

January 2007

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### Recommended Citation

David Solomon, *Informed Consent for Routine Infant Circumcision: A Proposal*, 52 N.Y.L. SCH. L. REV. 215 (2007-2008).

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DAVID SOLOMON

## Informed Consent for Routine Infant Circumcision: A Proposal

ABOUT THE AUTHOR: David Solomon is a pseudonym. This paper is adapted from a presentation given by the author at *LGBTQ Law 2006: Legal Issues Affecting Ourselves & Our Families*—a conference hosted by the Lesbian, Gay, Bisexual and Transgender Law Association Foundation of Greater New York. The author wishes to thank Dr. Ryan McAllister, Georgetown University Department of Biophysics, for his assistance on the scientific portions of this paper.

## I. INTRODUCTION

In early April 2007, the *New York Times* reported that the Health Department of the City of New York was discussing whether to promote, and even pay for, circumcisions for Hispanic gay men as a tool in fighting HIV/AIDS in New York.<sup>1</sup> The article was picked up by numerous news agencies across the globe, including several gay news agencies.<sup>2</sup> This proposal came on the heels of a call for massive voluntary and involuntary circumcision of males in Africa as a weapon in the fight against HIV/AIDS.<sup>3</sup> As a gay man myself, I have to admit at the outset that I was a bit perplexed by the almost incessant barrage of media coverage of circumcision as a tool in the fight against HIV. After all, the United States has practiced widespread circumcision for much of the twentieth century, and has a high rate of HIV, whereas European Christians do not generally practice circumcision, yet Europe has a much lower rate of HIV than the United States. Indeed, despite the routine circumcision of American males in the 1960s, 1970s, and 1980s, American gay males were decimated by HIV during the epidemic's peak.

These facts should give us pause when advocating for circumcision as a preventative measure against the transmission of HIV. In addition to the medical concerns, involuntary circumcision raises questions of individual sexual autonomy. Infant circumcision imposes choices on people who are not able to choose for themselves. As such, those who oppose circumcision based on an "individual autonomy" rationale share common ground with the gay rights movement, which has historically argued for the rights of LGBT individuals at least partly from an "individual autonomy" perspective.<sup>4</sup> Because of the centrality of the HIV issue to

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1. Donald McNeil, Jr., *New York City Plans to Promote Circumcision to Reduce Spread of AIDS*, N.Y. TIMES, Apr. 5, 2007, at B1.
  2. See *New York City Considers Circumcision for Men at High Risk of AIDS*, MICHIGAN PRIDE SOURCE, <http://www.pridesource.com/article.shtml?article=24497> (last visited Oct. 8, 2007); see also *NYC Eyes Circumcision Push to Fight AIDS*, USA TODAY.COM, Apr. 7, 2007, [http://www.usatoday.com/news/health/2007-04-07-nyc-circumcision\\_N.htm](http://www.usatoday.com/news/health/2007-04-07-nyc-circumcision_N.htm); Theresa Maher, *NYC Plans to Recommend Circumcision in Anti-AIDS Crusade*, NEWSLOCALE INDIA, Apr. 6, 2007, [http://www.newslocale.org/health/hnews/nyc\\_plans\\_to\\_recommend\\_circumcision\\_in\\_anti-aids\\_crusade\\_20070407256.html](http://www.newslocale.org/health/hnews/nyc_plans_to_recommend_circumcision_in_anti-aids_crusade_20070407256.html).
  3. See *Rwanda to Urge Male Circumcision in AIDS Fight*, REUTERS, Sept. 28, 2007, <http://www.reuters.com/article/americasCrisis/idUSL28773821>; *Significant Growth in Access to HIV Treatment in 2006*, WORLD HEALTH ORGANIZATION, Apr. 17, 2007, <http://www.who.int/mediacentre/news/releases/2007/pr16/en/>. There have also been similar calls to reintroduce mass circumcision in Canada and Australia, and to continue the practice in the United States. See, e.g., *Parents Should Consider Circumcision: AIDS Activist*, CBC NEWS CANADA, Apr. 11, 2007, <http://www.cbc.ca/health/story/2007/04/11/circumcision.html>; see also Clara Pirani, *Circumcision Bans Leave Parents in the Dark*, THE AUSTRALIAN, Aug. 24, 2007, <http://www.theaustralian.news.com.au/story/0,25197,22303973-23289,00.html>.
  4. At the outset, I would like to expose my own biases regarding the circumcision issue. I am an Israeli-born Jewish male who has spent his entire life in the United States. As such, my "support" for circumcision was sealed both from a religious perspective and from living in the United States, where circumcision is the norm for males of my age. After having spent quite some time living in Europe, I now know that the circumcised penis is the exception, not the rule, and that "intact" (i.e., uncircumcised) males, who account for approximately 85 percent of the world's male population, can and do lead normal, healthy lives. Approximately four years ago, I became interested in the legal issues surrounding both hospital circumcision

gay men and the history of sexual repression that our community has suffered, we bring a unique and important voice to the circumcision question.

The legal issues raised by involuntary circumcision are manifold, but at the law conference,<sup>5</sup> I focused on three main categories: (1) informed consent, (2) the validity of parental proxy consent, and (3) constitutional issues. This paper focuses only on informed consent, and I will attempt to determine if doctors are obtaining informed consent for the one million non-religious circumcisions performed every year in the United States.<sup>6</sup> My goal in this paper is to analyze whether or not doctors are in fact obtaining informed consent for those circumcisions. In this paper, I will synthesize the case law on the topic, and propose the kind of information I feel must be disclosed for consent to non-religious circumcision to be truly “informed.” I do not delve into the fundamental validity of pa-

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and its religious counterpart. I have chosen to use an alias, because I understand that circumcision can be a very emotional subject for Jews and non-Jews alike. My readers should note that according to Orthodox Judaism, the commandment of circumcision is of equal weight to the remaining 612 commandments. See Brit Yosef Yitzchak, *What is a Brit?*, <http://www.brityy.org/Content.asp?dept=1003&article=356&path=1003> (last visited Sept. 4, 2007).

5. David Solomon & Ryan McAllister, Address at the New York Law School Law Conference: LGBTQ Law 2006: Legal Issues Affecting Ourselves & Our Families (Nov. 4, 2006) [hereinafter LGBTQ Law Conference].
6. The presentation at the LGBTQ Law Conference introduced the attendees to the scientific questions regarding circumcision, and then followed with a discussion of several legal issues raised by this procedure. Dr. Ryan McAllister, of the Georgetown University Department of Biophysics, began by giving a scientific overview of the anatomy and functions of the male foreskin. He then gave a brief history of medical circumcision and outlined the main arguments currently made in favor of routine infant circumcision. He then showed flaws in those arguments and pointed out the position statements of major medical associations that do not recommend the procedure. He then discussed the recent HIV-circumcision controversy. He pointed out how those studies that showed a protective effect to the procedure were given much press time, while many more studies coming to the opposite conclusion were not mentioned in the mainstream media. Dr. McAllister pointed out several concerns with the very idea of using genital cutting to combat HIV, such as the failure of circumcision to prevent HIV in the United States, the fact that it would not protect receptive partners, and the risk of decreased condom use caused both by loss of sensation and increased belief in immunity. Dr. McAllister ended his portion of the presentation by discussing several physical complications and deformities that could result from botched circumcisions.

Although not the focus of this paper, I will now briefly summarize the main points of the other legal areas I discussed during the legal portion of the presentation. In the proxy consent portion, I began by stating the importance of allowing third parties to make medical decisions—namely to ensure medical care for incapacitated and underage patients. I also pointed out that questioning the validity of parental consent for circumcision was at best a theoretical question, since our legal heritage places a great value on parental autonomy in regards to child-rearing. See, e.g., *Meyer v. Nebraska*, 262 U.S. 390 (1923). I stated that, although a very cloudy area of the law, it seemed as though a “best interest of the child” approach was the standard used when questions of parental proxy consent arose. See, e.g., *Little v. Little*, 576 S.W.2d 493 (Tex. Ct. App. 1979). I also argued that the HIV issue could very well prove challenging to the genital integrity movement if it sought to limit parental wishes. This is because as studies exist on both sides of the HIV-circumcision debate, a parent could claim circumcision was at least arguably in her child’s best interest.

In addition, I addressed some constitutional law issues, admittedly a very broad topic. This portion of the presentation touched upon due process and equal protection issues, standing, and the role of asylum law in analyzing the male circumcision issue.

rental consent to non-necessary medical procedures and, for purposes of this proposal, I assume that parental consent to infant circumcision is valid. This paper does not discuss religious circumcision.

I begin, in Part II, by explaining what the foreskin is and follow with a brief description of the circumcision procedure. In Part III, I briefly outline the arguments made for and against circumcision by those in the medical (and general) community, including a short discussion of the positions of various medical associations. In Part IV, I describe the different practices hospitals have historically used and are currently using to obtain consent for infant circumcision. In Part V, I outline the case law on informed consent. In Part VI, I outline my proposal for informed consent for circumcision by listing the information that, based on my interpretation of the case law, I believe must be given for informed consent to be obtained for infant circumcision. I then revisit past and current practices in Part VII, giving suggestions for improvement and discussing whether such practices square with my proposal. In Part VIII, I discuss how informed consent serves the needs of doctors, parents, and children, and in Part IX, I conclude by discussing what the LGBT community can bring to this discussion.

## II. THE FORESKIN AND THE CIRCUMCISION PROCEDURE

Circumcision, as performed in U.S. hospitals, is the removal of the penile foreskin. The foreskin is a sheath of skin that covers the glans (often called the “head”) of the penis.<sup>7</sup>

One of the foreskin’s functions is to protect the penis and the entrance to the urethra (the meatus) by keeping bacteria and dirt from entering the urethra through the meatus.<sup>8</sup> According to a leading commentator in this area, Dr. Paul M. Fleiss, the glans of the penis is a semi-internal organ, only exposed when the foreskin naturally retracts during erection.<sup>9</sup> Dr. Fleiss also estimates that the foreskin contains anywhere from ten thousand to twenty thousand highly specialized and sensitive nerve endings.<sup>10</sup>

Circumcision opponents contend that the foreskin constitutes 30 to 50 percent of the mobile skin system of the intact penis.<sup>11</sup> According to opponents of the

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7. C.J. Cold & J.R. Taylor, *The Prepuce*, 83 BRIT. J. UROLOGY 34 (1999).

8. *Id.*

9. PAUL M. FLEISS, WHAT YOUR DOCTOR MAY NOT TELL YOU ABOUT CIRCUMCISION 2 (2002). It should be noted that the foreskin of infants and young children does not retract. Dr. Fleiss argues that the infant’s exposure to feces in the diaper makes the protective function of the foreskin even more important, and that the non-retraction component aids in this function. *Id.* at 9.

10. *Id.* at 2–3.

11. Recent media articles about circumcision inaccurately call it the removal of the “tip” of the penis. This is an erroneous assertion. *See generally* John A. Erickson, *The Three Zones of Penile Foreskin*, [www.foreskin.org](http://www.foreskin.org) (last visited Oct. 8, 2007) (showing several graphic images of the penile foreskin).

procedure, the intact penis has a natural “gliding action” as the foreskin glides back and forth over the glans. As another commentator, Gary Harryman, points out, “this non-abrasive gliding of the penis in and out of itself facilitates smooth, comfortable, and pleasurable intercourse for both partners.”<sup>12</sup>

Most circumcisions also remove the frenulum, the V-shaped “weblike tethering structure on the underside of the glans.”<sup>13</sup> The frenulum is the point of attachment of the foreskin to the penis.<sup>14</sup> According to Dr. Fleiss, both the lower and upper lips of the mouth have a frenulum-like structure that keeps them in place, and the frenulum serves a similar purpose for the foreskin.<sup>15</sup>

Circumcision opponents believe that the foreskin is essential for keeping the penis moist. Dr. Fleiss contends that the foreskin is “analogous to the eyelid . . . [and] protects and preserves the sensitivity of the glans by maintaining optimal levels of moisture.”<sup>16</sup> Circumcision opponents further argue that the foreskin is essential for the creation of an adult male’s natural lubricant. A man’s natural sebum is produced in the urethra and the foreskin shelters and distributes this secreted sebum. When a male is circumcised, this natural fluid quickly evaporates once it reaches the outside of the urethra, resulting in drier intercourse for both partners.<sup>17</sup>

The circumcision procedure is performed by placing the newborn boy on his back on a board called a circumstraint, which prevents the child from moving. Since the foreskin is attached to the glans during infancy by a substance called the synechia, the first step of a circumcision is the separation of the foreskin from the glans. This is done by inserting a hemostat into the non-retracted foreskin, and then turning this probe-like device around the circumference of the glans, separating the glans and the foreskin. The physician then inserts a scissor-like clamp into the foreskin, above the now-separated glans, and clamps it shut, creating a straight line down the penis. This is the incision line. The physician then makes a cut along this line and peels the layer of skin off the glans.<sup>18</sup> The procedure is painful,<sup>19</sup> and due to the risk of infant overdose, many circumcisions in the United States are performed with either minimal or no anesthesia. While there seems to be a perception among the general population that circumcision is quick

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12. Gary Harryman, *What is Lost to Circumcision*, CIRCUMCISION INFORMATION AND RESOURCE PAGES, June 3, 1999, <http://www.cirp.org/pages/parents/lostlist.html>.

13. *Id.*

14. FLEISS, *supra* note 9, at 8.

15. *Id.*

16. *Id.* at 27.

17. *Id.*

18. See *generally id.* at 34–42 (providing a more detailed description of the circumcision procedure and presenting the different methods used to circumcise infants).

19. See JOHN S. WIENER, CIRCUMCISION: IS IT RIGHT FOR MY SON? (Duke Univ. Med. Center 1998).

and painless, this is not the case.<sup>20</sup> A Canadian organization recently made a video of a circumcision, and I must say, watching it was extremely troubling for me. The child screamed during the entire twelve-minute procedure.<sup>21</sup>

In some hospitals, amputated foreskins are transferred to burn units to make skin bandages for burn victims. According to Dr. Fleiss, foreskins are also sold to pharmaceutical and cosmetic companies (for a profit) for a wide range of uses, including the testing of cosmetics,<sup>22</sup> the creation of artificial skin, and the manufacture of the widely used cancer drug Interferon.<sup>23</sup>

### III. CIRCUMCISION: THE PROS AND CONS

Every medical procedure has its supporters and opponents. Circumcision is no exception. In this section, I will attempt to summarize the main arguments on both sides of this debate.

#### A. *The Case for Circumcision*

Proponents of circumcision claim that the prophylactic benefits of the procedure lie in four major areas: cleanliness, reduced incidences of urinary tract infection (“UTI”), sexually transmitted diseases, and cancer.<sup>24</sup>

Circumcision supporters argue that dirt can get lodged inside the foreskin, making the maintenance of good hygiene more difficult.<sup>25</sup> Supporters, such as Thomas E. Wiswell, also cite evidence showing that infants who are not circumcised have a higher rate of UTIs during infancy, and that adults are more likely to have penile cancer and certain (but not all) sexually transmitted diseases later in life.<sup>26</sup> Recently, well-funded studies performed in Africa showed a significant prophylactic effect of male circumcision—in terms of prevention of female-to-

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20. Deborah Klinger, *Snip, Snip, All Done?*, INDEPENDENT, Dec. 17, 1999.

21. The circumcision video can be downloaded online at [www.intact.ca/video.html](http://www.intact.ca/video.html). A portion of this video was shown at the LGBTQ Law Conference presentation. One woman was so disturbed by it that she actually left the room. It should be noted that the length of the procedure varies depending on the physician and the method used, and that the average time frame for the actual circumcision performed in a hospital seems to be twelve to fifteen minutes.

22. Cosmetic and/or pharmaceutical companies that are known to use infant foreskins are Helene Curtis, LifeCell Corp., and Proctor & Gamble. FLEISS, *supra* note 9, at 141.

23. *Id.*

24. Melanie Howard, *Should We Circumcise Our Son?*, BABYTALK, Mar. 2003, at 58.

25. *See id.* at 62.

26. *Id.* at 58–60. Regarding HIV, supporters of circumcision hypothesize that the inner foreskin of an intact penis, being a highly erogenous mucous membrane, is more susceptible to the entrance of HIV than a circumcised penile shaft, which not having the covering of the foreskin, would be drier. *See* MediCirc.org, [http://www.medicirc.org/medicirc\\_topics\\_adults.html](http://www.medicirc.org/medicirc_topics_adults.html) (last visited Oct. 28, 2007).

male transmission of HIV.<sup>27</sup> As noted above, these studies have received quite a bit of positive treatment in the mainstream media.<sup>28</sup>

*B. The Case Against Circumcision*

Circumcision opponents respond to the claims of circumcision advocates in two ways: (1) by refuting their scientific findings regarding what the latter see as “benefits,” and (2) by affirmatively declaring the benefits of having an “intact” penis.

Regarding the scientific evidence supposedly favoring circumcision, the responses of circumcision opponents are three-fold: (1) the studies cited by proponents of the procedure are statistically flawed;<sup>29</sup> (2) the maladies that circumcision supposedly controls are extremely rare (penile cancer), very preventable (UTIs), and if contracted, easily treatable by conservative means (UTIs can be treated with antibiotics, for example); and (3) circumcision proponents neglect to do a cost-benefit analysis for the procedure.

Even if we assume that circumcision prevents penile cancer, it is difficult to justify performing more than one million circumcisions (and the loss of penile function that results) to prevent just one elderly man from getting penile cancer.<sup>30</sup> Regarding the HIV issues, circumcision opponents argue that there are many studies that show the opposite results, and that condom usage is a preferable and non-invasive way to prevent HIV.<sup>31</sup> Circumcision opponents also point to the fact that despite its widespread practice of circumcision, the United States has the highest rate of HIV in the industrialized West.<sup>32</sup>

Regarding the affirmative benefits of having a foreskin, opponents of the procedure argue that the foreskin has many important protective and sensory

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27. B. Auvert et al., *Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial*, 2 PLOS MEDICINE 298 (2005).
  28. The *New York Times* alone published five articles regarding circumcision and HIV in the two-week period from March 28 to April 14, 2007. If readers are interested in visiting the numerous pro-circumcision sites online, the most visited are [www.circumcisioninfo.com](http://www.circumcisioninfo.com), and [www.medicirc.org](http://www.medicirc.org). The latter is especially interesting in that it is run by Edgar J. Schoen, who previously chaired the American Academy of Pediatrics Taskforce on Circumcision.
  29. Mark Jenkins, *Separated at Birth*, MEN'S HEALTH, July/Aug. 1998, at 130, 133. Specifically, Martin Altschul, has argued that many of the infants used in the UTI studies had “congenital deformities” which may have been the real cause of their UTIs. *Id.* The statistical methodologies of the recent HIV studies have received a number of critiques, which I will not discuss at length here, as this would require an entire paper in its own right.
  30. FLEISS, *supra* note 9, at 153; Van Howe et al., *Involuntary Circumcision: The Legal Issues*, 83 BRIT. J. UROLOGY 63, 66 (1999).
  31. See Van Howe, *Does Circumcision Influence Sexually Transmitted Diseases? A Literature Review*, 83 BRIT. J. UROLOGY 52, 59 (1999).
  32. Van Howe, *Circumcision and HIV-Infection: Meta-Analysis and Review of the Medical Literature*, INT'L J. STD & AIDS 8, 8–16 (1999).

functions.<sup>33</sup> They argue that the loss of the “gliding action” caused by the removal of the foreskin, in addition to the constant exposure of the glans, desensitizes the penis. They also argue that removing the foreskin robs the male of the important protective coverage that the foreskin provides.<sup>34</sup>

### C. *The Positions of Medical Associations*

It is interesting to note that routine infant circumcision is not recommended by the American Medical Association (“AMA”) or the American Academy of Pediatrics (“AAP”), nor is it endorsed by any national medical association in the world. Although common in the United States, circumcision has been virtually abandoned in most English-speaking countries (the United Kingdom, Australia, and Canada) where it was once practiced. Circumcision has never been widely practiced in Continental Europe, non-Muslim Asia, or Latin America.

As Dr. Wiener of Duke University Urology points out, “[t]he United States is the only nation in which circumcision is routinely performed for non-religious reasons . . . .”<sup>35</sup> It is estimated that approximately 80 percent of the men in the world are intact.<sup>36</sup>

## IV. WHAT ARE PARENTS CURRENTLY TOLD?

The main question in this paper is whether the information doctors give to parents regarding circumcision meets the standard for informed consent. To answer this question, I will compare the information given to parents by four child-birthing centers and I will give anecdotal evidence of past practices. The goal of this paper is to determine the amount of information that would meet the informed consent standard. Because the question is a normative one, the number of birthing centers analyzed is not important, nor does the use of anecdotal evidence take away from the discussion.

Regrettably, up until recently, parents in the United States were given very little information (if any) regarding circumcision. According to one recent study conducted in 2001, 46 percent of parents said that they were given no informa-

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33. See *supra* Part II; see also Morris Sorrells et al., *Fine Touch Pressure Thresholds in the Adult Penis*, 99 BRIT. J. UROLOGY 864, 864–69 (2007).

34. It must also be noted that many opponents of circumcision make arguments against the practice based on human rights and individual choice. Many find it unacceptable that a parent can alter a child’s genitals for non-medical reasons, a decision with which the child must live for the rest of his life. Although the human rights aspects of the debate are outside the scope of this paper, the reader may wish to visit the following websites for more information on this topic: [www.nocirc.org](http://www.nocirc.org) (National Organization of Circumcision Information Resource Centers) or [www.circumcision.org](http://www.circumcision.org) (Circumcision Resource Center).

35. WIENER, *supra* note 19.

36. See Edward Wallerstein, *Circumcision: the Uniquely American Medical Enigma* 12 UROLOGY CLINICS N. AM. 123 (1985), available at <http://www.cirp.org/library/general/wallerstein/> (last visited Oct. 28, 2007).

tion about circumcision.<sup>37</sup> Hence, the parents in this group were told nothing about penile anatomy, medical/scientific arguments for and against circumcision, or details about the procedure itself. In addition, I personally have spoken with several individuals who have told me that not only were they not given any information regarding circumcision, but that they were not even asked for their consent.<sup>38</sup>

Some U.S. clinics actively encourage parents to choose circumcision. One registered nurse with whom I spoke told me that a clinic for which he worked instructed the entire nursing staff to tell parents that the clinic recommended circumcision, that it was a quick and painless procedure, and that a circumcised penis was cleaner.<sup>39</sup> One mother told a children's advocate that she perceived that the hospital where she gave birth was being overly aggressive about trying to covertly talk her into circumcising her son. She stated that she expressed her wishes to the hospital that her son not be circumcised. She stated, "it seemed every tech[nician], nurse, and doctor that came in to check [my son's] vital signs asked me if he had been [circumcised] yet."<sup>40</sup>

Several hospitals have instituted what is commonly referred to as "circumcision refusal forms." Advocated by Thomas Wiswell, these refusal forms are arguably problematic, for their existence seems to assume that circumcision is the default, and that the hospital has the right to circumcise a child if the parents do not refuse the surgery. According to the Circumcision Information Resource Pages, "no other hospital procedure or surgery requires a refusal form."<sup>41</sup>

#### A. Duke University Health System (Durham, NC)

The Duke University Health System's small booklet, entitled *Circumcision: Is it right for my son?* states that its purpose is "to help you make an informed decision."<sup>42</sup> It describes circumcision as follows:

Circumcision is the removal of the foreskin from the penis so that the head of the penis is fully exposed. At birth, the foreskin is completely attached to the head of the penis. In circumcision, these skin attach-

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37. R. Adler et al., *Circumcision: We Have Heard From the Experts, Now Let's Hear From the Parents*, 107 PEDIATRICS 20 (2001).

38. Interview with Eric Krueger (Oct. 18, 2003) (explaining that his mother was not asked whether she wanted him circumcised); Interview with Anne Louise Rutz (Jan. 17, 2004) (explaining that she was never asked whether she wanted her son circumcised, but that the nurse informed her that "oh yes, and we went ahead and circumcised your son").

39. Interview with nurse who would like to remain anonymous, in Durham, N.C. (Sept. 20, 2003).

40. Interview conducted by Amber Craig, Director of the N.C. Chapter of the Nat'l Org. of Circumcision Info. Res. Centers., in Chapel Hill, N.C. (Feb. 22, 2003).

41. George Hill, *Protection of Infant Boys from Wrongful Circumcision in American Hospitals*, CIRCUMCISION INFORMATION AND RESOURCE PAGE, Mar. 16, 2002, available at <http://www.cirp.org/pages/parents/protection/>.

42. WIENER, *supra* note 19.

ments are broken so that the entire head can be seen. The sleeve of foreskin covering the head is then removed. . . . A typical newborn circumcision . . . takes approximately 10 to 15 minutes.<sup>43</sup>

The booklet states that there are “medical benefits” to circumcision, namely the reduction of the risk of UTIs and penile cancer.<sup>44</sup> It also mentions that both of these conditions are rare and that proper hygiene “likely prevents penile cancer as much as circumcision does.”<sup>45</sup> It does not give a similar non-amputation prevention tip for UTIs. The booklet does mention that the United States is the only country in which a majority of males are circumcised at birth (stating that the current rate is between 60 and 80 percent), and that circumcision is becoming much less popular.<sup>46</sup>

Under the heading *What are the potential risks of circumcision?*, the booklet lists bleeding, risks of infection, injury, and the need for cosmetic revision of the circumcision, and then emphatically states, “[h]owever, in almost all circumcisions, there is no harm to the penis.”<sup>47</sup> The booklet does not mention any of the anatomical details of the foreskin or its function, or how circumcision changes the function of the penis. The booklet does mention the change in appearance of the penis.

The next heading, titled *What are the consequences of not circumcising my son?*, states that some males will need to be circumcised later in life due to foreskin infections or penile injury.<sup>48</sup> It also states that some intact males resent not being circumcised at birth and that, of course, some circumcised males resent having been circumcised.<sup>49</sup> There is no section titled, *What are the consequences of circumcising my son?*

Interestingly, the first page of the booklet does include an illustration of an intact penis, where the foreskin is of a lighter shade than the rest of the penis. The “incision line” is clearly delineated so that parents can see how much penis is removed.<sup>50</sup> The booklet seems to minimize the pain and suffering issue, arguably making the procedure seem quick and almost painless. The booklet states:

Medical research has shown that newborns do experience *some* pain during circumcision. In keeping with the Duke Pain Initiative, a program designed to minimize pain for all our patients, we take steps to lessen the *discomfort* your baby boy may experience during circumci-

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43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

sion. These steps include the use of pain medications that might be given either locally or by mouth. We also perform the circumcision in a quiet, carefully lit setting designed to *soothe* the baby.<sup>51</sup>

The booklet does not mention how the procedure is performed, nor does it mention what is done to infant foreskins after they are amputated.

*B. North Carolina Women's Hospital at the University of North Carolina (Chapel Hill, NC)*

If the parent requests information regarding the procedure, the North Carolina Women's Hospital at the University of North Carolina provides a two-page pamphlet, titled *Circumcision: A Choice*. The first full non-introductory paragraph of the pamphlet poses the question "what is circumcision?" and explains that "[c]ircumcision is a surgery to remove the *foreskin*. All newborn boys have skin that covers the end of the penis, called the *foreskin*. After the circumcision, the tip of the penis, called the *glans*, will be exposed."<sup>52</sup> The pamphlet then points out that the AAP does not recommend routine circumcision, but states that "some parents choose circumcision for their sons for cultural or religious reasons. Others choose circumcision because their family members are circumcised."<sup>53</sup> The pamphlet lists as risks of circumcision the following: bleeding, infection, "cutting the foreskin too short or too long," poor healing, and meatal stenosis (a condition where, due to the trauma of the circumcision, the meatal opening closes up—making urination difficult).<sup>54</sup> It then states that "none of these problems happen often."<sup>55</sup> Interestingly, the pamphlet does mention that there is pain involved with circumcision. It states: "Circumcision is painful but the pain can be reduced with numbing medicines and Tylenol. Your son will also have discomfort with urination and from the incision site rubbing against his diaper for several days."<sup>56</sup> The pamphlet does not, however, describe the circumcision procedure in any detail whatsoever—the strapping down of the child, the fact that although anesthesia is available, it is rarely used, or the fact that the procedure will take between ten and fifteen minutes.

The pamphlet does not discuss the important functions of the foreskin lost to circumcision, nor does it mention that almost 50 percent of babies born in the

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51. *Id.* (emphasis added).

52. N.C. WOMEN'S HOSPITAL PATIENT EDUCATION COMMITTEE, *CIRCUMCISION: A CHOICE* (2007) available at <http://mombaby.org/UserFiles/File/WomensHealthEducation/English/Circumcision.pdf> (emphasis in original).

53. *Id.*; see also Jenkins, *supra* note 29. It is interesting to note that having a son "look like his father" is the number one reason given for circumcision, according to several sources. *Id.* (quoting Kent Kleppinger, M.D.).

54. N.C. WOMEN'S HOSPITAL PATIENT EDUCATION COMMITTEE, *supra* note 52.

55. *Id.*

56. *Id.*

United States recently have been left intact. The pamphlet also does not tell parents what is being done with their son's foreskin after amputation. The attendant nurse who gave me the pamphlet informed me that the hospital does not take any kind of ethical position on the issue of circumcision—they simply give the pamphlet to those parents who request it.

*C. New York University Medical Center (New York, NY)*

New York University's Medical Center ("NYU Medical Center") has a website devoted to circumcision.<sup>57</sup> The website clearly states that circumcision is the removal of the foreskin. It also states that "in the United States, circumcision is mostly done for cultural and/or religious reasons."<sup>58</sup> Interestingly, the site then states, "[c]ertain health benefits are thought to be associated with circumcision, but many health professionals believe these benefits are negligible."<sup>59</sup> The next paragraph lists the common "pro" arguments for circumcision: decreased UTIs, reduction in the chance of getting penile cancer, etc. The NYU Medical Center site does discuss the recent studies that show a positive prophylactic effect in terms of HIV, but it does not discuss studies coming to the opposite conclusion.<sup>60</sup> In regards to pain, the site states that with proper anesthesia, the child "should feel only minimal pain."<sup>61</sup>

The site includes a graphic artist's rendition of both the intact and the circumcised penis. A section named "Outcome" focuses on swelling and the length of time for the healing of the circumcision wound.<sup>62</sup>

*D. Northwestern Memorial Hospital (Chicago, IL)*

Northwestern Memorial Hospital has two web-related informational pages relating to circumcision. One is a more detailed discussion of the procedure,<sup>63</sup> while the other relates more to how one takes care of a new baby, and therefore deals with a variety of issues, including circumcision.<sup>64</sup> I will focus more on the first site, although the second offers some important insight as well.

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57. N.Y. Univ. Medical Ctr., <http://www.med.nyu.edu/patientcare/library/article.html?ChunkIID=14792> (last visited Oct. 2, 2007).

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. Northwestern Memorial Hospital, Circumcision, <http://www.nmh.org/nmh/adam/pregnancy/000133.htm> (last visited Oct. 2, 2007).

64. Northwestern Memorial Hospital, Care of Your Baby, <http://www.nmh.org/nmh/prentice/pregnancyguide/carebaby.htm> (last visited Oct. 2, 2007).

Northwestern's information does state that circumcision is the removal of the foreskin.<sup>65</sup> It then states, "[t]here is *not* a compelling medical rationale for the procedure. Neither is there a compelling reason to avoid circumcision."<sup>66</sup> Northwestern acknowledges that the main reasons for circumcision are cultural or religious. In regards to the medical reasons for circumcision, Northwestern states that "86% of uncircumcised infants developed a urinary tract infection under one year of age," but the site does not cite where it derives this very large number.<sup>67</sup> The less-detailed page, which deals with general information about taking care of new babies, says that recently circumcised babies will need "some extra cuddling."<sup>68</sup>

## V. THE CASE LAW ON INFORMED CONSENT

It is axiomatic that for consent to a medical procedure to be valid, it must be *informed* consent.<sup>69</sup> The issue arises as to what "informed" actually means. Case law gives us some indication as to what the definition of "informed" might be.

The first important point to note is that a patient-physician relationship is not an "arm's length" relationship, i.e., the "buyer beware" standard does not apply.<sup>70</sup> As the D.C. Circuit Court of Appeals stated, in *Canterbury v. Spence*:

The patient's reliance on the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject.<sup>71</sup>

The *Canterbury* case dealt with a surgeon who was found not to have adequately informed a patient (and his mother) about the risks involved in a spinal surgery. In fact, the surgeon told the patient's mother that the surgery was no riskier "than any other."<sup>72</sup> In the end, the plaintiff-patient suffered a life-altering disability, the risk of which was never disclosed to him or his mother.

The *Canterbury* court emphatically stated, "[c]aveat emptor is not the norm for the consumer of medical services."<sup>73</sup> In order for consent to be truly informed, the physician must disclose "the options and the perils for the patient's edification"

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65. Northwestern Memorial Hospital, *supra* note 63.

66. *Id.* (emphasis in original).

67. *Id.*

68. Northwestern Memorial Hospital, *supra* note 64.

69. *See Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

70. *Id.* at 782.

71. *Id.*

72. *Id.* at 777.

73. *Id.* at 783 n.36.

and the “dangers inherently and potentially involved.”<sup>74</sup> But how do we measure whether the physician has given the patient all the necessary information? Two options available to us are the physician-centered approach and the patient-centered approach.

#### A. *The Physician-Centered Approach*

The physician-centered approach looks to behavior of other members of the profession to determine whether the doctor gave the patient enough information to meet the “informed consent” standard. For example, in Kentucky, a court looks at “the ‘accepted standard of medical . . . practice among members of the profession with similar training and experience.’”<sup>75</sup>

The physician-centered approach is problematic. Allowing a physician to simply hide behind the behavior of other doctors may put patients in danger. If physicians as a group are objectively not giving enough information (and thereby hurting patients), then the physician-centered rule will do nothing to alleviate this problem. Also, if we as a polity value consent, we must look at the patient’s perspective. The notion of “consent” is meaningless if we do not value the rights of patients (or customers) to unbiased and clear information that would assist them in making suitable decisions. As Professor H. Jefferson Powell notes, the notion of “informed consent assumes that the individual is the best custodian of his or her own interests.”<sup>76</sup>

It is also axiomatic that false information eviscerates true consent. If, for example, I purchase an automobile and the seller lies to me about the car’s condition, it can be easily argued that his false information induced my consent, and now the truth eviscerates that consent. If doctors as a group are misinforming or under-informing patients, doctors should not be able to use the justification that “everyone does it this way” as an argument that they have obtained consent.

#### B. *The Patient-Centered Approach*

The court in *Canterbury* finds much fault in the physician-centered approach.<sup>77</sup> To begin with, the court declares its affinity for personal choice and individual autonomy: “In our view, the patient’s right of self-decision shapes the boundaries of the duty to reveal.”<sup>78</sup> The court then dismisses the physician-centered approach because of the danger it presents to patients in failing to protect their autonomy—it allows physicians to essentially create their own standard—

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74. *Id.* at 782–83.

75. *Dixon v. United States*, No. 98-5330, slip op. at 2 (6th Cir. Mar. 26, 1999) (citing KY. REV. STAT. ANN. § 304.40-320(1) (1996)).

76. Interview with H. Jefferson Powell, Professor, Duke Univ. Sch. of Law (Oct. 24, 2003).

77. *Canterbury*, 464 F.2d at 783.

78. *Id.* at 786.

and because of the standard's inability to acknowledge the unique qualities of each patient:

There are, in our view, formidable obstacles to acceptance of the notion that the physician's obligation to disclose is either germinated or limited by medical practice. To begin with, the reality of any discernible custom reflecting a professional consensus on communication of option and risk information to patients is open to serious doubt. We sense the danger that what in fact is no custom at all may be taken as an affirmative custom to maintain silence, and that physician-witnesses to the so-called custom may state merely their personal opinions as to what they or others would do under given conditions. . . . [T]he myriad of variables among patients makes each case so different that [the] omission [of information] can rationally be justified only by the effect of its individual circumstances. . . . [T]o bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination . . . demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.<sup>79</sup>

### 1. *Material Risks Must Be Disclosed*

According to the court in *Canterbury*, all material risks must be disclosed.<sup>80</sup> As the court states, "all risks potentially affecting the decision must be unmasked."<sup>81</sup> But what does "material" mean? Because a doctor cannot know what each specific patient will need to know to make a decision, we must ask ourselves, "what would a reasonable patient want to know?"<sup>82</sup> The court further elucidates the meaning of "material" by stating:

A risk is thus material when a reasonable person, in what a physician knows or should know to be the patient's position, would be likely to attach a significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.<sup>83</sup>

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79. *Id.* at 783–84.

80. *Id.* at 787.

81. *Id.*; see also *Truscello v. Raezer*, 28 Phila. Co. Rptr. 544, 548 (Ct. Com. Pl. Phila. County 1994) (holding that the risks involved in a circumcision were not fully disclosed when a physician failed to inform the patient that he "could have a chordee and other complications from the circumcision").

82. *Canterbury*, 464 F.2d at 787.

83. *Id.*; see also *MacDonald v. United States*, 767 F. Supp. 1295, 1310 (M.D. Pa. 1991) (holding that to meet the informed consent standard, a physician must disclose "all those facts, risks, and alternatives that a reasonable man in the situation which the physician knew or should have known to be the plaintiff's would deem significant in making a decision to undergo the recommended treatment").

### 2. *Potential Disabilities Are “Material”*

One element that implicates materiality is the potential for disability resulting from a particular procedure or treatment. As the court in *Canterbury* states, “a potential disability which dramatically outweighs the potential benefit of the therapy . . . may summons discussion with the patient.”<sup>84</sup> What counts as a disability? The court gives several examples. It states that “a very small chance of death or serious disablement may well be significant.”<sup>85</sup> It then cites other cases as guidance. In *Bowers v. Talmage*,<sup>86</sup> a Florida District Court of Appeal required disclosure, if the procedure or treatment had a 3 percent chance of death, paralysis, or other injury.<sup>87</sup> In *Scott v. Wilson*,<sup>88</sup> the Texas Court of Civil Appeals required disclosure for a 1 percent chance of loss of hearing.<sup>89</sup> The question of potential for disability is an important question in the context of circumcision, because circumcision, like any surgery, carries the risk of death.<sup>90</sup>

### 3. *Alternatives Must Be Discussed*

*Canterbury* also requires that the physician discuss with her patient alternatives to the therapy being recommended.<sup>91</sup> This further serves the goal of patient autonomy. For, as the court states:

To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic *alternatives* and their hazards becomes essential.<sup>92</sup>

As a related matter, a physician must also disclose “the results likely if the patient remains untreated.”<sup>93</sup> Choosing to forego treatment is, after all, an alternative treatment.

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84. *Canterbury*, 464 F.2d at 788.

85. *Id.*

86. 159 So.2d 888 (Fla. Dist. Ct. App. 1963).

87. *Id.* at 890.

88. 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd*, 412 S.W.2d 299 (Tex. 1967).

89. *Id.* at 535.

90. See FLEISS, *supra* note 9. Some would also argue that the loss of penile function is a “disability.” This is a charged question that I will not deal with directly in this paper, because it implicates men’s perception of the quality of their sexual experiences, and is beyond the scope of this analysis. Suffice to say, however, that unlike the 1 percent chance of hearing loss cited in *Scott v. Wilson*, if one were to argue that the loss of penile function rises to the level of a disability, circumcision causes this loss virtually every time that it is performed, so its probability is close to 100 percent.

91. *Canterbury*, 464 F.2d at 781.

92. *Id.* (emphasis added); see *MacDonald v. United States*, 767 F. Supp. 1295, 1310 (M.D. Pa. 1991).

93. *Canterbury*, 464 F.2d at 787; see *MacDonald*, 767 F.Supp. at 1310.

#### 4. *Disclosure of Unknown Facts*

Under the *Restatement (Second) of Contracts*, a party's non-disclosure of a fact known to her is equivalent to an assertion that the fact does not exist if: (1) this party knows that the disclosure of this fact will correct a mistaken assumption under which she knows her adversarial party to be acting and upon which the adversarial party is making the contract, and (2) non-disclosure amounts to a failure to act in good faith.<sup>94</sup> The *Restatement Second* also requires that disclosure be made if there is a "relationship of trust and confidence" between the parties.<sup>95</sup> Section 161(b) of the *Restatement Second* requires that a disclosure be made if it would correct a known mistaken assumption of the other party. In other words, the non-disclosing party is under an obligation to disclose a fact if such party knows that this non-disclosed fact will alter the mind of the other party.

#### 5. *Childbirth: Trauma and Consent*

Another issue that may arise in the context of circumcision is whether consent can be valid if given by a woman who has just given birth. At least one court has dealt with this issue. In *Ferguson v. City of Charleston*,<sup>96</sup> the court held that the stress of childbirth may eviscerate a woman's ability to consent.<sup>97</sup> The court stated:

Medical distress may create a vulnerable subjective state that is inimical to voluntary consent in two ways. First, a patient who is in dire need of medical treatment will feel less free to refuse certain portions of that treatment, even if she is physically capable of doing so. Second, the physical strain of labor, birth, or serious illness will have a deleterious effect on the patient's mental process, limiting her ability to rationally consider whatever choices she has.<sup>98</sup>

Interestingly, the court held that the birthing experience does not necessarily eviscerate consent, but the party who obtained the supposed consent bears the burden of proving that the woman who has just given birth was actually able to consent.<sup>99</sup>

#### 6. *Disclosure of Doctor's Bias*

Some courts require that a doctor disclose a bias she may have in recommending a course of treatment to a patient. In a very important case from the

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94. RESTATEMENT (SECOND) OF CONTRACTS § 161(b) & (c) (1981).

95. *Id.* § 161(d).

96. 308 F.3d 380 (4th Cir. 2002).

97. *Id.* at 403.

98. *Id.* This case came up in the context of women consenting to be searched by law enforcement authorities.

99. *Id.*

Supreme Court of California, the court held that “a physician must disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect the physician’s professional judgment.”<sup>100</sup> The court held that such non-disclosure “may give rise to a cause of action for performing medical procedures without informed consent.”<sup>101</sup> In *Moore v. Regents of the Univ. of Cal.*, the court found that the plaintiff had a cause of action when challenging a hospital’s undisclosed use of his cells. The plaintiff, Mr. Moore, suffered from hairy-cell leukemia and had his spleen removed at the behest of his physician.<sup>102</sup> Over the course of six years, he also had samples of his blood, bone marrow, skin, and blood extracted by the University of California at Los Angeles Medical Center.<sup>103</sup> As it turns out, the hospital was selling Mr. Moore’s cells to various commercial entities for a sizeable profit without informing Mr. Moore of this commercial interest.<sup>104</sup> As the court states, during the period of treatment, “the defendants were actively involved in a number of activities which they concealed from [Moore]’ . . . [C]onducting research on Moore’s cells and [planning] to benefit financially and competitively” from the extraction of the cells.<sup>105</sup> The defendants eventually applied for a patent on technology they developed from Mr. Moore’s extracted cells. Mr. Moore was unaware of these actions.<sup>106</sup> As the court pointed out, Mr. Moore stated a case for lack of informed consent because, “the law already recognizes that a reasonable patient would want to know whether a physician has an economic interest that might affect the physician’s professional judgment.”<sup>107</sup>

### 7. *Synthesis of Case Law Requirements*

To summarize, the case law discussed above highlights several factors that should be considered when determining whether a patient has given informed consent:

- The “buyer beware” standard does not apply due to the medical and trusting nature of the relationship.<sup>108</sup>
- Some courts (but not all) will use the patient-centered approach, which essentially asks, “what would the reasonable patient want to know?” and requires that a doctor disclose all risks and dangers that are “material.”<sup>109</sup>

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100. *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990).

101. *Id.*

102. *Id.* at 481.

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.* at 481–82.

107. *Id.* at 482.

108. *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

109. *Id.* at 786–87.

- A risk is material if a doctor knows or should know that a reasonable patient would attach significance to it.<sup>110</sup>
- A potential disability caused by the proposed therapy is a “material” risk.<sup>111</sup>
- Informed consent doctrine also requires that doctors disclose to patients alternatives to the proposed treatment, including the likely results of not pursuing treatment.<sup>112</sup>
- Doctors are required to disclose facts if they know (or should know) that patients are in the dark about or mistaken about these facts.<sup>113</sup>
- The trauma of childbirth may eviscerate a woman’s ability to consent.<sup>114</sup>
- A doctor’s bias due to financial profit, if not disclosed, may eviscerate informed consent.<sup>115</sup>

## VI. INFORMED CONSENT FOR CIRCUMCISION: A PROPOSAL

Based on the requirements set forth in the law, I would like to propose a model for what informed consent for the circumcision of minors might look like. First, I will propose the information that I think doctors must tell parents about circumcision. I will then assess whether the past and current practices described in Part IV meet this proposed standard, and if not, where improvements can be made.

As mentioned earlier, the informed consent doctrine essentially requires doctors to ask themselves the question, “what would the reasonable patient want to know?”<sup>116</sup> Clearly, the reasonable patient does not have the time or intellectual interest to explore all of the minute details regarding the value of the foreskin, the consequences of circumcision, and the medical arguments for and against the procedure. Therefore, I have attempted to include those facts about the procedure that I feel are essential—the things a parent of reasonable intelligence has the right to know, things that might alter his or her decision.

The *Restatement Second* requires that a physician disclose a fact if she knows that the patient is making his or her decision under a mistaken assumption.<sup>117</sup> One of the unfortunate facts about circumcision in the United States is the general lack of knowledge about the subject. As noted above, 46 percent of parents said that they were given no information about circumcision upon the

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110. *Id.*

111. *Id.* at 788.

112. *Id.* at 781.

113. RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 94.

114. *Ferguson v. City of Charleston*, 308 F.3d 380, 403 (4th Cir. 2002).

115. *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483–84 (Cal. 1990).

116. *Canterbury*, 464 F.2d at 787.

117. RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 94.

birth of a male child.<sup>118</sup> Many people assume that circumcision is a quick and painless procedure that is tantamount to trimming finger nails, and that the procedure only removes the “tip” of the penis or a small piece of skin.<sup>119</sup> Doctors may know that parents are under these false impressions, and if this is the case, they have an affirmative duty to correct these mistaken assumptions. Most, if not all, of the facts I have listed in my proposal are things that the average, reasonable person may not know. Doctors have a duty to tell parents these facts if they are to obtain informed consent.

#### *A. Circumcision is Foreskin Amputation*

Many parents are under the mistaken impression that circumcision either involves the removal of only a small useless piece of skin, or that it does not involve the actual removal of anything.<sup>120</sup> Because circumcision is not a medically necessary procedure, it seems only fair that doctors should be required to tell parents that they are actually going to amputate their son’s foreskin permanently.

It seems fair to ask doctors to inform parents what the foreskin is, why it is there, and what it does, because they are being asked to consent to its permanent removal. Needless to say, it would not seem fair to require doctors to give parents a lengthy anatomy lesson. Nevertheless, it should be required that doctors discuss some basic information, such as the following:

- The foreskin covers and protects the penis, preventing bacteria, dirt, and in the case of diaper-wearing infants, fecal matter, from entering the meatal opening. Circumcised penises lose this protection.<sup>121</sup>
- The foreskin contains nerve endings, constitutes an integral part of the penile skin system, and its presence ensures the natural “gliding action” of the intact penis. Circumcision does change the way the penis functions to some extent, for circumcised penises do not usually exhibit this gliding quality to the same extent as intact/uncircumcised penises, if at all.<sup>122</sup>
- The foreskin shelters and ensures the presence of the sebum that keeps the penis well-lubricated.<sup>123</sup>
- If the frenulum is going to be removed as well, the doctor should discuss its sensory and structural importance.

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118. Adler et al., *supra* note 37, at 12.

119. Klinger, *supra* note 20, at 7.

120. *Id.*

121. See C.J. Cold & J.R. Taylor, *The Prepuce*, 83 BRIT. J. UROLOGY 34 (1999); FLEISS, *supra* note 9.

122. Harryman, *supra* note 12.

123. FLEISS, *supra* note 9, at 6.

### B. *Consequences of Circumcision*

Because I believe doctors are required to disclose what the foreskin is and does, I also believe that they must disclose the changes that the foreskin's amputation will cause. Because circumcision is the *permanent removal* of the foreskin (and likely the frenulum), the circumcised male loses all functions of the foreskin. He will no longer have the protective covering of his foreskin. As opposed to having an erect penis with shaft mobility, the skin of a circumcised male's erect penis is more or less taut. Masturbation without artificial lubricants is difficult. A circumcised male loses the nerve endings found in the foreskin, and the sebum produced by the inner foreskin dries up.

The information given above may seem biased toward leaving children intact. But I must tell my reader that none of this information is "slanted"—it is all scientifically factual. The fact that the foreskin covers the glans is not up to interpretation—it is simply reality. Regardless of how one may feel about circumcision, it is irrefutable that the removal of a body part causes the person to lose the functions of that body part.<sup>124</sup>

### C. *The Medical Pros and Cons*

Some studies purport to show medical benefits to circumcising male infants—mainly in the areas of penile cancer, UTIs, and HIV. Circumcision opponents argue that these studies are invalid and/or fraught with irregularities. As controversial as these studies may be, a doctor has every right to put her faith into them as she sees fit, and to quote these studies according to her personal conscience and medical training.

How does this fit into the "patient-centered" approach discussed above? A doctor has the right to take a position concerning these studies. It would seem permissible for a doctor to say to a patient, "it is my professional opinion that men who are circumcised have a lower chance of contracting HIV." However, the requirement that a doctor also disclose to the patient alternatives (including the consequences of not seeking treatment at all) would seem to dictate that a doctor must tell the patient that circumcision is not necessary to prevent HIV. In other words, a doctor, having informed a patient that (according to her opinion) cir-

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124. As mentioned in Part V, *Canterbury* requires that a doctor disclose all material risks and potential disabilities associated with a proposed medical intervention, including the risk of death. *Canterbury*, 464 F.2d at 780. Should doctors interpret *Canterbury's* use of the term "disability" broadly, and disclose the loss of penile function as a "disability?" On the one hand, it can be argued that the loss of shaft mobility does not rise to the level of a "disability" caused by the loss of hearing or paralysis mentioned in the other cases. However, we must recall that the court in *Scott v. Wilson*, 396 S.W.2d 532, required the disclosure of a 1 percent chance of hearing loss, and the court in *Bowers v. Talmage*, 159 So.2d 88, required the disclosure of a 3 percent chance of paralysis or death. Circumcision causes the loss of shaft mobility (if not all mobility) every time it is performed. Therefore, due to its almost certainty, an argument can be made that such loss of this shaft mobility should be disclosed. Because calling circumcised men "disabled" would be insulting and non-productive, I do not advocate going down this road, even theoretically.

cumcision may lower the risk of HIV and other STDs, should also tell her patient that HIV can be prevented equally well by the use of condoms, and that countries where circumcision is not practiced have lower rates of HIV than the United States. It goes without saying that it would be inappropriate for a physician to exaggerate the findings of the studies. Because the studies for UTIs and HIV, assuming they are valid, show slight statistical variances in the rates for these diseases, it would violate the “informed consent” doctrine for a doctor to somehow state to her patient that the differences in the rates of these maladies were anything more than slight.

At a minimum, doctors have, in my opinion, an ethical duty to inform patients that routine infant circumcision is not recommended by the AAP or the AMA, and that neither body sees the “potential benefits” of circumcision as rationales for making the procedure routine.<sup>125</sup>

#### *D. The Physician’s Bias*

Under the *Moore* decision, the physician must clearly disclose to the parents if she or the hospital are in some way benefiting from the amputation of the child’s foreskin beyond the circumcision fee.<sup>126</sup> Parents should be informed if the amputated foreskins are being sold for any commercial gain on the part of the hospital or if they are being donated to make skin grafts for burn victims in the intensive care unit of the same hospital. This is because the doctor’s use of the child’s amputated foreskin for either direct commercial or financial benefit, or for the benefit of the hospital and its patients in general, may bias the doctor’s opinion on circumcision.

#### *E. Must a Picture or Video of a Circumcision be Shown?*

I am of the opinion that parents have the right to see a video of a circumcision, if not at least a picture of a child restrained and being circumcised. One might question why I would advocate such a position, considering that we do not require videos and/or pictures to be shown for informed consent to be obtained for other procedures. I believe circumcision is different from other procedures in several respects. To make the analysis clearer, I will differentiate circumcision from, as an example, open-heart surgery.

As mentioned earlier, my reading of the *Restatement Second* is that it requires that a doctor disclose facts if she knows or should know that the patient (or parent of the patient) is making a decision under a false impression.<sup>127</sup>

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125. AM. ACAD. PEDIATRICS, TASK FORCE ON CIRCUMCISION, CIRCUMCISION POLICY STATEMENT (1999), available at [www.aap.org/policy/re9850.html](http://www.aap.org/policy/re9850.html). In the early part of the summer of 2007, the AAP announced that it would revisit its position, and possibly issue a new statement within six months to one year. However, as of October of 2007, the position had not changed.

126. See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990).

127. RESTATEMENT (SECOND) OF CONTRACTS, *supra* note 94.

The average person may not know a lot of detail about what the surgeon does to the heart muscle during open heart surgery. But I believe that the average person does know that open heart surgery involves anesthetizing the patient, cutting open his or her chest, and doing something to the heart and/or valves. It is my opinion that the average person has a picture in his or her mind of what open heart surgery “looks like,” and that this picture is not too far from reality. This is not the case for circumcision. Many people think that circumcision is a quick and painless procedure, and are in fact shocked when they find out that the procedure can take up to fifteen minutes, or when they see photographs of male infants being strapped down to circumstraint boards and screaming in agony.<sup>128</sup> In other words, the picture that the average, uninformed person has of circumcision is vastly different from the reality of circumcision. This is a “false impression,” and a reasonable doctor knows or should know that this false impression exists. As mentioned earlier, *Canterbury* requires that a doctor disclose information if she knows that a reasonable patient is likely to attach importance to it.<sup>129</sup> I would argue that the average reasonable parent, who may think circumcision to be a quick and painless procedure, would attach great importance to knowing that his or her newborn boy is about to experience a painful genital surgery.

Interestingly, one physician with whom I spoke about this issue agreed with me in principle about the importance of a circumcision video.<sup>130</sup> She was opposed to the practice of infant circumcision and actually counseled her patients against it with some success. She also confided in me of her certainty that if parents saw a circumcision video, they would never consent to it for their children. However, in the end, she decided not to show circumcision videos to expectant parents, because as she stated, “if I show circumcision videos, then I have to show videos of children being vaccinated, and I support vaccination.”<sup>131</sup>

This physician was onto something. The court in *Canterbury* entertained several situations (one might call them “exceptions” to the disclosure rule) in which a doctor may not have to disclose a piece of information to a patient. One such scenario would be an emergency situation.<sup>132</sup> Another scenario could occur when giving the patient the information would, because of fear or disturbance, hinder the patient from getting a treatment that he or she otherwise really

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128. See Klinger, *supra* note 20.

129. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

130. Interview with Dr. Valerie King (Sept. 28, 2003). Dr. King and I met at a health fair for expecting mothers held at the North Carolina Women’s Hospital at the University of North Carolina. I attended the health fair seeking out a “real life” perspective from physicians practicing in obstetrics and gynecology regarding their experiences with this issue.

131. *Id.*

132. *Canterbury*, 464 F.2d at 789.

needs.<sup>133</sup> The court summed this issue up into a question: will communicating the information “present a threat to the patient’s well-being?”<sup>134</sup>

Although infant vaccination is a controversial subject in its own right, many physicians and medical associations take the position that vaccinations are necessary, since they are administered in order to protect the child from life-threatening diseases to which they can be exposed simply by normal contact.<sup>135</sup> Therefore, a physician could reason that showing parents a vaccination video might cause the parents disturbance and make them decide not to vaccinate their child, hence putting the child’s well-being at risk. This is not the case for circumcision. The procedure is not medically necessary. Its supposed benefits are still hotly debated in the United States (and are not accepted in Europe), it is a procedure that is not recommended by the AAP, and it is clearly not necessary for the well-being of the child. Therefore, showing the circumcision video does not implicate the “exception for patient’s well-being” test of *Canterbury*.

I am therefore of the opinion that, based on the fact that people’s perception of what a circumcision is differs so radically from what actually happens during a circumcision, doctors are under an obligation to show parents a video, or if not, at least a photograph, of a baby being circumcised.

#### *F. Coercive Tactics of Obtaining Consent*

Any coercive tactics used to get women (or men) to agree to the circumcision of their infant son must be stopped immediately. By coercive tactics I include (but do no limit myself to) the following:

- Obtaining consent for the circumcision (whether it be verbally or through the signing of a consent form) when the woman is in labor, or immediately after the trauma of childbirth, as per the decision in *Ferguson*.<sup>136</sup>
- Instructing nurses to try to “persuade” parents to “consent” to circumcision by having the nurses say things to parents like “it’s quick and painless,” “everyone does it,” or “oh, you don’t want your son circumcised?” (as if the parents are strange for not wanting the surgery).<sup>137</sup>

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133. *Id.*

134. *Id.*

135. This paper does not take any position on the pros and cons of infant immunization. I am well aware that there are many individuals who are opposed to the routine immunization of children. Those opposed to the practice point to the toxicity of the vaccines and the negative health effects they have on children.

136. *See Ferguson v. City of Charleston*, 308 F.3d 380 (4th Cir. 2002).

137. All of these kinds of tactics have been and continue to be used at American hospitals. *See* George Hill, *Protection of Infant Boys from Wrongful Circumcision in American Hospitals*, <http://www.cirp.org/pages/parents/protection/> (last visited Oct. 7, 2007); *see also supra* notes 37–41 and accompanying text (describing several interviews conducted with parents and nurses describing the relatively sparse and misleading information provided to parents regarding the circumcision procedure).

- Outright lying to parents by telling them that circumcision is mandatory, that it is necessary for good health, or that women will not want to have sex with their son if he is not circumcised.<sup>138</sup>
- Exploiting the language barrier of non-English-speaking patients to obtain consent. In August 2003, a federal court in Brooklyn heard a civil rights claim brought against Elmhurst Hospital in Queens, NY, a facility owned by the City of New York, for the wrongful circumcision of a child born to an Ecuadorian mother and a Greek father. The suit alleged that the hospital had “a pattern and practice of inducing Spanish-speaking mothers to sign ‘consent’ forms for circumcision when they [did not] understand what they were signing and without first being informed . . . of the risks, harms and alleged benefits of male circumcision.”<sup>139</sup>

### G. *Can There Be Too Much Counseling?*

Could instituting the above proposal amount to too much counseling, hindering parents from making decisions for their own children? Although I am not aware of any case law specifically dealing with circumcision and the notion of “too much counseling,” it can be very useful too look at the case law in regards to abortion and informed consent.

In *Planned Parenthood v. Casey*,<sup>140</sup> the Supreme Court dealt with, among other things, the issue of whether a state statute requiring physicians to obtain informed consent for abortions constituted a “substantial obstacle” to a woman exercising her constitutional right to an abortion.<sup>141</sup> The Court held that although a woman “has the right to choose to terminate or continue her pregnancy before viability, it does not follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed.”<sup>142</sup> The Court stated that “not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right. . . . The fact that a law . . . has the incidental effect of making it more difficult . . . to procure an abortion cannot be enough to invalidate it.”<sup>143</sup> A law will only be invalidated as an “undue burden” if it places a

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138. As bizarre as this may seem, comments like these (especially the latter) have in fact been made to parents. See Paul M. Fleiss, *Protect Your Uncircumcised Son: Expert Medical Advice for Parents*, MOTHERING, Nov–Dec. 2000, at 40.

139. J. Steven Svoba, *\$25 Million Civil Rights Circumcision Case to Protect Spanish-speaking Families Starts Trial Monday in Federal Court*, ARC NEWS, July 31, 2003, available at <http://arclaw.org/news/0000001a.htm>.

140. 505 U.S. 833 (1992).

141. *Id.* at 881.

142. *Id.* at 872.

143. *Id.* at 873–74.

“substantial obstacle in the path” of an individual seeking to exercise a constitutionally protected right.<sup>144</sup>

The informed consent law that was in question in *Casey* required doctors to inform their patients “of the nature of the procedure, the health risks of the abortion and of childbirth, and the ‘probable gestational age of the unborn child’” at least twenty-four hours before the abortion was to be performed.<sup>145</sup> The law also required physicians to inform their patients of “the availability of printed materials . . . describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide[d] adoption and other services as alternatives to abortion.”<sup>146</sup> The Court upheld the requirement, noting that the information being given was “truthful” and “non-misleading.”<sup>147</sup>

The Court did, however, hold unconstitutional a statute that forbade doctors from performing an abortion, unless such doctors received from the woman a signed statement that the latter had notified her husband of her intent to get an abortion.<sup>148</sup> The Court noted that “in this country there are millions of women who are victims of regular physical and psychological abuse at the hands of their husbands.”<sup>149</sup> Should these women become pregnant, informing their husbands of their desire to get an abortion could expose them to further abuse.<sup>150</sup> The Court held that:

[T]he spousal notification requirement is thus likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle.<sup>151</sup>

In regards to circumcision, I can foresee challenges to my informed consent proposal based on the argument that too much counseling would amount to hindering parents from exercising their constitutionally protected right to raise their children as they see fit. Jewish parents, who circumcise their children for religious reasons, might also argue that an informed consent requirement runs afoul of the First Amendment’s Free Exercise Clause. But I do not believe that either of these challenges can stand, based on the decision in *Casey*. First, all of the information that I propose be disclosed is simply “truthful and non-misleading.”<sup>152</sup>

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144. *Id.* at 877.

145. *Id.* at 881 (amounting to a twenty-four hour waiting period for the abortion).

146. *Id.* at 833.

147. *Id.* at 882.

148. *Id.* at 887–95.

149. *Id.* at 893.

150. *Id.*

151. *Id.* at 893–94.

152. *Id.* at 882.

Secondly, unlike women in abusive relationships who seek abortions, both Jewish and non-Jewish parents can still have their children circumcised even after having been told about the foreskin and seeing the video or the photographs. Jewish parents, it must be remembered, can always seek the circumcision services of a *mohel*.<sup>153</sup>

#### VII. HOW DO PAST AND CURRENT PRACTICES FARE UNDER MY PROPOSAL?

Obviously, those hospitals that are obtaining consent from parents through trickery or deception violate my proposal. This includes hospitals that have a pattern or practice of obtaining consent from mothers during labor or immediately following labor, clinics that give non-English-speaking mothers consent forms only in English, and health care organizations that instruct their nurses to talk parents into circumcision by false comments like “everyone does it” or “it’s cleaner.” Not giving any information whatsoever, as may be the case 46 percent of the time,<sup>154</sup> is also unacceptable. In addition, I would argue that circumcision refusal forms are an affront to medical decency and their use must be stopped immediately.

##### A. Duke University Health System (Durham, NC)

Duke’s booklet is to be commended for informing parents that circumcision is the permanent removal of the foreskin, and also for telling them that the foreskin is attached to the glans at birth.<sup>155</sup> The booklet also mentions that the procedure takes ten to fifteen minutes, that the United States is the only country in the world where non-religious circumcision is common, and that even the rate in this country is dropping.<sup>156</sup> The booklet’s greatest strength is that it includes an illustration of an intact penis, where the foreskin is of a lighter shade than the rest of the penis, allowing parents to see just how much penis is actually removed.

But the booklet has some weaknesses. It does not discuss the function of the foreskin. I was also not satisfied with how, in discussing the risks of circumcision, it emphatically states that circumcision causes “no harm to the penis,” as if the foreskin is somehow not part of the penis.<sup>157</sup> The booklet also, in my view, minimizes the pain issue, by stating that infants experience “some” pain and then calling that pain “discomfort.”<sup>158</sup>

I would call the section titled *What are the consequences of not circumcising my son?* inappropriate. By asking “what are the consequences of not cir-

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153. A *mohel* is a Jewish ritual circumciser who performs the *brit milah* (ritual circumcision).

154. See Adler, *supra* note 37.

155. See WIENER, *supra* note 19.

156. *Id.*

157. *Id.*

158. *Id.*

cumcising?” the pamphlet is somehow connoting that circumcision is the only natural “good parent” thing to do, and that by not circumcising, a mother is somehow running the risk of being a bad parent. Can one imagine a booklet on newborns asking, “what are the consequences of not amputating my daughter’s breast tissue?”

Also, Duke’s pamphlet does not discuss what, if anything, is done with the foreskins once they are amputated. I will note, however, that this is not a short-coming only of Duke’s pamphlet. None of the pamphlets I discuss disclose this information.

*B. North Carolina Women’s Hospital at the University of North Carolina (Chapel Hill, NC)*

The pamphlet is to be commended for telling parents that circumcision is foreskin removal and for mentioning that the glans will be permanently exposed after circumcision.<sup>159</sup> The pamphlet also mentions that the AAP does not recommend circumcision, that the procedure is painful, and that it does have certain risks. However, the pamphlet has many shortcomings. For one, the risks it discusses are only those inherent in the procedure (bleeding, infection, etc.). My understanding of the case law leads me to believe that parents also have the right to know about the consequences of circumcision—such as the loss of penile shaft mobility, the loss of the protective covering of the foreskin, and the decreased sexual sensitivity. The pamphlet explains what the foreskin is, but it does not explain what the foreskin does. It also misleadingly calls the glans the “tip” of the penis. I doubt any man would agree that his penile glans constitutes but the “tip” of his penis.<sup>160</sup> As I mentioned earlier, it is my opinion that parents have the right to see what their baby boy is going to experience. The pamphlet does not show a picture of a baby being restrained or circumcised. Since many Americans have their children circumcised so that they will “look like other boys,” I would have also liked to see the pamphlet mention that almost 50 percent of the boys in 2002 were left intact.<sup>161</sup>

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159. See N.C. WOMEN’S HOSPITAL PATIENT EDUCATION COMMITTEE, *supra* note 52.

160. A very good comparison of the penis intact and circumcised can be viewed at <http://www.bartleby.com/107/pages/page1248.html> (last visited Oct. 7, 2007). The reader can see that with both the intact and the circumcised penis, the glans constitutes approximately one-fourth to one-third of the length of the genitals.

161. Statistics regarding the percentage of American boys undergoing circumcision vary depending on who is doing the counting. The National Center for Health Statistics estimates that the circumcision rate in 2005 was about 57.3 percent. See National Center for Health Statistics, <http://nchspressroom.files.wordpress.com/2007/07/circumcision-1979-2005.pdf> (last visited Oct. 7, 2007). This amount is consistent with a recent study done by the National Health and Social Life Survey. See Rachel Konrad, *Parents Reconsidering Decisions on Circumcision*, OAKLAND TRIB., June 19, 2007, available at [http://findarticles.com/p/articles/mi\\_qn4176/is\\_20070619/ai\\_n19305525](http://findarticles.com/p/articles/mi_qn4176/is_20070619/ai_n19305525).

C. *New York University Medical Center (New York, NY)*

The NYU Medical Center is to be commended for showing pictures of the intact and circumcised penis side by side, as well as for discussing how to care for the circumcision wound. On the negative side, the information given on the site only gives one side of the HIV debate. As with other pamphlets, the information provided by the NYU Medical Center regarding “risks” only discusses those that are inherent in the procedure, and the “outcome” section does not disclose the loss of penile function. Since most doctors do not use anesthesia for circumcision, due to the risk of the infant overdosing, the line about the child feeling only minimal pain if a painkiller is used could be misleading.<sup>162</sup>

D. *Northwestern Memorial Hospital (Chicago, IL)*

Of the four pamphlets discussed, Northwestern’s is the most problematic. Although it does state that circumcision can be foregone, and that the procedure is not recommended by the AAP, there is absolutely no discussion or portrayal of the anatomy of the penis, nor is there any discussion of the functions of the foreskin. I am troubled by the fact that the more detailed pamphlet states that 86 percent of intact males get UTIs. This statistic surprised me. If the 86 percent rate were in fact true, I would think that the AAP would recommend circumcision of infants, as an 86 percent UTI rate is nearly universal. Without knowing where Northwestern obtained this number, we are left to wonder whether it is true, and I cannot find any medical evidence to support this statistic. Stating such a high number is a tacit promotion of circumcision, and I would argue that in conjunction with the pamphlet’s other short comings, it makes such a promotion inappropriate.

### VIII. INFORMED CONSENT HELPS PATIENTS AND DOCTORS

Historically, the information (if any) given to parents of newborn males regarding circumcision has often fallen below the standard of informed consent. By not obtaining informed consent, doctors who perform circumcisions may be exposing themselves to liability for a myriad of medical malpractice (and even battery) suits. Already, some parents of circumcised children—and even circumcised adults themselves—are bringing lawsuits against physicians for performing circumcisions without having obtained informed consent.<sup>163</sup> These parents are saying: “if you had told us the truth, we would never have consented.”<sup>164</sup>

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162. Taddio A., Katz J., Ilersich A.L. & Koren G., *Effect of Neonatal Circumcision on Pain Response During Subsequent Routine Vaccination*, LANCET, Mar. 1, 1997, at 599–603.

163. Adam Liptak, *Circumcision Opponents Use Legal System and Legislatures*, N.Y. TIMES, Jan. 23, 2003, at A14; *Suing over Circumcision: Man Says Lack of Foreskin Hurts Sex Life*, ABC NEWS, Mar. 12, 2001, available at <http://www.cirp.org/news/ABCnews03-12-01/>.

164. Liptak, *supra* note 163.

This issue will likely become more prevalent in the future. As imperfect as the media's coverage of the HIV-circumcision debate may be, such coverage is putting the circumcision issue front-and-center before the American public. Many men, who up until now may have taken the fact that they were circumcised as a given, may now start to question, ponder, and do research on the part of their anatomy that was removed shortly after they were born. One may argue that as more information becomes available, more circumcised men will learn about what was done to them, and some may want to bring suit. I will not pretend to be able to predict whether we will see more lawsuits stemming from informed consent and circumcision, but it is definitely a possibility.

Hospitals should deal directly with the issue of informed consent, because the grown men who were circumcised decades ago are not the only ones to consider. Increasing information given to parents will lessen the likelihood that parents who consent to circumcision from this point forward will later bring suit against the hospital for lack of informed consent. In addition, increasing the accuracy of information given to parents also makes sense from a "customer service" perspective. Hospitals should and do care about the well-being of their patients, and making sure the consent to a medical procedure is obtained legally and legitimately is the right thing to do. If we believe that parents have the right to make this decision, then they have the right to make an informed decision. Therefore, obtaining informed consent makes good sense for doctors, hospitals, and the legal professionals who represent medical practitioners.

#### **IX. GAY RIGHTS AND CIRCUMCISION**

Although my paper has discussed circumcision from the perspective of informed consent, we must not lose sight of the fact that this issue is much broader than simply hospital compliance with the laws and norms of disclosure.

LGBT individuals have an important voice to bring to the general debate about the propriety of altering the genitals of our male population, because today the circumcision debate centers around the issue of HIV prevention. As I mentioned in my introduction, the United States has practiced mass circumcision since at least the 1950s, yet the American gay community was decimated by HIV in the 1980s and 1990s. It is safe to say that most of those men were circumcised.<sup>165</sup> Hence, I will admit that as an American gay male, I find it insulting that those who seek to profit from this surgery are now exploiting a fear of AIDS to promote circumcision. Although admittedly still in the "discussion" phase, the fact that the Health Department of New York City is considering paying adult Hispanic men to get circumcised—a move that would be more costly than providing condoms and education—is equally baffling. The American experience, with

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165. The National Health and Social Life Survey states that the circumcision rate peaked in the late 1960s and early 1970s and was around 90 percent. See Konrad, *supra* note 161.

widespread circumcision and HIV, is ample proof that circumcision does not prevent transmission of the virus.<sup>166</sup> In addition, the European experience, with a much lower rate of HIV, and a Christian population that does not practice circumcision, shows that a society can allow its males to keep their genitals intact and simultaneously control the spread of HIV in an effective manner.

In the final analysis, we must acknowledge that with all the medical arguments and media hype put to the side, circumcision is an issue of sexual autonomy. As such, LGBT individuals bring an important perspective to this debate. The LGBT community knows first hand about the issue of having our sexual freedom and individuality suppressed by others. Even if we assume that parents have the right to make this decision for their sons, it helps to always have the human rights issue in the background. We should always remind ourselves that we are talking about another human being's genitals, and that this person will one day have to live with the consequences of a choice made for him by another.

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166. See Van Howe, *supra* note 32.