this procedure as an essential expression of deeply held religious and cultural beliefs. We have lessons that can help though. The experience of Western intervention in communities where female genital mutilation (FGM) is practised tells us this: first, multiple players are vested in such entrenched practices in varying roles (providers, brokers, users) often invisible to "outsiders." Second, draconian prohibitions by "outsiders" are neither welcome nor effective. Third, dialogue *can* be fostered within identifiable communities and the alternative practices can evolve (some women now choose a form of needle prick as rite of passage in lieu of traditional, scarring FGM practices). Already it is clear that communities of both Jewish and Muslim parents are beginning to consider routine circumcision in new ways (Somerville 2000).

On the troubling list of pediatric health and healthcare ethics issues, there are more pressing concerns (access to healthcare, socioeconomic impediments to health, and children as research participants, among many others). Still, neither should we neglect this issue: as parents, as health professionals, our sons deserve as much. Benatar and Benatar have helped focus our attention and our discourse. ■

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I Paid Out-of-Pocket for My Son's Circumcision at Happy Valley Tattoo and Piercing: Alternative Framings of the Debate over Routine Neonatal Male Circumcision

Armand H. Matheny Antommaria, University of Utah

Michael Benatar and David Benatar (2003) frame their analysis of routine neonatal male circumcision (RNMC) in terms of the "medical" costs and benefits of a surgical procedure. This is a common structure for the analysis of this issue, used for example by the American Academy of Pediatrics' (AAP) Task Force on Circumcision and the Canadian Paediatric Society's Fetus and Newborn Committee. The authors argue that the claims that RNMC is unethical because it constitutes mutilation, unacceptable mutilation, or is performed without the infant's consent are contingent on the procedure's costs and benefits. The authors, however, neglect to consider other possible framings that entail important ethical considerations:

1. they neglect to consider the economic costs of the procedure;
2. they do not analyze it from a community perspective;
3. they ignore parents' actual reasons for having the procedure performed; and
4. they contend that analyzing what "nonmedical" benefits medicine should be used to secure is beyond the scope of their paper.

Analysis of these alternative framings could yield vastly different normative conclusions, ranging from "RNMC is mandatory to decrease the transmission of the Human Immunodeficiency Virus (HIV)" to "it is discretionary but should not be performed by physicians."

An analysis of costs and benefits should be comprehensive. In their analysis the authors focus on the "medical" costs and benefits: the pain and complications of the procedure, as well as the prevention of penile cancer, urinary tract infections, and sexually transmitted diseases. The authors do not consider the dollar cost in their analysis of "Alleged Costs and Benefits." If the potential benefits only slightly outweigh the costs, the monetary cost of the procedure is surely a legitimate consideration in the parents' decision making. The profitability of the procedure might also have an indirect effect on physicians' attitudes toward it.

The authors do refer to financial costs under the heading "Culture," where they state, "Two papers that performed a formal cost-benefit analysis of neonatal male circumcision also reached the conclusion, given the nature of the medical evidence, that cultural and religious considerations should determine whether circumcision is performed." Ganiats et al. (1991) do not fully support this interpretation. Their cost-utility analysis includes most of the common considerations, such as preventing urinary tract infections, but it eliminates other factors, including the prevention of sexually transmitted disease. They conclude that RNMC is not cost-effective: in contrast to most medical interventions that cost money to save health, RNMC both costs money and decreases health. When the net dollar costs and health effects are calculated per person, they are $102 and 14 hours of healthy life. Ganiats and colleagues assert that these effects are negligible and that personal factors are therefore legitimate considerations. Benatar and Benatar cite the latter conclusion, privileging the analysis at the individual level over the community level without justification.

The aggregate cost-effectiveness of RNMC is important for decisions regarding community healthcare expenditures such as Medicaid. Several states, including South Carolina and Arizona, have withdrawn Medicaid funding of RNMC. Arizona's recent decision to eliminate funding was, in part, an attempt to balance the state's budget and was estimated to save the state $554,400 in direct Medicaid payments (Griffiths 2002). Alternatively, one could use cost-effectiveness data to compare RNMC to other potential medical interventions.

RNMC could also be framed as a public-health issue rather than as a decision made by parents. Public health focuses on the prevention of disease and premature death through collective action. Interestingly, the discussion of RNMC focuses on prevention but tends to be individualist rather than community focused. The authors argue that circumcision seems to lower susceptibility to HIV infection in high-risk heterosexual groups. This is, however, interpreted in the context of parental decision making. Others have used this data to call for randomized controlled trials of circumcision as an HIV prevention strategy (Bailey, Plummer, and Moses 2001). Additionally, recent data, that the authors do not cite, demonstrates that male circumcision is associated with a reduced risk of cervical cancer in a selected population. This was true in women who reported having had only one sexual partner but whose partner was at high risk for human papillomavirus infection (Castellsague et al. 2002). RNMC might, therefore, be an effective public-health measure.

Such public-health measures raise important empirical and ethical questions that the authors fail to address. The case of cervical cancer is particularly interesting because, in contrast to other widely accepted public-health measures such as immunizations, the primary risks and benefits would be borne by different groups. An analysis of this issue from the perspective of a feminine ethic of care, which emphasizes relationships, would be particularly interesting.

Finally, the authors characterize circumcision as a medical or surgical procedure and focus on its "medical" costs and benefits. While using the language of "medical value or risks" and "medical gain or loss," the authors do not indicate how medical and cultural or religious values should be distinguished except implicitly. Is, for example, the ease of genital hygiene a medical benefit apart from its contribution to reducing balinitis or penile cancer?

Evidence from surveys and educational interventions suggests that "nonmedical" benefits are paramount to parents. For example, Brown and Brown (1987) found that the reason most frequently cited as most import for the circumcision decision by fathers was "I don't want him to look different" and by mothers was "It will make him easier to keep clean." Only 9% of fathers and mothers gave "There will be less chance of infection or cancer" as a reason (see also Tiemstra 1999). Additionally, following the AAP Fetus and Newborn Committee's 1975 "Report of the Ad Hoc Task Force on Circumcision" a number of investigators designed educational interventions intended to reduce the circumcision rate (Thompson et al. 1995). The majority found that such interventions had no effect (see Herrera et al. 1982; Christensen-Szalanski et al. 1987; Rand, Emmons, and Johnson 1983). For example, Herrera et al. (1982) randomized 174 couples either to be interviewed and counseled during the second trimester or to not receive any special counseling. The circumcision rate in the groups was 98% and 96% respectively. These studies suggest that the parents make their decisions based on "nonmedical" concerns.

Such concerns, however, do not receive serious attention in the debate over RNMC. Benatar and Benatar conclude that RNMC does not unequivocally inflict serious harms and, therefore, that cultural values are acceptable reasons for performing the procedure. The authors, however, fail to differentiate the various "nonmedical" benefits and consider their relative weights. Are there, for example, relevant differences between the claims regarding cleanliness, general appearance, or similarity to other family members? Is the claim "a circumcised penis is easier to care for" falsifiable, and, if one proved it false, would one no longer perform circumcisions for parents who wanted them for this reason? Would a pediatric plastic surgeon consider operating on an infant's nose to increase the family resemblance? Whether and how these considerations differ and how they should be weighed are important ethical issues that need to be analyzed.

If RNMC is performed for cultural reasons, why continue to characterize it as a medical procedure? Circumcision in Western culture was primarily a religious ritual among Jews and Muslims. It became medicalized in the late-nineteenth century based in part on the theory of reflex neurosis—the belief that diseases are caused by "irritation." Genital irritation or phimosis was believed to cause diseases such as paralysis, reflex muscular contraction, curvature of the spine, and acquired deformity. While parallel procedures on women, such as clitoredecotomy, fell out of favor, circumcision persisted as a sanitary precaution. The underlying conception of clean and dirty was not strictly medical but was loaded with moral, social, and cultural meanings (Gollaher 2000). If the reasons for the medicalization of RNMC are no longer valid and it persists for cultural reasons, might it be preferable to have nonphysicians perform it, provided sufficient safeguards can be established? *Mohels,* Jewish ritual circumcisers, are an example of such an entity. The continued debate about the "medical" costs and benefits of RNMC might reify the procedure and perpetuate its inappropriate medicalization.

In framing their argument, the authors adopt the common analytical structure of balancing the "medical" costs and benefits. The selection of this methodology is problematic. In general, it might inappropriately perpetuate the medicalization of RNMC. In particular, the exclusion of economic costs and the focus on individuals are not justified. Such considerations raise additional factual and ethical issues that could lead to a range of different conclusions. Instead of the authors' conclusion that RNMC is discretionary, one might conclude that it is mandatory to reduce the transmission of HIV. Alternatively, one might agree that it is discretionary but argue that it should not be paid for by Medicaid or even that it should not be performed by physicians. ■

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Circumcision—A Victorian Relic Lacking Ethical, Medical, or Legal Justification

J. Steven Svoboda, Attorneys for the Rights of the Child

Michael Benatar and David Benatar (2003) are to be commended for raising the issue of male circumcision for ethical consideration. However, we cannot agree with their conclusion that "nontherapeutic circumcision of infant boys is a suitable matter for parental discretion," nor that "religious and cultural factors, though preferably subject to critical evaluation, may reasonably play a role." Doctors may not properly act as cultural brokers, and male circumcision is not a medically, ethically, or culturally neutral practice, suitable to be left to parental whim, but rather a clear violation of a number of central principles from the disciplines of medicine, ethics, law, and human rights.

In order to protect patients and doctors alike, it is ethically and legally essential that our default assumption