Walbiri explicitly equate circumcision with ritual killing.

Subincision is performed on youths of the Walbiri people at 17 years of age. Subincision has been described by Meggit as follows:[25]

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23 Meggitt MJ *Initiation among the Walbiri* in *Religion in Aboriginal Australia : An Anthology* 1986 at 241.

24 Id at 253. At 261 Meggit describes the operation:

> A brother seizes the novice and places him face upward on the table, with his feet toward the fire. Another brother straddles him and presses his pubes against the lad's face to silence his cries, while a third grips his legs. A brother holds the shaft of the boy's penis, in order to protect 'the inside bone' from injury; one of the circumcisers stretches the foreskin several inches, and another cuts it off with two or three quick slices. The rest of the brothers watch closely for it is their duty to kill the operator at once if he mutilates the boy. (It is small wonder that some men are literally grey with anxiety when they perform their first operation.)

25 Id at 265-266. Subincision has been abandoned in a number of communities. See Gray DA *Revival of the Law : The Probable Spread of Initiation Circumcision* in *Religion in Aboriginal Australia : An Anthology* 1986 at 432-433. See also Pounder DJ *Ritual Mutilation: Subincision of the Penis in Australian Aborigines* The American Journal of Forensic Medicine and Pathology Vol 4 No 3 Sept 1983 227.

> To the accompaniment of loud chanting by the company, the man deftly slices open the youth's penis from the meatus to a point about an inch along the urethra. An elder brother also holds the penis, to ensure that the "inside bone" is not cut, while other brothers stand ready to kill the incisor if he bungles his task. The operator withdraws immediately he makes the cut ... it is not until he is betrothed, a couple of years after he has been subincised, that the men begin to regard him as an adult.

(d) Current practice

Over the past two decades the popularity of neonatal circumcision has decreased.[26] By 1980 only 40 per cent of Australian male babies were circumcised.[27]

It is unclear what the current rate of circumcision is in Australia, although estimates range from 25 per cent[28] to 35 per cent.[29]

The number of circumcisions qualifying for a Medicare reimbursement in Australia has remained fairly static over the last 5 years[30] and may have actually decreased slightly on a per capita basis, given the increase in number of live male births over that time.

The highest proportion of circumcisions Australia-wide and in Queensland were performed on infants less than 6 months of age, which suggests that they were performed for religious, cultural or perceived prophylactic purposes.[31] Relatively few circumcisions are performed on public patients in public hospitals in Queensland. Some public hospitals have adopted a policy of not performing routine neonatal circumcisions. When circumcisions

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26 Although this is not evident from the relatively small but seemingly increasing numbers of circumcisions performed in public hospitals on public patients in Queensland. See Appendix 2.

27 Wirth JL *Current Circumcision Practices in Australia* Medical Journal of Australia Vol 1 1982 at 177-179.

28 Little K *Circumcision: Pros and Cons* Modern Medicine September 1992 37. Williams G *Newborn Circumcision - An Enigma of Health* Paper delivered to The Second International Homebirth Conference 4-7 October 1992, Sydney.

29 Little K *Circumcision: Pros and Cons* Modern Medicine September 1992 37 suggests a total rate for Australia of approximately 30 to 35%:

> Overall there has been a slow but consistent decrease in the number of children being circumcised, and this trend is expected to continue into the future.

30 See Appendix 1.

31 See Appendix 1. The number of circumcisions performed on infants under 6 months of age in 1988/89 for which Medicare provided a reimbursement was 14,674. In 1992/93, the number was 14,604. In 1988 there were 126,223 live male births in Australia. In 1992 there were 135,601 live male births. The number of infant circumcisions per live male births has decreased in that period from 11.6% to 10.76%.

are performed in public hospitals, they tend to be performed on older children.[32] This may indicate a reluctance to circumcise newborns. It could also indicate a medical need to circumcise older infants.

In the United States, circumcision rates remain high at between 50 - 75 per cent.[33]

It has been estimated that between 75 per cent[34] and 85 per cent of the world's male population are not and will not be circumcised.[35] In most European countries circumcision is not an approved routine procedure.

3. THE PROCEDURE

Various methods have been used or promoted for circumcision or for procedures designed to bring about the same results.[36]

(a) Jewish Ritual Circumcision

The circumcision which Abraham performed on himself and other male members of his household was the removal of the tip of the prepuce. This procedure is referred to as *Milah* by Jews and was practised by Jews for approximately 2,000 years.

During the Hellenic period and at least by AD 140 a second step to ritual

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32 The most recent available figures, provided by the Health Information Services Unit of Queensland Health on 26 November 1993 are set out in Appendix 2. In 1988 15 babies under 6 months of age were circumcised as public patients in public hospitals. This rose to 77 (preliminary figures) in 1991. For infants 6 months to 10 years of age, 250 were circumcised in 1988 and 304 in 1991.

33 Schoen E *The Status of Circumcision of Newborns* The New England Journal of Medicine 1990 1308, Williams G *Newborn Circumcision - An Enigma of Health* Paper delivered to The Second International Homebirth Conference 4-7 October 1992 Sydney at 1.

34 Williams G *Newborn Circumcision - An Enigma of Health* Paper delivered to The Second International Homebirth Conference 4-7 October 1992, Sydney.

35 Milos MF and Macris D *Circumcision: A Medical or Human Rights Issue?* Journal of Nurse-Midwifery Vol 37 No 2 1992 875 at 905. See also Hirst G *Controversies Surrounding Circumcision* Patient Management September 1984 at 12 who suggests that a maximum of only 3 per cent of the world's population were subjected to routine circumcision at its peak incidence.

36 Descriptions of some Australian Aboriginal circumcision techniques are referred to above at pp 8,9.

circumcision (*Pariah*) became prevalent. This involved the tearing of the remaining lining of the prepuce off the glans (the head of the penis to which the prepuce is normally attached during infancy) and, with a sharpened fingernail, removing all mucous tissue that comprises the inner lining of the prepuce.

A final step in this circumcision procedure, the *Metzitzah*, was added to the ritual during the Talmudic period (AD 500-625):[37]

> Now follows the exsuction of the wound in such a manner that the Mohel takes the circumcised member in his mouth and with two or three draughts sucks the blood out of the wounded part. He then takes a mouthful of wine from a goblet and spurts it, in two or three intervals, on the wound.

Not all Jews adopted this procedure. Some modified it by including the use of a glass tube for sucking the blood to avoid the spread of disease through mouth-to-genital contact.

Recently, with the spread of HIV, the Rabbinate also approved placing cotton in the glass tube to prevent blood from entering the Mohel's mouth.

Most Jewish baby boys in Australia are now circumcised by doctors using the same procedures as are described below for non-ritual circumcision, although a religious ceremony would normally also take place at the same time.

(b) Non-Ritual Circumcision

This involves the surgical removal of the prepuce from the glans. Because it is common for babies as young as 8 days old to be circumcised, it is not the usual practice to anaesthetise the child.

Commonly, an instrument is used not dissimilar in appearance from a pair of pliers. The foreskin is removed and the ends are sutured. In free-hand excision, clamps may be used.

A more recent practice involves inserting a plastic ring with a groove on its periphery inside the prepuce. A string is tied around the outside of the prepuce over the groove. A plastic bell fits over the top of the prepuce. The head of the device is broken off, removing the prepuce. It is trimmed by the doctor. The ring, which clamps the wound, falls off within a week.

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[37] This information is from a 1992 United States of America publication. The Commission would prefer information to be provided by those experienced in Australian Jewish circumcision practices.

4. THE LEGALITY OF CIRCUMCISION

Because the vast majority of circumcisions of males in Australia take place within the first few days of life, the question of whether or not a child consents to the procedure rarely arises. If circumcision is suggested for a child who is old enough to understand the nature and consequences of the procedure, then it is apparent that his consent should be sought.[38]

For infants, the parents or guardian have traditionally been considered as the most appropriate parties to consent or refuse to consent to the procedure taking place.

The over-riding qualification to a parent or guardian's ability to consent to any medical procedure being performed on their child is that the procedure has to be in the child's best interests.[39]

Obviously, if a child is circumcised against the wishes of his parents or guardians, or against the child's wishes if he is mature enough to understand the procedure, in other than an emergency situation, those performing the operation and those associated with it may be criminally or civilly liable for assault. They may also be liable for damages resulting from any negligence in the procedure.

Any voluntary touching of another person is generally unlawful unless the other person has consented to that touching. Without consent, even the slightest degree of physical contact may give rise to a civil claim (eg for assault) or to a criminal assault charge.[40]

Under the criminal law, a person can consent to what would otherwise be a simple assault but consent does not remove criminal responsibility for more serious injuries such as wounding being done to that person by another. However, a doctor would not be criminally liable for grievous bodily harm (such as the removal of an organ or the amputation of a limb) if the procedure was for the patient's benefit and was reasonable "having regard to the patient's state at the time and to all the circumstances" (Queensland *Criminal Code* section 282).

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38 See *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 and *Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security* [1986] 1 AC 112.

39 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

40 *Collins v Willcock* [1984] 3 All ER 374; *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

In addition to the requirement that medical procedures cannot, except in emergency situations, be carried out on individuals without consent, such consent must be "real" consent. Consent is not real consent if it has been obtained by fraud or by misrepresentation as to the nature of the procedure and/or where the patient has not been informed in broad terms of the nature of the proposed procedure before giving consent.[41]

The 'real' consent of a person to the touching by another, relieves that other from civil liability even though the other may be criminally liable for his or her actions. Consent is intended to ensure protection for the patient against unauthorised interference with his or her right to bodily integrity and, for the health-care provider, against possible legal action. There are certain statutory exceptions to a health-care provider's liability for treating a patient without his or her consent - for example, when the procedure is to be performed on a person in an emergency situation in circumstances where the person is unable to consent.

In the absence of 'real' consent, circumcision of male infants would fall within the definition of assault under section 245 of the Queensland *Criminal Code*. It might also be an offence endangering life or health. A number of criminal offences may be committed depending on the circumstances of the case, such as:

* It could be seen as intended to cause grievous bodily harm[42] and be punishable under section 317 of the *Criminal Code*.

> Any person who, with intent to maim, disfigure, or disable, any person, or to do some grievous bodily harm to any person ... [u]nlawfully wounds or does any grievous bodily harm to any person by any means whatever ... is guilty of a crime. [maximum sentence of imprisonment for life]

Circumcision may result in disfigurement (detracting from personal appearance), disablement (creating a permanent disability), maiming (permanent injury).[43] To constitute a "wounding" the true skin must

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41 *Chatterton v Gerson* [1981] 1 QB 432, 443; *Sidaway v Board of Governors of Bethlem Royal Hospital* [1984] 1 QB 493, 511 (CA).

42 S.1 of the *Criminal Code* defines 'Grievous bodily harm' as:

> Any bodily injury of such a nature as to endanger or be likely to endanger life, or to cause or be likely to cause permanent injury to health".

43 See 1 Hawk c15 s.2 where it is stated:

> And therefore the cutting off or disabling or weakening a man's hand or finger or striking out his eye or fore-tooth or castrating him are said to be maims; but the cutting off his ear or nose etc are not

be broken,[44] which is an obvious result of circumcision.

* Assault occasioning bodily harm on indictment under section 339 of the *Criminal Code* (with a maximum sentence of imprisonment with hard labour for 3 years). "Bodily harm" is defined in section 5 of the Code as any bodily harm which interferes with health or comfort. Alternatively, it may be appropriate to try the matter summarily before a magistrate as an assault occasioning bodily harm under section 343A of the *Criminal Code* (with a maximum sentence of a fine of one thousand dollars and in default 2 years imprisonment or two years imprisonment in the first instance).

* Grievous bodily harm without intent is also an offence under section 320 of the *Criminal Code*:

> Any person who unlawfully does grievous bodily harm to another is guilty of a crime [maximum sentence of imprisonment for 14 years].

* Wounding without intent is a misdemeanour under section 323 of the *Criminal Code*:

> Any person who -
>
> (1) unlawfully wounds another is guilty of a misdemeanour, and is liable to imprisonment with hard labour for seven years.

A person who wounds another or causes bodily harm to another may be excused for his or her conduct under section 282 of the Queensland *Criminal Code*:

> **Surgical operations.** A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable having regard to the patient's state at the time and to all the circumstances of the

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esteemed maims, because they do not weaken, but only disfigure him.

44 A break in the outer skin would not be sufficient and an injury is unlikely to be a 'wound' unless it bleeds. *R v Devine* (1983) 2 A Crim R 45.

case.[45]

Whether or not circumcision would be for the benefit of the particular child, and whether or not it would be reasonable having regard to the child's state at the time and to all the circumstances of the case, would need to be assessed on a case-by-case basis.

In Queensland there is no statutory definition of surgical operations, nor is there a statutory restriction on who can perform a surgical operation.

A person cannot hold an appointment in Queensland as a physician, surgeon or medical officer in any public or private hospital or other institution or society for affording medical relief in sickness, infirmity, or old age, or as a medical inspector, medical officer of health, or health officer unless he or she is a registered medical practitioner.[46] However, there is nothing in the criminal law preventing any person performing surgical procedures on others, provided that they are performed "in good faith and with reasonable care and skill ... for [the other's] benefit ... if the performance of the operation is reasonable having regard to the patient's state at the time and to all the circumstances of the case."[47]

Whether or not medically qualified, a person performing a circumcision on a child in Queensland would be under a duty to have reasonable skill and to use reasonable care in doing such an act.[48] The person will be held to have caused any consequences which result to the life or health of the child by reason of any omission to observe or perform that duty.

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45 Note also s.52 of the *Medical Act 1939* (Qld) where the procedure is considered necessary by the medical practitioner to save or prolong the child's life and where a relation of the person is not reasonably available to consent to the surgical procedure: the hospital or institution's medical superintendent or the medical practitioner with responsibility for patients in the hospital or institution can consent. It is unlikely that circumcision would fall within this emergency provision.

46 *Medical Act 1939* (Qld) s.31.

47 *Criminal Code* (Qld) s.282.

48 *Criminal Code* (Qld) s.288. There would also be a duty imposed by reason of having control of a dangerous thing (scalpel or other instrument used for circumcision) under s.289 *Criminal Code* (Qld).

5. THE PREPUCE

(a) Function of Prepuce

Dr Douglas Gairdner[49] has described how the prepuce and glans[50] develop from the same block of tissue before birth and are still in the course of developing at birth. At birth, there is a common layer of squamous epithelium[51] between the glans and the deep surface of the prepuce, and this explains why 96% of male neonates have a non-retractile prepuce. The prepuce gradually becomes detached from the glans and retractable over it. In 90% of boys this process is completed by the age of 5 years.

In the first two years of life the prepuce functions to protect the glans and especially the urinary opening (meatus), from the effects of 'nappy rash' (ammoniacal dermatitis) and protects the glans from irritation and faecal material. The prepuce is one of the most sensitive parts of the penis and is said to enhance sensation during sexual intercourse.[52]

(b) Removal of Prepuce

With the removal of the prepuce the exposed glans develops dermal layers up to twelve times the skin thickness. This has been described as the formation of a cornified layer - an additional outer covering of compressed, dead cells. Due to this scarification process, circumcision may render the penis less sensitive.[53]

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49 Gairdner D *The Fate of the Foreskin* British Medical Journal Vol 2 1949 1433-143. Subsequent to Dr Gairdner's article the British National Health Service discontinued payment for circumcision and the practice diminished greatly.

50 The glans penis is the terminal end of the penis.

51 Scale-like closely-packed sheet of cells.

52 Little KET *Circumcision: pros and cons* Modern Medicine 1992 37 at 40; Sorrells ML *Still More Criticism* Paediatrics Vol 56 1979 339; Black JS *Circumcision* Patient Management 1992 70 at 71.

53 Ibid.

6. HEALTH REASONS FOR REMOVAL OF PREPUCE

(a) Neonatal Circumcision

There appear to be no universally accepted, unequivocal medical indications for neonatal circumcision.[54]

The Australian Medical Association does not encourage routine neonatal circumcision. The Association has written to the Commission stating:[55]

> Circumcision of the newborn male infant is a practice which the Australian medical profession generally discourages, always recognising that there may be medical justification for it in conditions such as phimosis. While the AMA has no formal policy on the matter, it generally supports the relevant policy position adopted by the Australian College of Paediatrics.

The Australian College of Paediatrics policy statement reads:

1. The Australian College of Paediatrics should continue to discourage the practice of circumcision as in the newborn male infant.

2. Educational material on the topic of circumcision should be available to parents before the birth of their baby and also in maternity hospitals. This will facilitate informed discussion with their medical attendant.

3. Some parents after considering medical, social, religious and family factors will opt for circumcision of their male child. It is then the responsibility of the medical attendant to recommend that this circumcision is performed at an age and under medical circumstances that reduce the hazards to a minimum.

The Royal Australian College of Obstetricians and Gynaecologists also discourages routine male circumcision. The College states:[56]

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54 Hirst G *Controversies Surrounding Circumcision* Patient Management September 1984 14.

55 Letter to the Commission from the Assistant Secretary-General of the Australian Medical Association 5 October 1993.

56 Letter to Commission from the President of the Royal Australian College of Obstetricians and Gynaecologists 12 October 1993.

> The suggested benefit does not outweigh the financial cost of the procedure on a community basis and the real cost of the occasional fatality in male infants directly arising from circumcision.

The Queensland Nurses Union does not have a specific policy on routine circumcision but would support the refusal of any of its members to participate in the procedure.[57]

Neonatal circumcision should not be considered when the neonate is premature, has a neonatal illness, any congenital anomaly (most importantly hypospadious[58]) or has a bleeding disorder. The procedure should never be performed within the first 24 hours of life.[59]

Routine neonatal circumcision continues to be performed by a number of general medical practitioners and possibly specialists in Queensland.

(b) Non-neonatal Circumcision

There are a number of conditions which may indicate a need for circumcision in older children or men.

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57 The Australian Nursing Federation (of which the Queensland Nurses' Union is a branch) adopted the following policy in September 1992:

> 1. Nurses (including students of nursing) have a right to refuse to participate in procedures to which they hold a conscientious objection, except that nurses in the course of their employment should not refuse to carry out urgent tasks which are life-saving measures.
>
> 2. In cases of conscientious objection, the nurse should express a desire not to participate in advance and should be removed from the procedure area as soon as possible without any discriminatory action being taken.

Definition:

> Conscientious Objection is a right to refuse to participate in procedures where that refusal is based on beliefs about that which is right or wrong to do, and where this belief of personal conscience is the dominant guide to the individual's decision. Fear, personal convenience or preference are not sufficient basis for conscientious objection.

58 A congenital defect of the wall of the male urethra so that instead of the normal external orifice there is an opening for a greater or lesser distance on the underside of the penis.

59 It has also been suggested that it should not be performed within the first eight days of life - to allow clotting factors to develop.

(i) Phimosis[60]

This is a medical condition in which the prepuce will not pull back over the glans of the penis because the 'opening' is too tight. This is not a problem for young boys. When erections occur the preputial opening may split. Healing then causes linear contraction and further narrowing of the circular orifice. If very tight, it may restrict urine flow and cause ballooning of the preputial sac. It may also lead to infection or balanoposthitis.[61] This would be an indication for circumcision.

Ballooning without phimosis is not an indication for circumcision. It may occur in a normal prepuce because of malalignment of the urinary opening with the preputial orifice, or, solely because of the length and laxity of the prepuce. This can normally be managed by retraction of the prepuce under general anaesthesia.[62]

(ii) Paraphimosis

This is an uncommon condition resulting in the inability of the phimosed prepuce to be pulled forward again. The prepuce tends to become oedematous[63] and a tight constriction then develops at the coronal sulcas behind the glans, aggravating the condition. This is more common in older men and rare in children. Circumcision will be necessary in younger men, but in the elderly a dorsal slit, under local anaesthetic, will suffice. In one study, paraphimosis in boys was found to be usually caused by an overzealous parent forcibly retracting, in the bath, a still congenitally adherent foreskin in a child less than 3 years of age, on the misguided advice of a doctor.[64]

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60 From the Greek word for "muzzled".

61 Inflammation of the glans penis and the prepuce.

62 Cooper GG Thomson GL and Raine P *Therapeutic Retraction of the Foreskin in Children* British Medical Journal 1983 186-187. In a retrospective study of 91 boys who had a non-retractable but non-fibrosed prepuce treated by retraction under general anaesthesia, 67 obtained relief and 12 were later circumcised (the remaining boys were lost track of).

63 Excessive fluid in intercellular tissue spaces due to increased transudation of fluid from the capillaries.

64 Leitch IOW *Circumcision - A Continuing Enigma* Australian Paediatric Journal Vol 6 1970 59 at 64. Leitch states:

> Surely this shows the need for proper education of those members of the medical profession most closely associated with these problems.

(iii) Non-retractable Prepuce

Adhesions normally exist between the prepuce and the glans from birth and are progressively broken down as erections occur. By three or four years of age the prepuce is usually fully retractable. Plugs of smegma[65] may be retained behind the prepuce and be mistaken for 'pus' or may predispose to infection.

Dr E P Arnold has observed:[66]

> Non-retractable prepuce is not usually an indication for circumcision and can be managed conservatively in the expectation that the adhesions will break down as the child grows. If infections become a problem, the adhesions can be separated satisfactorily an hour after applying a transcutaneous local anaesthetic cream (e.g. EMCA). For two weeks after this, daily saline baths, gently withdrawing the prepuce for cleaning and then applying vaseline to the glans before pulling the prepuce forward again, are useful manoeuvres to prevent re-formation of adhesions. Should they recur or infections remain a problem, circumcision should be advised.

Leitch observes:[67]

> A prepuce made fully retractable after the age of 3 years by simple separation of adhesions with a blunt probe, not necessarily under anaesthesia, would assist hygiene, decrease balanitis and true phimosis, and prevent the accumulation of smegma, thus decreasing the risk of carcinoma of the penis, possibly to an almost negligible level.

By 16 years of age only about one per cent of boys still have a non-retractable prepuce.[68]

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65 An oily substance with a peculiar odor. Secreted by small preputial glands on the raised posterior margin of the glans penis and on the neck of the penis. A similar substance is secreted by glands around the clitoris and labia minora in females.

66 Arnold EP *If Anyone Asks 'Should I have him Circumcised'?* Patient Management November 1990 15.

67 Leitch IOW *Circumcision - A Continuing Enigma* Australian Paediatric Journal Vol 6 1970 59 at 63-64.

68 Id at 63.

(iv) Recurrent balanitis[69]

This is a condition of inflammation of the glans penis, usually where phimosis is present.

(v) Complications of previous, inadequate neonatal circumcision

7. PROPHYLACTIC REASONS FOR REMOVAL OF PREPUCE

There are those who argue strongly in favour of routine circumcision. For example, a Brisbane general practitioner, Dr T Russell states:[70]

> The evidence of the benefits of neonatal circumcision is now so strong that it may be unethical or even negligent not to recommend circumcision.

A United States medical practitioner, much relied upon by pro-routine circumcision lobbyists, Dr Edgar Schoen, states:[71]

> The benefits of routine circumcision of newborns as a preventive health measure far exceed the risks of the procedure ...

A number of arguments have been promoted for routine male circumcision on the basis of preventative health.

(a) Hygiene

It is important for uncircumcised males to retract and clean beneath the prepuce to avoid infections. The need for regular cleaning is often used as an argument in favour of circumcision. Of course, hygiene is widely regarded as a preventative health measure in relation to a wide range of illnesses and disease. Cleaning the uncircumcised penis has been likened

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69 From the Greek word "balanus" meaning the glans penis.

70 Russell T *The Case for Circumcision* Medical Observer 10 October 1993.

71 Schoen E *The Status of Circumcision of Newborns* The New England Journal of Medicine May 3 1990 1308 at 1311.

to cleaning the intact labia of females - both of which could be regarded as a commonsense preventative health measure.[72] Circumcision reduces the need for males to practice genital hygiene.

But, as Dr Hirst states:[73]

> One frequently hears the argument that 'my father had to have it done in the Middle East in World War II' or 'My brother in Vietnam ... so let's prevent that risk'. Is it not facetious to suggest that removal of an organ, however small it might be, is the appropriate way to obviate a problem of cleanliness?

Obviously, if girls can be taught genital and menstrual hygiene, boys can be taught penile hygiene, although some may reject this analogy. Dr Russell has written:[74]

> What man, after a night of passion, is going to perform 'penile hygiene' before rolling over and snoring the night away (with pathogenic organisms multiplying in the warm moist environment under the prepuce)?

Many groups which have traditionally practised routine circumcision, such as Jews, Muslims, Australian Aboriginals - originally lived in dry, arid conditions where facilities for personal hygiene were not optimal. Circumcision may therefore have had appeal as a prophylactic measure against balanitis.

(b) Risk of Cancer

There is some evidence that circumcision may reduce a man's risk of developing cancer of the penis.

Carcinoma of the penis is exceptionally rare. In countries where circumcision is not routinely performed, such as Denmark and Japan, the

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72 Milos MF and Macris D *Circumcision: A Medical or a Human Rights Issue?* Journal of Nurse-Midwifery Vol 37(2) 1992 875 at 905.

73 Hirst G *Controversies Surrounding Circumcision* Patient Management September 1984 12 at 14.

74 Russell T *The Case for Circumcision* Medical Observer 1 October 1993. In that article, a study of British schoolboys is referred to which showed that penile hygiene as such does not exist. An obstetrician and gynaecologist writing in *Patient Management* March 1992 at p.70 notes:

> The operation came into existence thousands of years ago in Middle Eastern desert lands where to get sand under one's foreskin must have been murder!

rates of penile cancer are similar to those found in countries like the United States where the majority of males have been circumcised.[75] The incidence of cancer is much lower in the uncircumcised when associated with good hygiene. Dr J S Black, an obstetrician and gynaecologist notes:[76]

> Studies have shown that in uncircumcised cultures with good hygiene the incidence of cancer of the glans is low, but in circumcised cultures with poor hygiene the incidence is high. Clearly, it is good hygiene, not the presence or absence of the foreskin that matters.

Dr M L Sorrells notes:[77]

> All studies report almost total absence of hygiene in all victims of this cancer ... the relationship of circumcision to cancer of the penis seems real, but even minimal hygienic standards are probably just as effective in prevention.

Cancer of circumcised penises has been reported.

Dr Schoen reports:[78]

> There are 750 to 1000 cases of penile cancer annually in the United States; however, in the past 20 years only 3 cases of penile cancer have been reported in men who had been circumcised as newborns. There have been six major studies of cancer of the penis in the United States since 1932, and none of the more than 1600 patients studied had been circumcised in infancy.

Marshall determined the incidence of carcinoma of the penis in the United States to be 0.2 to 0.9 per 100,000 uncircumcised males. Using this data, he estimated that between 111,000 and 500,000 circumcisions needed to be performed to prevent one case of penile cancer.[79] Hirst[80] refers to older

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75 Arnold EP *If anyone asks: 'Should I have him circumcised?'* Patient Management November 1990 15 at 16.

76 *Patient Management* March 1992 at 71.

77 *Still More Criticism* Paediatrics Vol 56 1979 at 339.

78 Schoen E *The Status of Circumcision of Newborns* The New England Journal of Medicine May 3 1990 1308 at 1309.

79 Marshall VF *Should circumcision of infant males be routine?* Medical Record Annals Vol 48 1954 790.

United Kingdom figures suggesting that such a number of circumcisions might result in more than 20 neonatal deaths "although recent papers quote lower mortality rates."

Other studies have reported:[81]

* Of 156 patients with carcinoma of the penis treated at the University of Michigan Medical Center - all were uncircumcised. One third died as a result of the disease.[82]

* Five major reported series of cases between 1932 and 1989 in which not one victim of penile cancer had been circumcised neonatally.[83]

* Fifteen cases of penile cancer arising in circumcision scars in Saudi Arabia - although, as is the custom, all had been circumcised as teenagers.[84]

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80 Hirst G *Controversies surrounding circumcision* Patient Management September 1984 12 at 16.

81 Leitch IOW *Circumcision - A Continuing Enigma* Australian Paediatric Journal Vol 6 1970 59 at 62 reports:

> Moslems are circumcised between the ages of 4 and 12 years, and comparisons of the incidence in Moslems and Jews show a lower incidence in Jews, who are circumcised on the eighth post-natal day. However, Jewish circumcision demands the removal of more prepuce than the Moslem ritual.
>
> Carcinoma of the penis in the Chinese accounts for 18.5% of all carcinomata, compared with 2% in the U.S.A. ... There are wide geographic variations, and the disease is associated with a congenitally tight or a long redundant foreskin. The disease is rarely seen among the more well-to-do, whose level of personal hygiene is higher. Circumcision has been thought to provide complete protection from carcinoma of the penis, but recently two cases have been reported in Jews circumcised in infancy ... and five cases of carcinoma of the penis in non-Jews circumcised in infancy ...
>
> Carcinoma of the penis seems to be associated with lack of circumcision which by no means affords absolute protection. Also associated are a long redundant, and a congenitally adherent foreskin, while good personal hygiene appears to decrease the incidence.

82 Dagher R, Selzer ML, Lapides J *Carcinoma of the Penis and the Anti-Circumcision Crusade* Journal of Urology Vol 110 1973 at 79-80. Approximately 70 per cent of the patients underwent surgical procedures, including local excision of the lesion, circumcision, partial penectomy, radical amputation of the penis and lymphadenectomy.

83 American Academy of Paediatrics *Report of the Task Force on Circumcision* Paediatrics Vol 84(4) 1989 388-391.

84 Swadey JG *Letter to the Editor* Southern Medical Journal Vol 80(4) 1987 537-538. But see Dagher R, Selzer ML, Lapides J in *Carcinoma of the Penis and the Anti-Circumcision Crusade* Journal of Urology Vol 110 1973 79-80 state:

> Our evidence leads us to believe that circumcision at any age will virtually prevent the onset of squamous cell carcinoma of the penis if the neoplasm is not present at the time of circumcision and the prepuce is completely removed. We do not agree with the concept that

* In Australia there were 78 deaths from carcinoma of the penis between 1960 and 1966. In the same period there were 2 reported deaths from circumcision.[85]

There has been the suggestion of a link between lack of circumcision and the incidence of carcinoma of the prostrate. There is no evidence for this assertion.[86]

It has been suggested that a lower-than-usual incidence of carcinoma of the cervix in Jewish women is due to the universal circumcised state of their sexual partners. There is no scientific basis for this suggestion.

It has been noted, however, that Muslim women, whose husbands are circumcised in infancy, have a much higher rate of cervical cancer than Jewish women. Parsees of India, who do not circumcise, have a much lower rate of cervical cancer than their Muslim neighbours who do circumcise.[87] Complete circumcision is found about as frequently in husbands of patients with cancer of the cervix as in husbands of controls.[88]

The strongest predisposing factors in cervical cancer are a history of intercourse at an early age and multiple sexual partners, sexual hygiene, parity,[89] contraceptives, coitus interruptus, and frequent intercourse.[90]

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circumcision after the neonatal period is ineffective in preventing epidermoid neoplasms of the penis. Many adult patients with phimosis, condyloma acuminata and leukoplakia have been circumcised at this medical center and none has reappeared with penile neoplasm.

85 Leitch IOW *Circumcision - A Continuing Enigma* Australian Paediatric Journal Vol 6 1970 59-65.

86 Id at 62 and Hirst G *Controversies Surrounding Circumcision* Patient Management September 1984 12 at 16. Demetrakopoulos GE *A Different View of the Facts* Paediatrics Vol 56 1979 339 at 340.

87 Leitch IOW *Circumcision - A Continuing Enigma* Australian Paediatric Journal Vol 6 1970 59 at 62. Note also that the human papilloma virus type 16 has been found in 50% of males with carcinoma of the penis and this virus, among others, is also implicated in the aetiology of carcinoma of the cervix in female partners - see Arnold EP *If anyone asks: 'Should I have him circumcised'?* Patient Management November 1990 15 at 16.

88 Demetrakopoulos GE *A Different View of the Facts* Paediatrics Vol 56 1970 339 at 340.

89 The condition of having borne children.

90 Ibid. See also Demetrakopoulos GE *A Different View of the Facts* Paediatrics Vol 56 1979 339 at 340, and Sorrells ML *Still More Criticism* Paediatrics Vol 56 1979 at 339 states:

> The level of hygiene in both male and female indeed seems to be a factor in the aetiology of cervical cancer, but that circumcision increases hygienic standards is patently not true.

For each of these cancers, it appears that more factors are involved than circumcision and non-circumcision. Personal hygiene seems to be the most consistently relevant factor.[91] The incidence of breast cancer in women and prostrate cancer in men are far more common in Australia than cancer of the penis, yet it is rare to hear learned arguments in favour of routine mastectomies for women and routine prostatectomies for men in order to prevent such cancer from developing.

(c) Urinary Tract Infections

Such infections are said to be more common in uncircumcised male babies. The evidence for this is scientifically suspect as it all comes from hospital-based retrospective studies.[92] Bacterial infection of the glans and prepuce are relatively uncommon in the child where there is no known aetiological factor, whereas in adults it usually occurs as a result of phimosis or poor hygiene.[93]

(d) Sexually Transmitted Diseases

Unless men are sexually active and in a risk group for contracting sexually transmitted diseases, circumcision will not offer protection against such diseases. Boys, whether circumcised or uncircumcised, are obviously at far less risk of contracting sexually transmitted diseases including the Human Immunodeficiency Virus prior to becoming sexually active or adopting a high-risk lifestyle. Presumably, at that point, they would be old enough to consent on their own behalf to circumcision if they believed that would offer them some protection.

The risk of transmitting or contracting certain sexually transmitted diseases including the HIV virus may be increased for men already in a risk group

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91 Leitch IOW *Circumcision - A Continuing Enigma* Australian Paediatric Journal Vol 6 1970 59 at 62. The *US Task Force on Circumcision* Paediatrics Vol 84(4) 1989 388 at 389.

92 Arnold EP *If anyone asks 'Should I have him Circumcised'?* Patient Management November 1990 15 at 16 notes that in adults, if a catheter is passed and the patient subsequently develops a urinary infection, the organism is usually identical to that found on the culture of the urethral meatus or preputial sac at the time the catheter was passed. "There is support, therefore, for the belief that infections arise from the ascending route."

93 Hirst G *Controversies Surrounding Circumcision* Patient Management September 1984 12 at 14 notes that recurrence of these infections may be a medical indication for circumcision.

who have uncircumcised penises although other factors may be relevant.[94]

In 1947 a Canadian study on the incidence of circumcision amongst soldiers with venereal disease found that uncircumcised men were nine times more likely than circumcised men to have syphilis and almost three times more likely to have gonorrhoea. It was observed, however, that cleanliness of the genitals was commonly neglected among the soldiers. Further, tears and abrasions of the prepuce were often noticed on sick parade:

> Small abrasions of the delicate coronal membrane must be very common during brothel intercourse. Both provide a portal of entry for the spirochaete.[95]

In a 1983 Western Australian study of men attending a special treatment clinic it was estimated that uncircumcised men were twice as likely as circumcised men to have herpes genitalis or gonorrhoea, and five times as likely to develop candidiasis or syphilis.[96]

No attempt was made in the study to measure the socioeconomic status of the subjects - it had previously been suggested that uncircumcised men tend to come from lower socioeconomic backgrounds and to have poorer personal hygiene and a greater chance of exposure to infection.[97] Another possibility canvassed by the researchers is that circumcised and uncircumcised men have similar rates of disease but that uncircumcised men are more likely to develop symptoms and, thus, to seek medical attention. This was considered most likely to be so in the case of candidiasis.

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94 Many of the studies which are relied upon to substantiate the increased risk are not well-controlled and do not eliminate variables such as geographic location, hygiene, life-style, race, socioeconomic factors or access to medical care. See *Report of the Task Force on Circumcision* Paediatrics Vol 84(4) 1989 388 at 389. Also, Little KET *Circumcision; pros and cons* Modern Medicine of Australia September 1992 37 at 39.

95 A bacterium.

96 Parker SW, Stewart AJ, Wren MN, Gollow MM, Straton JAY *Circumcision and Sexually Transmitted Disease* Medical Journal of Australia Vol 2 1983 288-290.

97 See Schoen E *The Status of Circumcision of Newborns* 1990 The New England Journal of Medicine 1308 who observes:

> From the early 1940s until the mid-1970s ... educated middle-class parents almost always had their newborn sons circumcised [to prevent cancer of the penis and cervical cancer in sexual partners, as well as to prevent phimosis and to promote genital cleanliness]. Those middle-class parents were willing to pay for the procedure (there were few insurance programs in the 1940s and 1950s) . The infant sons of poor parents were usually uncircumcised because their parents were unaware of the benefits and could not afford the cost.

The authors concluded:[98]

> The evidence at present certainly does not warrant the recommendation of circumcision on the ground that it prevents Sexually Transmitted Diseases. If these findings are confirmed in other studies, it would seem that attention should be directed to the improvement of personal hygiene among uncircumcised men.

The most recent available research findings on the relationship between lack of circumcision and HIV infection indicate that, for men involved in a high-risk lifestyle, circumcision may offer some protection from HIV infection, although not all studies reveal such a link.[99]

The protective effect of circumcision may be reduced when other factors are taken into account such as history of genital sores.[100]

In a 1988 study in Nairobi of 340 men attending a sexually transmitted diseases clinic uncircumcised heterosexual men were found to be 2.7 times more likely to have HIV infection than circumcised men.[101] Uncircumcised men were more frequently infected with HIV, regardless of history of genital ulcers. Uncircumcised men frequently had more history of genital ulcer disease than circumcised men. Genital ulcers may increase men's susceptibility to HIV, or they may increase the infectivity of women infected with HIV. The researchers concluded that the intact prepuce may operate to increase the susceptibility to HIV.

One suggested explanation given by the Nairobi researchers for the link between lack of circumcision and HIV infection is:[102]

> The presence of an intact foreskin provides a warm, moist environment that allows a longer time for viral survival and penetration.

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98 Ibid.

99 See Appendix 3 for summaries of recent research findings.

100 Ibid.

101 Simonsen JN, Cameron DW, Gakinya MN, Ndinya-Achola JO, D'Costa LJ, Karasira P, Cheang M, Ronald AR, Plot P, Plummer FA *Human Immunodeficiency Virus Infection Among Men with Sexually Transmitted Diseases* New England Journal of Medicine Vol 319 (5) 1988 274.

102 Id at 277.

Further, the cornified skin covering which develops on the circumcised penis may protect it from the microabrasions which facilitate HIV entry.[103]

The prepuce may also be subject to trauma during intercourse.[104]

Hirst reports:[105]

> Symptomatic monilial balanitis, usually resulting from sexual contact, is a common problem seen almost exclusively in the uncircumcised, particularly in a population where oral contraceptives are in widespread use. Treatment of both parties usually eradicates the infection, but occasionally circumcision is necessary to effect a cure.

(e) Psychological and Sociological

There may be an argument that for a child to be uncircumcised in a family or country where most males have been circumcised will place the child in an uncomfortable and embarrassing position. This may be more so when the community within which he lives has a religious or strong cultural reason for circumcising its males.

As the majority of boys in Australia are now uncircumcised, it is less likely than it was a few years ago, that a boy will be made to feel out-of-place amongst his peers for being uncircumcised. This should also be the case within families when the majority of fathers are uncircumcised. Presumably the old argument of fathers wanting their sons to look like them is less significant.

8. ARGUMENTS AGAINST ROUTINE REMOVAL OF PREPUCE

Apart from the controversy concerning the possible health reasons for removal of the prepuce and the prophylactic advantages of routine removal, a number of fundamental arguments have been promoted against routine circumcision of male infants. Dr R G Birrell, a paediatrician, writing to the

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[103] Ibid.

[104] Ibid.

[105] Hirst G *Controversies Surrounding Circumcision* Patient Management September 1984 16.

Australian Paediatric Journal notes that:[106]

> The neonatal period provides the time for maximal risk of complication for this procedure.

He suggests that, if the procedure is to be done, delay until 12-15 months of age seems the only reasonable approach. Although infection is then less of a hazard, the risks of complications still remain very significant.[107] Another paediatrician, Dr E Durham-Smith, suggests elective circumcision in the second or third year of life:[108]

> Anaesthesia is required at this time, and the risks of this must be weighed against the advantages of circumcision.

He goes on to state that:[109]

> Under the conditions pertaining in most neonatal nurseries, and especially the serious, albeit rare, complication of septicemia, routine circumcision in the neonatal period should not be performed; and in fact is undesirable at any time during the first year of life.

(a) The prepuce has a function

In babies, the prepuce protects the glans from urine and faeces and thus

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[106] Birrell RG *Circumcision* Australian Paediatric Journal Vol 6 1970 66-67.

[107] The *US Task Force on Circumcision* [Paediatrics Vol 84(4) Aug 1989 388 at 389] noted a number of techniques that may reduce postoperative complications:

(1) Using a surgical marking pen to mark the location of the coronal sulcus on the shaft skin preoperatively;
(2) Identifying the urethral meatus;
(3) Bluntly freeing the foreskin from the glans with a flexible probe;
(4) Completely retracting the foreskin; and
(5) Identifying the coronal sulcus

all before applying the clamp or Plastibell and before excising any foreskin. Electrocautery should not be used in conjunction with metal clamps.

[108] Durham Smith E *Another View of Circumcision* Australian Paediatric Journal Vol 6 1970 66 at 68.

[109] Id at 69.

reduces the likelihood of infection.[110]

(b) Pain

Neonatal circumcision is the only surgical operation routinely conducted without anaesthesia. Even local anaesthesia may lead to complications - mainly haematomas and local skin necrosis and, occasionally, death.[111] The United States Task Force on Circumcision notes:[112]

> Even a small dose of lidocaine can result in blood levels high enough to produce measurable systemic responses in neonates. Local anesthesia adds an element of risk ... Circumferential anesthesia may be hazardous.

Neonates experience pain. Circumcision can inflict considerable pain.

(c) Complications

It has been suggested that complications will arise in approximately 15 per cent of cases.[113]

* Death

The most serious complication is death. Although it is rare for babies

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[110] This function has been recognised for many years. See Gairdner D *The Fate of the Foreskin* British Medical Journal Vol 2 1949 1433 at 1434. See also information distributed by health authorities such as the Child Adolescent and Family Health Service (SA) *Health Thoughts: Uncircumcised Baby Boys*:

> The foreskin protects the 'glans' on top of the penis from the irritation of wet nappies and reduces the likelihood of infection. A circumcised baby is more likely to develop problems because he lacks this protection.

[111] See case referred to on p.33 below.

[112] *Report of the Task Force on Circumcision* Paediatrics Vol 84(4) 1989 388 at 390.

[113] Leitch IOW *Circumcision - A Continuing Enigma* Australian Paediatric Journal Vol 6 1970 59 at 61. In a study of 200 cases at the Adelaide Children's Hospital, complications arose in 31 cases or 15.5%. Complications included haemorrhaging (from mild to moderate), meatal ulcers, recircumcision - after being circumcised in the neonatal period for social reasons. Of 19 recircumcisions, 18 were simple circumcisions and in one a dorsal slit was followed by circumcision. Complications in the recircumcisions involved infection, meatal stenosis and mild haemorrhaging. Note, however, the mean age of patients in the survey was 2 years 4 months. Russell T in *The Case for Circumcision* Medical Observer 1 October 1993 at 60 suggests that a child is exposed to less risk of complications if circumcised earlier.

to die as a result of circumcision, there are a number of reports of death. The Commission has been advised of a recent case in Queensland where an infant was being circumcised in a general practitioner's surgery. Because the child was exhibiting signs of discomfort, more than the recommended dose of local anaesthetic was applied. As a result of the overdose of anaesthetic, the baby suffered a seizure and a cardiac arrest. The doctor did not have appropriate resuscitation equipment in his surgery. The baby was rushed to hospital but died shortly after.[114]

Gairdner referred to a United Kingdom mortality rate of 1.8 per 10,000 circumcisions.[115]

In a more recent New York study, 500,000 circumcisions were completed without a death.[116]

A Western Australian study of four desperately ill newborns in Australia with bacterial meningitis from infected circumcision sites reported that two of the babies recovered, one survived with cerebral palsy and one died.[117]

* **Damage to shaft**

Excessive skin of the penile shaft may be removed, resulting in a concealed penis or a denuded shaft.[118]

* **Damage to urethra**

The urethra may be caught in a circumcision clamp. This usually results in a fistula at the corona. It may be difficult to close the fistula.

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[114] Oral report from a Consultant Paediatrician who was involved in the treatment of the dying baby.

[115] Gairdner D *The Fate of the Foreskin* British Medical Journal Vol 2 1942 1433-1437 (1949).

[116] King LR *Neonatal Circumcision in the United States in 1982* Journal of Urology Vol 128 1982.

[117] Scurlock JM *Neonatal Meningitis and Circumcision* Medical Journal of Australia 1977 323-333.

[118] Hirst G *Controversies Surrounding Circumcision* Patient Management September 1984 12 at 16.

This may require two separate procedures.[119] The Commission has been advised of a recent case in Queensland where a child haemorrhaged after a circumcision operation performed in a general practitioner's surgery. The doctor stitched the wound and mistakenly stitched the urethra at the same time. The child was admitted to hospital a few days later, not having urinated during that time, gravely ill with septicaemia.[120]

* Amputation

The glans or even the penis may be amputated. There are reports of gangrene of the penis, avulsion of the scrotum and removal of needed skin for hypospadias repair.[121]

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[119] Ibid.

[120] Oral report from a Paediatric Surgeon who treated the sick infant.

[121] See *St Margaret's Hospital for Women (Sydney) v McKibbin* 1987 Aust Torts Rep 69009 (NSW C of A) where 19 year old plaintiff sued for damages resulting from loss of glans of penis as result of negligent neonatal circumcision (at 6 days old). Number of social, psychiatric and psychological problems resulted. Jury at trial awarded $500,000. Award reduced to $275,000 an appeal.

In a number of reported US cases male infants were circumcised by an electrosurgical knife. The device was designed to cut and cauterize but was not meant to be used on tiny penises. In four cases in Georgia, surgeons destroyed the penises. In one case, it was decided to do a transsexual procedure - turning the boy into a girl. [Refer *Patients Set on Fire as Surgeons get Careless* The Age 15 October 1993 p.9].

Williams G *Newborn Circumcision - An Enigma of Health*, delivered to The Second International Homebirth Conference 4-7 Oct 1992, Sydney, describes a case reported by Money J and Tucker P [*Sexual Signatures* Little, Brown and Company Boston Toronto 1975 pp.91-98]:

> A young couple took their normal, identical twin boys to a physician to be circumcised when the boys were seven months old. The physician in the operating theatre used an electric cauterizing needle to remove the foreskin of one twin. When the baby's foreskin didn't give on the first try, or on the second, the doctor increased the current. On the third attempt, the surge of heat from the electricity literally cooked the baby's penis. Unable to heal, the penis dried up, and in a few days sloughed off completely, like the stub of an umbilical cord. At the age of twenty-one months the 'little girl' was brought back to The John Hopkins Hospital for surgical feminization and removal of testes. Her mother reported that dolls and a doll carriage headed her Christmas list when she was five and that, quite unlike her brother, the girl was neat and dainty, experimented happily with styles for her long hair, and often tried to help in the kitchen. Finger pressure applied above the urethral opening ensured a downward urine stream. Vaginoplasty and hormone replacement were planned at puberty but the girl was not ready to accept hospitalisation.

King LR *Neonatal Circumcision in the United States in 1982* Journal of Urology Vol 128 1982 at 1135 notes that:

> The glans or even the penis itself may be amputated. Reanastomosis should be attempted using microsurgical techniques, which have been successful. ... Cautery also has burned the penis completely when applied to circumcision clamps. These complications can be terrible and usually are the result of use of a circumcision clamp by inexperienced operators. Freehand techniques are much preferred by the occasional operator ... Fortunately, new microsurgical techniques allow construction of a missing penis from revascularized and reinnervated grafts. These patients eventually can be outfitted with a penile prosthesis for erection, permitting intercourse. However, the nerve endings of the glans cannot be replaced. Obviously, boys who lose the penis in infancy should continue to be reared and reconstructed as girls.

* **Unsightly appearance**

Asymmetrical or inadequate removal of the prepuce may result in an unsightly appearance - "the frilly lizard look". This is frequently the basis for a request for re-circumcision.[122]

* **Urethral fistulas**

Bleeding may require a suture. If the suture is misplaced, it may result in a urethral fistula at the corona.

* **Haemorrhage**

Haemorrhage, which may go undetected when nappies are used, has been the cause of death.[123]

* **Incision line**

May become infected.

Hirst reports:[124]

> This is usually responsive to local treatment, but there are reports of progression on to the staphylococcal scalded syndrome, and in some cases, septicaemia occasionally leading to death of the infant.

* **Phimosis**

Phimosis can occur as a direct result of inadequate circumcision

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[122] Hirst G *Controversies Surrounding Circumcision* Patient Management September 1984 12 at 19.

[123] Ibid.

[124] Ibid.

rather than as a primary indication for the procedure. Hirst explains:[125]

> The re-approximated line between the skin and the deep preputial layer heals by scarring and where an inadequate removal of the prepuce has been performed, contracture of the scar prevents retraction of the residual prepuce and hence a phimosis. Recircumcision is then required.

* **Infections of meatus**

Hirst explains:[126]

> Meatitis and meatal stenosis may occur ... the intact foreskin protects the glans and meatus from the noxious effects of ammoniacal dermatitis [nappy rash]. In the absence of the prepuce, 'nappy rash' may affect the glans and particularly the meatus, causing meatitis. Healing produces narrowing of the orifice and resultant meatal stenosis. Meatal stenosis may cause a diminished or angulated stream, but rarely results in bladder outlet obstruction. Meatal stenosis may require a definitive meatomy.

One Australian paediatrician describes a personal series of 5 proven cases of septicaemia in a 6 year period - 3 other cases of septicemia in which the circumcision site was probably the portal entry of the bacterium, were also treated:[127]

> In the 5 proven cases the organism cultured in the blood and on the infected site matched perfectly as to anabiotic sensitivities.
>
> Two of these proven cases were gravely ill, and one child survived peripheral circulatory failure, pneumonia, pyonephrosis and 2 sites of osteomyelitis. From another babe 5 pathogens-proteus, strep. facealis, staph. aureus and 2 types of E.Coli were cultured from his circumcision site. The proteus caused the septicaemia in this later case. No deaths occurred in this series of cases, but required intensive care.

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125 Ibid.

126 Ibid. Also, Birrell RG *Circumcision* Australian Paediatric Journal Vol 6 1970 66-67 notes:

> The bared glans often bleeds where adhesions have been broken down, and is commonly left to rub against a urine-sodden 'nappie'. This predisposes to meatalulceration, and often significant stenosis when the healing is complete.

127 Id at 66.

(d) The cost

Newborn circumcision is not paid for by the National Health Service in Britain. In 1948 it was classified as cosmetic surgery and the rate of circumcision dropped off to .5%.[128]

In 1985 the Australian Federal Health Minister removed the rebate for circumcision from the Medical Benefits Schedule.[129] The rebate was returned as a result of the resulting community outcry. The Minister suggested that circumcision rates should be reduced by education and community discussion. He expressed a fear of 'back-yard' circumcisions with a greater risk of fatality, trauma and infection.[130]

The financial cost of circumcision is difficult to calculate. In 1992/93 Medicare reimbursed parents $98,781 for circumcisions performed on infants less than 6 months of age. If the procedure is performed on a newborn prior to leaving hospital after birth, there is unlikely to be a hospital bed charge. Medicare will pay 85% of the scheduled fee and there is no gap paid. Private health funds are prohibited from paying the gap in these circumstances because newborns are not considered patients under the *Health Insurance Act 1973* (Cmth) unless in a neonatal intensive care unit.

If the child is returned to hospital after birth for circumcision, there will be a bed charge. Medicare will pay 75% of the scheduled fee and private funds may pay up to the remaining 25%. For an infant under 6 months of age, the doctor's scheduled fee is $33.10 [significantly more for older children]. The Australian Medical Association recommends that doctors charge $57 for performing a circumcision on an infant under 6 months of age.

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128 Williams G *Newborn Circumcision - An Enigma of Health*, Paper delivered to The Second International Homebirth Conference 4-7 Oct 1992, Sydney.

129 This action had been advised by the National Health and Medical Research Council at its 95th Session in Adelaide, June 1983 (see Report of Session at p.130):

> The Council recommended that the Director-General of Health draw the attention of the Medical Benefits Schedule Revision Committee of the Commonwealth Department of Health to the Council's statement on the subject of neonatal circumcision made at its Ninety-fourth Session which states:
>
> > The Council having considered the opinion of the Australian College of Paediatrics and the Health Commission of N.S.W., was of the opinion that there is no medical indication for undertaking routine circumcision on newborn male infants, and that hazards of the operation at this age outweigh any possible advantages.
>
> In this context the Council requested that the Medical Benefits Schedule Revision Committee be asked to consider whether routine neonatal circumcision should be removed from the Medical Benefits Schedule.

130 Ibid. Perth *Sunday Times* July 14 1985.

If the procedure is performed on a public patient in a public hospital there will be no additional hospital fee. If the procedure is performed as a private patient in a public hospital or on a private patient in a private hospital there will be additional charges which will vary from hospital to hospital. Queensland private hospitals charge up to $173 for bed fees or theatre fees. MBF will pay up to $115 of hospital fees for members with top hospital cover.

The real cost to the community per infant (under 6 months of age) will be in the vicinity of $175 (hospital) + $57 (doctor's fee) per procedure.[131]

9. CONCLUSION

The common law operating in Queensland appears to be that if the young person is unable, through lack of maturity or other disability, to give effective consent to a proposed procedure and if the nature of the proposed treatment is invasive, irreversible and major surgery and for non-therapeutic purposes, then court approval is required before such treatment can proceed. The court will not approve the treatment unless it is necessary and in the young person's best interests.[132] The basis of this attitude is the respect which must be paid to an individual's bodily integrity.

Application can be made to the Family Court for approval of such treatment for young people. The extent of the Family Court's jurisdiction in this regard has not been fully explored.

Types of treatment which are most likely within the Family Court's jurisdiction include sterilisation, the turning off of life support, transplantation of organs for the benefit of a sibling, and the like. Others are less clear. For example - an obstetrician seeking approval by the Court for a caesarean section in circumstances where the young mother would not consent to the procedure, applications in relation to the performance of cardiac surgery on children where parental consent has been refused, and applications in relation to profoundly handicapped neonates. The Family Court has recently given its approval for a 14 year old child to undergo gender reassignment by the construction of male sexual organs.[133] At birth, the child had been

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[131] 1992/93 in Queensland 3,780 private patients under 6 months x $232 = $876,960. In 1991 77 public patients under 6 months of age were circumcised. 304 public patients between 6 months and 10 years of age were circumcised in that year. 150 patients over 10 years old were circumcised (information provided by Health Information Services Unit, Queensland Health, 26 Nov 1993).

[132] See the High Court of Australia in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992) 175 CLR 218.

[133] In *Re A* (1993) 16 Fam LR 715.

diagnosed as a female child with masculinisation of the genitalia. The child had undergone genital reconstruction to give her a feminine appearance but received inadequate hormone replacement treatment. Recurrent masculinisation of the child's physical structures had occurred with a change in mental behaviour and attitude. The child wanted to undergo the reassignment procedure but in this case the Court held that the child was not mature enough to understand the nature and consequences of the procedure. As the procedure would require invasive, irreversible and major surgery, the child's parents could not consent - and Family Court approval was required.

If any surgical procedure to be performed on a child, whether 'therapeutic' or 'non-therapeutic', is not in the particular child's best interests, it cannot proceed. Further, if the procedure is performed in an unskilled manner the person performing the procedure may be criminally as well as civilly liable for the consequences, irrespective of the validity of the consent obtained prior to the procedure.

Unless there are immediate health benefits to a particular child from circumcision, it is unlikely that the procedure itself could be considered as therapeutic.

Whether the procedure is within the best interests of any particular child will depend upon the circumstances of the particular case. For example, adherence to the religious and cultural beliefs and practices of the child's community could be seen as being within the child's best interests. This view may vary according to the likelihood of a child wanting to continue to adhere to such beliefs and practices when of an age that he can decide for himself the type of life he wishes to lead.

The circumcision procedure is invasive, irreversible and major. It involves the removal of an otherwise healthy organ part. It has serious attendant risks.

As a prophylactic procedure, circumcision of neonates does not appear to be the least restrictive alternative. For a number of the adverse health conditions which have been associated with non-circumcised penises, the least restrictive preventative measure would be education of children in genital hygiene and in responsible, safe sexual practices. Circumcision as a prophylactic procedure may be appropriate for older males who have the capacity to consent to the procedure.

On a strict interpretation of the assault provisions of the Queensland *Criminal Code*, routine circumcision of a male infant could be regarded as a criminal act. Further, consent by parents to the procedure being performed may be invalid in light of the common law's restrictions on the ability of parents to consent to the non-therapeutic treatment of children.

Although practices such as circumcision involve an infringement of the bodily integrity of the child, it is likely that the State will only intervene through criminal and child welfare laws when the harm of the infringement outweighs the benefit that the child would receive from acceptance within a cultural or religious group of which the child and the child's family are an integral part.

Although male circumcision is not now generally encouraged for medical reasons in the light of modern medical and scientific knowledge,[134] there is an argument that it should not be made unlawful because the harm to the child involved in the pain suffered, a potential disfigurement or any medical risk may be outweighed by the benefits to the child of being accepted into his cultural or religious group. Whether routine circumcision for non-religious and non-cultural reasons is in the child's best interests may be less clear. However, because of the fairly widespread community acceptance of the procedure it is unlikely, at this time, that a prohibition on routine neonatal male circumcision would be universally supported. It is also unlikely at this time that a medical practitioner acting in good faith and with due care and skill would be prosecuted for assault for performing a circumcision on a male infant.

It is less clear whether a child could sue the doctor for damages for assault under the civil law.[135] The child's ability to sue would not be dependent upon the criminality of the doctor's actions. It would, however, be dependent upon the absence of real consent. It could be argued that because the circumcision of a particular child was not in that child's best interests, the parents could not have given real consent to it taking place. It could also be argued that, without adequate information being provided to the parents prior to the procedure taking place on the nature and possible consequences of the procedure, consent by the parents was not 'real' consent.

10. POSSIBLE REFORMS:

It may be reasonable to require, either by law or by a professional *Code of Practice*, medical practitioners to inform parents of all arguments for and against circumcision before, and possibly at least a number of days before, undertaking the procedure. A statutory consent form containing information

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[134] See pp 18, 19 above.

[135] The only lawsuit which, to the Commission's knowledge, has been commenced on behalf of a male child against a doctor for performing a circumcision was begun by the mother, as guardian ad litem of Adam London, before the Superior Court of California, Marin County, then on appeal to the Court of Appeal in California. A petition to have the California Supreme Court review the rulings of the lower Courts was summarily rejected by the Supreme Court. See Morris RW *The First Circumcision Case* The Truth Seeker 1989 at p.47.

on arguments for and against circumcision, could be drafted. The form should be regularly up-dated with new information.

It might also be reasonable to require that all circumcisions be performed by medical practitioners or other experienced and skilled people in circumstances which reduce to a minimum any adverse consequences.[136]

The Commission has yet to decide what, if any, reform of the law should be recommended in relation to infant male circumcision.

[136] For example, access to appropriate resuscitation equipment; knowledge of dangers of local anaesthetics, etc.

APPENDIX 1

HEALTH INSURANCE COMMISSION STATISTICS

CIRCUMCISIONS - AUSTRALIA 1988 - 1993[1]

1. Number of Circumcisions (all ages)

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT	UK	AUST
1988/89	229	8,054	4,290	3,864	1,680	1,229	441	168	10	19,965
1989/90	208	8,267	4,167	3,981	1,681	1,209	433	210	4	20,160
1990/91	248	8,271	4,120	3,905	1,769	1,278	374	171	1	20,137
1991/92	229	8,314	3,838	3,978	1,798	1,282	386	217	-	20,042
1992/93	220	8,432	3,828	4,518	1,776	1,311	359	233	-	20,679

[1] **Note:** Figures include only those services which qualify for Medicare Benefit and for which a claim has been processed. Figures do not include services provided by hospital doctors to public patients in public hospitals, services as a result of a compensation or insurance claim, or services which qualify for a benefit under the Department of Veterans' Affairs National Treatment Account.

2. Cost to Medicare of Circumcisions (all ages)

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT	UK	AUST
	$	$	$	$	$	$	$	$	$	$
1988/89	6,857	255,854	144,927	108,721	48,805	39,144	13,091	5,928	299	623,626
1989/90	6,969	277,170	156,225	117,254	52,935	39,701	13,672	6,903	96	670,925
1990/91	8,101	292,328	163,189	119,192	57,479	45,561	12,564	6,016	51	704,479
1991/92	8,229	312,197	163,739	125,546	59,338	48,159	14,157	7,086	-	738,450
1992/93	8,951	326,022	168,855	147,373	60,583	51,999	12,980	7,380	80	784,222
TOTAL COST 1988 - 1993										**3,521,702**

3. Number of Circumcisions (less than 6 months of age)

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT	UK	AUST
1988/89	183	5,781	2,807	3,219	1,364	866	332	114	8	14,674
1989/90	155	5,816	2,533	3,323	1,343	855	324	153	4	14,506
1990/91	191	5,809	2,369	3,285	1,417	842	375	123	-	14,311
1991/92	178	5,761	2,112	3,358	1,441	849	263	174	-	14,136
1992/93	156	5,842	2,110	3,780	1,426	838	259	192	1	14,604

4. Cost of Circumcisions (less than 6 months of age)

	ACT	NSW	VIC	QLD	SA	WA	TAS	NT	UK	AUST
	$	$	$	$	$	$	$	$	$	$
1988/89	3,922	127,471	63,234	72,058	30,909	18,579	7,178	2,601	167	326,119
1989/90	3,477	135,043	59,973	77,760	32,005	19,264	7,288	3,753	96	338,639
1990/91	4,550	141,810	57,770	80,181	35,318	19,868	6,650	3,051	-	349,198
1991/92	4,598	149,622	53,202	85,182	36,808	20,863	6,702	4,398	-	361,376
1992/93	4,143	156,580	54,986	98,781	37,581	21,210	6,911	4,941	24	385,156
TOTAL COST 1988 - 1993										**1,760,488**

APPENDIX 2

NUMBER OF CIRCUMCISIONS PERFORMED QUEENSLAND PUBLIC HOSPITALS ON PUBLIC PATIENTS 1988 - 1991[1]

	Under 6 months of Age	6 months - 10 years of age	Over 10 years of Age
1988	15	250	131
1989	34	299	141
1990	46	252	161
1991[2]	77	304	150

1 Information kindly provided by Health Information Services Unit, Queensland Health.

2 Preliminary data.

APPENDIX 3[1]

CIRCUMCISION AND HIV INFECTION

1. *Studies indicating that lack of circumcision is a risk factor for HIV infection*

2. *Studies indicating little or inconclusive relationship between circumcision status and risk of HIV infection.*

1. STUDIES INDICATING THAT LACK OF CIRCUMCISION IS A RISK FACTOR FOR HIV INFECTION

* Cameron D W et al *Female to Male Transmission of Human Immunodeficiency Virus Type 1: Risk Factors for Seroconversion in Men* Lancet 2 1989 Aug 19 403-7 confirmed a causal relation between lack of circumcision, genital ulcer disease and susceptibility to HIV-1 infection in men who acquired HIV from contact with HIV infected prostitutes.

* Bongaarts J et al *The Relationship between Male Circumcision and HIV Infection in African Populations* AIDS 3 (6) June 1989 373-377 reviewed anthropological literature relating to circumcision practices for 409 African ethnic groups and HIV rates in capital cities. The findings were consistent with existing clinic-based studies indicating lower risk of HIV infection among circumcised males.

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1 Summaries from full text or abstracts from AIDSLINE Collection Search and Citations Search Results 25 November 1993 kindly provided by AIDS Medical Unit, Queensland Health.

* Moses S et al *Geographical Patterns of Male Circumcision Practices in Africa: Association with HIV Seroprevalence* Int J Epidemiol 19 (3) 1990 Sept 693-697 indicated that in locations where circumcision is practised HIV seroprevalence was considerably lower than in areas where it is not practised. This supports the hypothesis that lack of circumcision is a risk factor for HIV transmission.

* Jessamine P G et al *Human Immunodeficiency Virus, Genital Ulcers and the Male Foreskin: Synergism in HIV-1 Transmission* Scand J Infect Dis Supp 69 1990 181-186 indicated from a review of epidemiological studies in Nairobi and elsewhere in Africa that uncircumcised men had an increased risk of seroconversion which was independent of their risk of genital ulcer disease.

* Praul A et al *Sexual Behaviour, AIDS and Poverty in Sub-Saharan Africa* (editorial) Int J STD AIDS 2 (1) 1991 Jan-Feb 1-9 reviews reported data on AIDS in sub-saharan Africa and includes lack of circumcision as one of a number of causal and facilitating factors - virtually all of which are related to poverty.

* Bwayo J et al *Long Distance Truck-Drivers: Prevalence of Sexually Transmitted Diseases (STDs)* East Afr Med J 68 (6) 1991 Jane 425-9 showed lack of circumcision, past history of genital ulcer disease and urethritis were significantly associated with HIV seroconversion.

* Zekend L et al *Prevalence in Patients with Sexually Transmitted Diseases in Yaounde (Cameroon) in 1989 and 1990: Necessity of an STD Control Programme* Genitourim Med 68 (2) 1992 April 117-119 monitored HIV seroprevalence among patients attending an STD clinic. HIV seroprevalence was relatively low - possibly due to many factors such as the high level of circumcision of males and a different spectrum of STDs and the recent introduction of the virus in the country.

* Pepin et al *Association between HIV-2 Infection and Genital Ulcer Diseases Among Male Sexually Transmitted Disease Patients in the Gambia* AIDS 6 (5) 1992 May 489-493 indicated that circumcised patients with a residual foreskin were more likely to be HIV-2 infected than patients with complete circumcision.

* Miotti P G et al *The Situation in Africa* Baillieres Clin Obstet Gynaecol 6 (1) 1992 March 165-186 suggest that lack of circumcision, traditional healing practices and oral contraceptives may affect the risk of viral

transmission, but may not be major or modifiable risk factors.

* *Diallo M O et al HIV-1 and HIV-2 Infections in Men Attending Sexually Transmitted Disease Clinics in Abidjan Cete d'Ivoire* AIDS 6 (6) 1992 June 581-585 indicate that risk factors associated with HIV-1 as well as with HIV-2 infections after multivariate analysis were a history of sex with prostitutes, lack of circumcision, being an unskilled worker and a history of prior genital ulcers.

* Whittington W L et al *HIV-1 in Patients with Genital Lesions attending a North American STD Clinic: Assessment of Risk Factors* Int Conf AIDS 5 1989 June 409. A study of 177 men with genital lesions found that HIV-1 infection was associated with homosexual/bisexual preference and lack of circumcision. Among all men HIV infection associations were found between HIV infection and lack of circumcision and between syphilis and lack of circumcision. The latter may indirectly increase risk for HIV-1 acquisition by increasing the likelihood of acquiring ulcerative genital lesion diseases such as herpes and syphilis.

* Moses S et al *Male Circumcision in Eastern and Southern Africa: Association with HIV Seroprevalence* Int Conf AIDS 4 1989 June 4-9 search of anthropological data base to ascertain practice of male circumcision among major ethnic groups in Eastern and Southern Africa and review of population - based HIV seroprevalence data. Preliminary findings suggest geographical patterns of HIV seroprevalence are consistent with the hypothesis that uncircumcised men are at higher risk of acquiring HIV infection. Further studies examining the relationship between male circumcision and the risk of acquiring HIV infection were recommended.

* Tyndall M et al *The Effect of HIV Infection on the Clinical Features and Response to Treatment of Genital Ulcer Disease due to Chancroid* Int Conf AIDS 7 (1) 1991 June 16-21 256 in a study of men presenting to a Nairobi STD clinic with chancroid it was observed that uncircumcised men were more likely to be HIV positive although when circumcision was controlled for, HIV positivity remained a significant factor in the group which failed to respond to treatment for chancroid.

* Hellman N S et al *Risk Factors for HIV infection among Ugandan Couples* Int Conf AIDS 7 (1) 1991 June 16-21 318. A lack of circumcision and a history of genital sores were significantly associated with HIV seropositivity in the male sexual partners of HIV

positive females.

* Ankrah E M et al *Sexual Behaviours in Eastern Uganda* Int Conf AIDS 7 (1) 1991 June 16-21 411 suggested that wider promotion of condom use and circumcision is needed in the two regions studied as risk reduction measures for HIV transmission.

* McLaughlin M et al *Risks Associated with Acquiring Chancroid Genital Ulcerative Disease and HIV Infection: A Case Control Study* Int Cont AIDS 5 1989 June 4-9. In a study of men presenting with chancroid and gonorrhoea to a New York City STD clinic - it was found that chancroid was strongly associated with a positive result for syphilis, an exchange of drugs or money, and a lack of circumcision.

* Job B et al *HIV Infection in Long Distance Truck Drivers in Kenya: Seroprevalence, Seroincidence and Risk Factors* Int Cont AIDS 8 (1) 1992 July 19-24. It was found that lack of circumcision and past history of STD were risk factors for HIV positivity.

* Kreiss et al *The Association between Circumcision Status and HIV infection among Homosexual* Men Int Conf AIDS 8 (2) 1992 July 19-24 it was found that uncircumcised homosexual men in Seattle had two-fold increased risk of HIV infection.

> On a global basis, approximately 80%[2] of the male population is uncircumcised. If the relative risk that we observed in Seattle were also present in other populations, the population attributable risk of uncircumcised status for HIV in homosexual men would be 40%, i.e., 40% of homosexual transmission of HIV could be potentially preventable with universal circumcision. The role of circumcision as an intervention strategy to reduce both homosexual and heterosexual transmission of HIV warrants consideration.

* Fischl M et al *Seroprevalence and Risk Factors associated with the Heterosexual Transmission of HIV in a Sexually Active Non-drug Abusing population* Int Cont AIDS 8 (2) 1992 July 19-24. It was found that multiple sexually transmitted diseases, positive serology for syphilis, a history of syphilis, a sexual partner with genital herpes or blisters, sexual contact with a person with AIDS or HIV infection and lack of male circumcision were significantly associated with HIV

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[2] **Note:** Other estimates of the uncircumcised world population vary from 97% to 85%. See p.11 above.

infection.

* Hellman et al *Modifiers of the Protective effect of Circumcision* Int Cont AIDS 8 (2) 1992 July 19-24. In a study of patients visiting an STD clinic in Uganda it was found that circumcised patients were less likely to be HIV infected especially if Muslim. This indicates that the timing and reason for circumcision may modify its protection effect. The protective effect of circumcision was independent of a reported history of genital sores in contrast to previous reports. The authors have initiated investigations into age at circumcision, reason for circumcision and HIV infection.

* Tyndall M et al *HIV-1 prevalence and Risk of Seroconversion among Uncircumcised Men in Kenya* Int Conf AIDS 8 (2) 1992 July 19-24. In men with acute genital ulcer disease presenting at an STD clinic in Nairobi, HIV-1 prevalence and seroconversion rates were much higher in the uncircumcised. The authors concluded that male circumcision may be an important intervention strategy to control the spread of AIDS in some populations.

* Wagner H et al *Muslims at lower Risk of HIV-1 Infection in Rural S W Uganda: Circumcision or Other life style Factors?* Int Conf AIDS 8 (2) 1992 July 19-24. The number of lifetime sexual partners, religion and marital status all appeared to be associated with HIV-1 infection in this population. "It was not possible to distinguish between effect of circumcision and being Muslim, but since adjustment for other behaviour variables did not alter the effect of religion, circumcision may have a protective effect, both to the men and indirectly to their partners."

2. STUDIES INDICATING LITTLE OR INCONCLUSIVE RELATIONSHIP BETWEEN CIRCUMCISION STATUS AND RISK OF HIV INFECTION.

* Barongo L R et al *The Epidemiology of HIV-1 Infection in Urban Areas, Roadside Settlements and Rural Villages in Mwanza Region, Tanzania* AIDS 6 (12) Dec. 1992 1521-8 showed no evidence that lack of circumcision is a risk factor in this population.

* Henry K *Documented Male-to-Female Transmission of HIV-1 after Minimal Vaginal Exposure in the Absence of Other Co-factors for Infection* Minn Med 74 (10) 1991 Oct 32-34 reports a United States case study of transmission of HIV from HIV infected circumcised male

to female in absence of all other possible major risk factors such as lack of circumcision in male partners. The only risk factor for enhanced HIV transmission was the woman's use of oral contraceptives.

* Moss G B et al *HIV Transmission in Stable Sexual Partnerships in Kenya* Int Conf AIDS 5 1989 June 4-9 113 found that HIV seropositivity was not significantly associated with past genital ulcers, injections, blood transfusions, scarification, circumcision, oral contraceptive use, or number of sex partners.

* Surick I et al *HIV Infection and Circumcision Status* Int Conf AIDS 5 June 4-9 analyses two studies done in New York City's Sexually Transmitted Disease (STD) Clinics. No independent relationship was found between circumcision status and HIV infection.

* Kane F et al *Penetration of HIV-1 in a Rural Area of Senegal* Int Conf AIDS 6 (2) 1990 June 20-23 in a study of HIV infection among Senegalese expatriates travelling to Central Africa and transmission to their families living in rural areas - found that cultural practices such as circumcision, tattooing, scarification and clitoridectomy were not associated with HIV infection. Rather, for men seroprevalence was associated with sexual risk factors such as number of sexual partners and previous STDs.

* Stigum H et al *The effect of Heterogeneous Transmission on the Potential for spread of HIV in the Heterosexual Population, a Model Study* [Norway] Int Conf AIDS 7 (2) 1991 June 16-21 concluded that heterogeneous HIV transmission caused by a cofactor that is non-transmissible, leads to a lower potential for the spread of HIV. Examples of such cofactors are the lack of circumcision or genetic traits. The analysis applies to both heterogeneous transmissibility and susceptibility.

* Cruz E et al *Warts and HIV Infection among Homosexual Men in Mexico City* Int Conf AIDS 7 (2) 1991 June 16-21 it was found in a study of homosexual and bisexual men in Mexico City that there was a significant association between HIV infection and warts - a situation which persisted in spite of taking into account education, anal intercourse, circumcision, number of sexual partners and condoms. Thus, in men whose sexual practices are in the high risk category, papilomavirus infection shows a definite association with HIV.

* Guilmaraes M et al *Heterosexual Transmission of HIV: A Multicenter Study in Rio de Janeiro, Brazil* Int Conf AIDS 7 (2) 1991 no association was found between HIV infection and age, education, income, male genital ulcer or circumcision. Only no condom use and number of sexual contacts were independently associated with HIV infection.

* Moss G et al *Despite Safer Sex Practices After Counselling, Seroconversion is High among HIV Serodiscordant Couples in Nairobi, Kenya* Int Conf AIDS 7 (2) 1991 Jane 16-21 it was found that seroconversion was not significantly associated with sexual activity, condom usage, sexually transmitted diseases, lack of circumcision in men, cervical ectopy in women, pregnancy, presence of HIV associated symptoms.

* Seidlin M et al *Risk Factors for HIV transmission in steady Heterosexual Couples* Int Conf AIDS 5 1989 June 4-9. The serostatus of partners of HIV infected people was not related to the latters' risk group or circumcision status. Prevalence of HIV seropositivity in the partner was related most strongly to crack use and anal intercourse.

* Senkoro K et al *Syphilis and STD Syndromes in Northern Tanzania: Prevalences, Risk Factors and Association with the Seroprevalence of HIV* Int Conf AIDS 8 (2) 1992 July 19-24. A negative association was found between syphilis and male circumcision. HIV infection was more frequent in patients with syphilis than in those without.

* Salehe O et al *HIV Infection Among STD Patients and Correlated Conditions in Mbeya, Tanzania* Int Conf AIDS 8 (2) 1992 July 19-24. In a study of patients attending STD clinics no significant difference was found in HIV infection among circumcised and non-circumcised men.

* Seidlin Me et al *Male to Female and Female to Male Transmission of HIV in steady Heterosexual Couples* Int Conf AIDS 8 (3) 1992 July 19-24. Anal intercourse, heavy alcohol use, bleeding as a result of intercourse were strongly associated with seropositivity. Gender, race, circumcision, sex during menses, other drug use and STDs were not significantly associated with serostatus.

* Sy A et al *Impact of Cultural Aspects on AIDS Prevention in Africa* Int Conf AIDS 8 (2) 1992 July 19-24. The authors note that traditional practices such as male and female circumcision, etc are still operated with soiled materials and contribute to the spread of HIV.

* Mboya R O *Traditional Behaviours and AIDS - Analysis and Change Through Community Participation* Int Conf AIDS 8 (2) 1992 July 19-24. The author suggests that traditional surgical practices in Kenya such as scarification, uvulectomy, deliveries, circumcision of boys and girls, craniotomy using contaminated equipment help in the spread of AIDS.