Cultural Bias in American Medicine: The Case of Infant Male Circumcision

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ABSTRACT

In 2012 the American Academy of Pediatrics (AAP) released a policy statement and technical report stating that the health benefits of newborn male circumcision outweigh the risks. In response, a group of mostly European doctors suggested that this conclusion may have been due to cultural bias among the AAP Task Force on Circumcision, in part because the AAP's conclusion differed from that of international peer organizations despite relying on a similar evidence base. In this article, we evaluate the charge of cultural bias as well as the response to it by the AAP Task Force, focusing on possible sources of subjective judgments that could play into assessments of benefit versus risk. Along the way, we discuss ongoing disagreements about the ethical status of nontherapeutic infant male circumcision and draw some more general lessons about the problem of cultural bias in medicine.

INTRODUCTION

In 2012 the American Academy of Pediatrics (AAP) released a policy statement and technical report in which it concluded that the "health benefits of newborn male circumcision outweigh the risks."[1] In contrast to most policies issued by the AAP, this one proved controversial, not only in the United States but internationally. Part of the reason for the controversy was that its primary conclusion concerning benefits and risks differed from that of previous AAP task forces: while previous task forces had acknowledged both positive and negative aspects to newborn circumcision (with earlier policies recommending against the procedure and later policies adopting a more neutral stance), none had found that the negatives were outweighed by the positives.[2] More striking, however, was the fact that this same conclusion differed from that of all contemporary peer organizations—that is, national pediatric or general medical societies in other countries with comparable public health environments—despite relying on a similar evidence base.[3] Following the release of the AAP documents, international critics raised concerns regarding how the main conclusion had been reached (see table 1).[4]

The most prominent criticism came in the form of an article entitled "Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision," authored by a large group of pediatric and other health authorities from mainland Europe, the United Kingdom, and Canada. According to these authors, "only 1 of the arguments put forward by the [AAP] has some theoretical relevance in relation to infant male circumcision; namely, the pos-

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sible protection against urinary tract infections in infant boys, which can easily be treated with antibiotics without tissue loss."[5] According to this view, since approximately 100 circumcisions would be needed to prevent one urinary tract infection (UTI),[6] and since the same theoretical UTI could be treated nonsurgically—as it would be if the child were female—without significantly increasing the absolute risk of serious adverse consequences, most boys with a normally developing anatomy should expect to receive no net medical benefit from circumcision prior to their sexual debut.

The other claimed health benefits, according to the critics, including a reduced risk of female-to-male heterosexually transmitted human immunodeficiency virus (HIV) and penile cancer, "are questionable, weak, and likely to have little public health relevance in a Western context, and they do not represent compelling reasons for surgery before boys are old enough to decide for themselves."[7]

Assessing Benefit and Risk

Let us first assess the empirical disagreement concerning benefits and risks. Bostrom and Ord have proposed a "reversal test" for weighing alternative policy options that is useful for framing such an analysis.[8] Consider the following question: If the AAP had recommended *not* performing circumci-

TABLE 1. Key Reasons for International Skepticism Regarding the 2012 AAP Findings

1. Internal inconsistency
   The AAP technical report states that "the true incidence of complications after newborn circumcision is unknown"—due to such problems as inadequate follow-up and conflicting diagnostic criteria—but nevertheless states that the benefits of the surgery outweigh these unknown risks.[1]
2. Questionable methodology
   The report does not mention any formal procedure used to assign weights or values to individual benefits and risks, nor does it mention any heuristic by which these could be directly and meaningfully compared, suggesting that no such procedure was used. The AAP Task Force stated in a later publication, the "benefits were felt to outweigh the risks."[2]
3. Underestimation of adverse consequences
   The AAP Task Force did not consider the most serious complications associated with circumcision, typically documented in case reports or case series, as these were excluded from their literature review.[3]
4. Inadequate description of penile anatomy
   The AAP Task Force did not describe the anatomy or functions of the foreskin (the part of the penis removed by circumcision), suggesting that it did not consider this genital structure to have any inherent value. If the foreskin does have value, however, its removal is itself a harm, and this must be factored into any benefit-risk analysis.[4]
5. Inappropriate use of research findings
   The AAP Task Force conflated findings from studies assessing the effects of adult circumcision in sub-Saharan Africa (regarding, e.g., HIV transmission and sexual function) with findings pertaining to newborn circumcision in the U.S., without demonstrating that the two procedures or environments are appropriately analogous.[5]

NOTES

1. AAP, "Male Circumcision (Technical Report)," *Pediatrics* 130, no. 3 (2012): e756-85, e757.

2. AAP, "The AAP Task Force on Neonatal Circumcision: A Call for Respectful Dialogue," *Journal of Medical Ethics* 39, no. 7 (2013): 442-43, 442.

3. See, e.g., J.S. Svoboda and R.S. Van Howe, "Out of Step: Fatal Flaws in the Latest AAP Policy Report on Neonatal Circumcision," *Journal of Medical Ethics* 39, no. 7 (2013): 434-4.

4. The implicit perspective of the AAP Task Force appears to be inconsistent with the value typically assigned to the foreskin in societies where most men retain one (and thus have personal experience with the relevant tissue). The foreskin is a highly touch-sensitive, functional sleeve of tissue that can be manipulated during sex and foreplay: it is therefore *prima facie* reasonable to regard it as having value. For extensive discussion, see B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56. The apparent view of the AAP Task Force is also inconsistent with normative medical evaluations regarding other nondiseased body parts: see J.M. Hutson, "Circumcision: A Surgeon's Perspective," *Journal of Medical Ethics* 30, no. 3 (2004): 238-40. Consider the female genital labia, for instance, whose functional, sensory, and other attributes would be fully described in any comparable report discussing the merits and demerits of excising them: see e.g., M.P. Goodman, "Female Genital Cosmetic and Plastic Surgery: A Review," *Journal of Sexual Medicine* 8, no. 6 (2011): 1813-25.

5. M. Frisch et al., "Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision," *Pediatrics* 131, no. 4 (2013): 796-800, 796.; J.A. Bossio, C.F. Pukall, and S. Steele, "Review of the Current State of the Male Circumcision Literature," *Journal of Sexual Medicine* 11, no. 12 (2014): 2847-64.

sion (because its primary health benefit in childhood could be achieved less invasively and in a more targeted manner via treatment with antibiotics, as noted by the critics), would any significant medical harm result to children, on balance, if all physicians followed that advice?

The most likely answer is "no."[9] A recent analysis of 18 years of data from the capital region of Denmark, where nonreligious male circumcision is rarely performed except out of medical necessity, suggests that approximately 99.5 percent of boys will go through infancy, childhood, and adolescence without requiring a circumcision for therapeutic reasons.[10] To put this finding a different way, the data suggest that less than 1 percent of boys in settings comparable to that of the Danish study will face a foreskin-related medical problem requiring circumcision before an age of consent.

By contrast, what would happen if the AAP guidelines were followed? Although the AAP documents do not explicitly recommend newborn circumcision, the "affirmative" position regarding net benefit has been interpreted by some circumcision advocates as entailing a similar conclusion, such that it "should logically result in an increase in infant circumcisions in the United States."[11] If this does occur, the consequence would be that an indeterminate number of boys will have undergone a medically unnecessary genital surgery, the risks of which have not been adequately studied.

For example, with respect to surgical complications, the AAP Task Force states that, due to disagreements about diagnostic criteria and other limitations with the available data, the "true incidence" of surgical complications is currently unknown.[12] Other risks, including psychosexual risks,[13] risks to the developing nervous system, and long-term risks to neuroendocrine and immune system stress responses[14] are even less well studied. Finally, some risks, including feelings of loss or resentment, dissatisfaction with one's penile appearance, body-image problems, *et cetera*, are largely subjective in nature. This inherent subjectivity renders these risks difficult if not impossible to measure using standard scientific modalities.[15] Predicting such outcomes across a range of individual difference variables poses an even greater empirical challenge.[16]

The Importance of Subjective Factors

Whether boys and men regard themselves as having been harmed versus benefited by nontherapeutic circumcision depends on numerous factors. Among them are differences in attitudes concerning, for example, what constitutes a personally relevant benefit or risk when it comes to a medically elective surgery.[17] Recognizing such variability, a member of the AAP Task Force later acknowledged certain difficulties with the methodology employed by the task force in carrying out its risk-benefit assessment. Specifically, there was a "lack of a universally accepted metric to accurately measure or balance the risks and benefits [as well as] insufficient information about the actual incidence and burden of non-acute complications."[18]

Why is there no "universally accepted metric" for balancing risks and benefits? One reason is that any such metric is likely to be influenced, whether consciously or unconsciously, by the beliefs, values, and personal preferences of those applying it to the evidence.[19] As Akim McMath notes, "People disagree over what constitutes a harm and what constitutes a benefit" when it comes to circumcision.[20] For example, "some people believe circumcision benefits the child by bringing him closer to God, while others disagree" (see box 1).[21]

Such divergent prior beliefs, in turn, may influence how one interprets the relevant medical evidence. Consider a person who is committed to circumcising infants on religious grounds. Perhaps believing, on first principles, that God would not endorse a practice that was physically harmful, it is possible that such a person would be less inclined to regard the risks that have been attributed to circumcision as being empirically well supported. This inclination, in turn, could lead a person to give relatively more credence to evidence that appears to suggest a benefit-to-risk ratio in favor of circumcision, at least partially independently of the actual strength of the evidence.[22]

Now consider someone who regards nontherapeutic genital surgery performed on children as immoral, perhaps believing that such surgery violates a child's right to bodily integrity. Compared to a religious supporter of circumcision, this person might evaluate the same evidence rather differently. Since a finding of net medical or other harm would be *prima facie* more congenial to their moral stance, this person might give relatively more credence to evidence that appears to suggest a benefit-to-risk ratio weighing against circumcision, again at least partially independently of the actual strength of the evidence.

Even when there is widespread agreement about what constitutes a harm or benefit, the *weight* to be assigned to the outcome may still differ from person to person. Relevant factors in assigning such weight include one's tolerance for certain types of risk compared to others (for example, risks of omis-

sion versus commission, risks affecting some parts of the body versus others); the availability of alternative risk-reduction or benefit-promoting strategies and how one ranks these compared to the surgical option; and one's preferences and values regarding bodily aesthetics, sexual behavior, and the importance of conforming or not conforming to prevailing sociocultural norms.

To illustrate, some men might be less comfortable taking on the risks of circumcision, an act of commission (for example, glans amputation or loss of sexual function), than they are taking on the risks of failing to undergo circumcision, an act of omission (for example, acquiring a treatable infection or developing a rare form of cancer in old age). For many people, the risks associated with acts of commission, versus acts of omission, loom larger in the mind, creating a greater psychological burden and potential for regret. This asymmetry may obtain even when the absolute likelihood of an "omitted" risk is greater than that of a "committed" risk. Without knowing which type of risk a person is more comfortable taking on, however, it is not possible to determine which one "outweighs" the other.

For another example, consider that some men assign a positive value to the foreskin itself, to sexual

BOX 1. Disagreement about Benefits and Risks: What Are the Ethical Implications?

Faced with the problem of disagreement over what constitutes a benefit or risk when it comes to circumcision, it is often concluded that "the parents should decide." However, this does not necessarily follow. As McMath notes, "the child will have an interest in living according to his own values, which may not reflect those of his parents . . . . Only the child himself, when he is older, can be certain of his values." Thus, "if disagreement over values constitutes a reason to let the parents decide, it constitutes an even stronger reason to postpone the decision until the child himself can decide."[1]

Against this view, it is sometimes argued that infant circumcision is less risky than adult circumcision, such that the two are not equivalent choices. It is true that the two choices are not identical. However, at least two issues need to be clarified before the ethical implications of this fact can be assessed. First, the claim of "less risk" is not uncontroversial. It is based largely upon retrospective comparisons of nonconcurrent studies with results drawn from dissimilar populations, using dissimilar methods and criteria for identifying complications. Therefore, such comparisons do not adequately control for the skill of the practitioner, the specific technique employed, the setting of the surgery, the methods of data collection, and so on.[2]

Second, even if one were to grant an increase in the *relative* risk of complications in adulthood versus infancy, it is the difference in *absolute* risk that is more ethically relevant. Even strong proponents of infant circumcision contend that the absolute likelihood of clinically important, difficult-to-resolve surgical complications associated with circumcision is "low," regardless of the age at which the procedure is performed.[3] Given such a low baseline risk, according to the proponents, the existence of a relative risk reduction in the incidence of adverse events in infancy compared to adulthood is unlikely to be morally decisive. Instead, as the U.S. Centers for Disease Control and Prevention (CDC) states, "Delaying male circumcision until adolescence or adulthood obviates concerns about violation of autonomy" such that any medical disadvantages associated with such a delay "would be ethically compensated to some extent by the respect for the [bodily] integrity and autonomy of the individual."[4]

NOTES

Materials in this box are adapted from B.D. Earp, "Male Circumcision: Who Should Decide?" *Pediatrics* 37, no. 5 (2016): e-letter; B.D. Earp, "Do the Benefits of Male Circumcision Outweigh the Risks? A Critique of the Proposed CDC Guidelines," *Frontiers in Pediatrics* 3, no. 18 (2015): 1-6.; B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56.

1. A. McMath, "Infant Male Circumcision and the Autonomy of the Child: Two Ethical Questions," *Journal of Medical Ethics* 41, no. 8 (2015): 687-90, 689.

2. H.A. Weiss et al., "Complications of Circumcision in Male Neonates, Infants and Children: A Systematic Review," *BMC Urology* 10, no. 2 (2010): 1-13; J.S. Svoboda and R.S. Van Howe, "Circumcision: A Bioethical Challenge," *Journal of Medical Ethics* 40, no. 7 (2013): e-letter.

3. B.J. Morris and E.C. Green, "Circumcision, Male," *Blackwell Encyclopedia of Health, Illness, Behavior, and Society* (Hoboken, N.J.: Wiley-Blackwell, 2014).

4. U.S. Centers for Disease Control and Prevention, "Background, Methods, and Synthesis of Scientific Information Used to Inform the Draft Recommendations for Providers Counseling Male Patients and Parents Regarding Elective Male Circumcision and the Prevention of HIV Infection and Other Adverse Health Outcomes," *U.S. Centers for Disease Control* (2014): 1-61, 39-40.

activities that require manipulation of the foreskin, or to the embodied state of genital intactness (that is, having a surgically unmodified penis).[23] Compared to men who assign a neutral or negative value to the foreskin, perhaps due to differing beliefs or cultural norms, the former are at a far greater risk of losing a good to circumcision: nearly 100 percent for the above-mentioned factors.[24] The magnitude or importance of that risk, in turn, depends on how much value a man places on such factors, which is not something that can be known before he is mentally mature.

Consider, for instance, a recent study of 196 sexually active Canadian adults that found that men who have sex with men (MSM), compared to heterosexual females, "indicated a strong preference toward intact penises for all sexual activities assessed and held more positive beliefs about intact penises."[25] This finding suggests that parents who authorize an elective circumcision for their infant son may risk differentially affecting his future sexual enjoyment depending upon his sexual orientation—something that will not be apparent until years later (see box 2 for further discussion).

To summarize, assessments of the comparative worth or weight of particular benefits and risks come down in large part to what one values or prefers. In asserting that the benefits of circumcision outweigh the risks, therefore, the AAP Task Force appears to have substituted its own subjective preferences and

BOX 2. Dealing with Uncertainty About Infants' Future (Bodily) Preferences

Not knowing a child's future preferences poses a challenge to parental and clinical decision making with respect to a wide range of potential pediatric interventions. When it comes to surgeries that permanently alter the body (for example, by removing nonregenerating tissue), it is sometimes pointed out that, whatever choice they make, parents will foreclose at least one future option for their child. Specifically: "parents who decide in favor of early surgery close off the child's future ability to make his own decision regarding surgery . . . while parents who refrain from early surgery close off the option for the [child] to undergo the surgery *during infancy or early childhood.*"[1]

Are these cases symmetrical? Circumcision provides a good illustration. If a noncircumcised adult is considering circumcision, for whatever reason, he can perform his own risk-benefit analysis of the surgery, taking into account his known preferences and the fullness of his social, sexual, and other circumstances. If he then chooses circumcision, he will be secure in the knowledge that he has done so voluntarily, undertaking a certain amount of risk to achieve a desired outcome. In other words, the adult with unmodified genitals—who now prefers that they be altered—has an option available with which to satisfy the preference, even if it is not ideal from his current perspective. By contrast, the man whose early circumcision was not desired, and is now a cause of significant distress, has no comparable remedy. He may attempt artificial foreskin "restoration"—if he has enough remaining penile skin to do so—but this may take years to accomplish, and the result will be a mere approximation of a prepuce, lacking the original tissue and nerve endings. Thus, it appears that the two cases are not symmetrical. In the deferred surgery case, there is far greater leeway for the individual to rectify an undesired situation.

Now, it could be argued that the noncircumcised man who wishes he were circumcised cannot truly satisfy his preference either. He may wish, for example, that the surgery had already taken place, perhaps in infancy, so that he would not now have to face the inconvenience. In this respect, he is not unlike the adult female in a similar social context who decides to undergo elective labial surgery for what she considers to be cosmetic reasons. Perhaps it would have been better—from her current perspective—to have undergone the procedure shortly after birth, so that she likewise would not have to face it now. But very few people in Western medicine would take this possibility as an argument in favor of neonatal labiaplasty. Indeed, such statements as "she won't even remember it," "she'll heal faster," "her future sexual partners will find her genitals to be more appealing," and "it's relatively less risky at this age" (see box 1)—all of which are commonly invoked in defense of infant male circumcision—would be considered problematic. The expectation thus appears to be that girls should be able to make such personal decisions for themselves when they are older and can understand what is at stake.

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Materials in this box are adapted from text in the essay "Circumcision, Sexual Experience, and Harm," which should be consulted for primary source citations; B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56.

1. A. Carmack, L. Notini, and B.D. Earp, "Should Surgery for Hypospadias Be Performed before an Age of Consent?" *Journal of Sex Research* 53, no. 8 (2016): 1047-58, 1057.

values for the unknown, individually and culturally variable preferences and values of future boys and men. It is for this reason that careful consideration of the influences that may have played into those subjective factors is needed.

The Charge of Cultural Bias

Noting that the conclusions of the AAP Task Force were "far from those reached by physicians in most other Western countries,"[26] the authors of the international critique raised the prospect of cultural bias[27] as a possible explanation: "Seen from the outside, cultural bias reflecting the normality of nontherapeutic male circumcision in the United States seems obvious."[28] They went on to state that in "Europe, Canada, and Australia, where infant male circumcision is considerably less common than in the United States, the AAP report is unlikely to influence circumcision practices," because again, "the conclusions of the report and policy statement seem to be strongly culturally biased."[29]

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Recent events appear to support this prediction. For example, the 2015 policy on newborn circumcision from the Canadian Pediatric Society, which has historically endorsed the position of the AAP, instead rejected it, failing to conclude that the benefits of infant circumcision outweigh the risks.[30] Similarly, upon revisiting its 2010 policy in light of the AAP findings, the Royal Australasian College of Physicians reaffirmed its view that "the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand."[31]

In addition, the president of Germany's pediatric society, the Berufsverband der Kinder- und Jugendärzte, stated in a government hearing that "there is no reason from a medical point of view to remove an intact foreskin from underage boys or boys unable to give consent," adding that "the statement from the AAP [has] been graded by almost all other pediatric societies and associations worldwide as being scientifically untenable."[32] And in 2016 the Danish Medical Association released a statement characterizing nontherapeutic male circumcision as being sufficiently risky that it should "only be performed on children when there is a documented medical need."[33]

Nevertheless, the AAP Task Force contested the charge of cultural bias in a response piece. The critical passage from their reply is as follows: "All of [our critics] hail from Europe, where the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis. In contrast, approximately half of US males are circumcised, and half are not. Although that heterogeneity may lead to a more tolerant view toward circumcision in the United States than in Europe, the cultural 'bias' in the United States is much more likely to be a neutral one than that found in Europe, where there is a clear bias against circumcision."[34]

Our aim for the rest of this article is to assess this response by the AAP Task Force. Was the task force successful in dispelling the charge, levied by its international critics, that its evaluation of the medical literature may have been unduly influenced by cultural or other extrascientific factors? We consider the key claims of the AAP Task Force in turn.

DISCUSSION

The first claim of the AAP Task Force concerns differing cultural norms surrounding circumcision between the U.S. and Europe. In this context, we begin by correcting the assertion that all of the authors of the international commentary "hailed from Europe." In fact, one of the signatories was the Canadian pediatrician Noni MacDonald, a member of the Canadian Academy of Health Sciences, founding editor of *Pediatrics & Child Health*, and the first woman to become a dean of medicine in Canada.[35] However, the other signatories were indeed from Europe, where, according to the AAP Task Force

members, "the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis."[36] This claim inspires two observations that require further discussion.

Norms, Values, and Terminology

First, the AAP Task Force uses the term "uncircumcised" to describe whole or intact male genitalia. All normally developing boys are born with a foreskin, and most boys and men around the world do not have a surgically modified penis.[37] Despite this fact, the term "uncircumcised" frames circumcision as the default status, and recasts the natural penis as the linguistically marked category.[38] For a point of comparison, the AAP does not refer to infant girls' vulvae as "unlabiaplastied."[39] In other words, the choice of terminology employed by the AAP Task Force appears to reflect the prevailing cultural assumption(s) under which it was operating: namely, that the normative status for males is to be circumcised, rather than genitally intact.

The second observation has to do with the AAP Task Force's reference to a "cultural norm" in Europe, which "clearly favors" the intact penis. Given the comparative rarity of nontherapeutic circumcision outside of minority religious groups in European countries,[40] it is certainly possible that a norm exists that favors surgically unmodified male genitalia. However, a similar "norm" exists throughout Europe that favors surgically unmodified female genitalia, as well as surgically unmodified body parts generally. In other words, it is unclear whether the lack of a tendency to excise nondiseased tissue, whether from the body of a child or an adult, is the sort of thing that should be described as a "norm," unless all nonperformed actions are eligible to be called "norms" if their nonperformance is typical in some group.

But let us simply grant that there is a "cultural norm" in Europe that "clearly favors" the intact penis. It does not follow from this, as the AAP Task Force implies, that its European counterparts are "biased" against circumcised penises. This is because, whatever the wider cultural norm concerning circumcision happens to be in Europe, there is also a relevant *medical* norm, not only in Europe, but also in the U.S., which holds that (1) medically unnecessary surgeries should generally not be performed on healthy children, and (2) surgery should almost always be a last resort, rather than a first resort, for managing or preventing disease.[41]

Thus, it is not just a matter of two local, arbitrary cultural norms being pitted against one another. Rather, the *shared* norms governing responsible medical practice in Western countries are typically "biased" against such nontherapeutic procedures. Accordingly, by suggesting that a cultural norm that favors the nontherapeutic surgical modification of a child's penis "is somehow on par with, or just as reasonable as, a medical-ethical norm favoring the avoidance of such surgery unless it is absolutely required," the AAP Task Force could be seen as revealing its cultural hand.[42]

Indeed, only the U.S. and Israel, among Western developed nations, maintain a majority practice of routine neonatal male circumcision.[43] In the latter case, the explanation for the practice is predominately religious, being derived from a perceived scriptural mandate along with a historically rooted sense of shared Jewish identity, of which male circumcision in infancy is a symbol.[44] The historical process by which ritual circumcision became "medicalized" in the U.S.—and later entrenched as a wider cultural practice—has been documented elsewhere.[45] The point here is that the unique position of the U.S. medical establishment in favoring the nonreligious circumcision of male newborns suggests that it is the AAP Task Force, rather than its critics, that bears the greater burden in justifying its background cultural norms.

This view is further supported by research on "cultural cognition." As Yale psychologist Dan Kahan explains, a major tenet of cultural theory is that "individuals gravitate toward perceptions of risk that advance the way of life to which they are committed."[46] According to this view, moral concern guides not only response to risk, but also the basic faculty of risk perception.[47] Thus, each way of life and associated worldview "has its own typical risk portfolio," that "shuts out perception of some dangers and highlights others" in ways that selectively sustain the norms and practices to which one is most deeply devoted.[48]

With respect to the debate over cultural bias between the members of the AAP Task Force and their international critics, it is difficult to see how "not circumcising" would meet the criteria for being a distinctive component of a "worldview" or a "way of life" that might directly influence the risk perception of the mostly European group of doctors. In other words, while circumcising infant boys is (1) an entrenched birth custom in American culture that is deeply tied up with implicit and explicit notions of "good parenting,"[49] and (2) a central ritual practice within Judaism and Islam, it is less clear in what sense "not circumcising" is (or could be) either an entrenched birth custom or a central ritual practice in "European" culture. In fact, it is by defi-

nition not a practice, but the lack of one. Moreover, this lack of practice is not closely associated with "European" cultural identity in any specific, coherent sense: rather, it is simply one of a large number of rituals and other practices that is not particularly common in Europe.

A Child's Right to Physical Integrity

To see how anomalous the U.S. medical community's support for newborn male circumcision is, it may be useful to consider the nearest anatomical analog, namely, the nontherapeutic surgical modification of female genitalia (for example, for cultural or religious reasons).[50] Not only is such surgery normatively discouraged before an age of consent in Western medicine, but it is strictly forbidden by national and international law, primarily on the grounds that it violates a child's right to physical integrity.[51] According to the World Health Organization (WHO), this right is violated (see box 3) by all medically unnecessary alteration of the female genitalia, no matter how superficial or hygienically performed.[52] As a consequence, Western prohibitions of such genital alteration extend even to those forms that are significantly less invasive than male circumcision. This includes ritual "pricking" of the clitoral hood—FGM WHO Type 4—that does not remove tissue, rarely leads to long-term adverse health consequences, and is often carried out by trained healthcare providers in sterile settings.[53]

To explain this apparent discrepancy in treatment regarding male versus female children, the AAP Task Force argues that "the right to physical integrity is easier to defend in the context of a procedure that offers no potential benefit."[54] This is presumed to be the case for nontherapeutic female genital cutting (FGC). However, this response deserves closer scrutiny.

First, the "potential benefit" to which the AAP Task Force refers in this sentence is "medical benefit" or "health benefit." However, in the case of male circumcision, the AAP Task Force shows a willingness to consider potential nonmedical—that is, sociocultural—benefits as well, stating that "it is reasonable to take these nonmedical benefits . . . into consideration when making a decision about circumcision."[55] As the British Medical Association (BMA) notes, "Where a child is living in a culture in which circumcision is [believed to be] required for all males, [exclusion] may cause harm by, for example, complicating the individual's search for identity and sense of belonging."[56] However, the BMA also notes that "very similar arguments are also used to try and justify very harmful cultural procedures, such as female genital mutilation or ritual scarification. Furthermore, the harm of denying a person the opportunity to choose not to be circumcised must also be taken into account, together with the damage that can be done to the individual's relationship with his parents and the medical profession if he feels harmed by the procedure."[57]

Second, it may never be known whether a minor, sterilized form of FGC—such as neonatal labiaplasty—would offer a "potential benefit" in the sense implied by the AAP Task Force, because it would be illegal to conduct a properly controlled

BOX 3. A Child's Right to Physical Integrity: How Should it Be Applied?

A child's right to physical integrity is not absolute. Interventions that are clearly in the child's best interests, especially if they cannot be delayed until the child is competent to consent or decline (for example, emergency surgery to correct a heart defect) are universally agreed to be permissible. Trivial, superficial, or easily reversible interventions (for example, getting a haircut), or more serious, risky, or permanent interventions to which the child can give age-appropriate consent (for example, cosmetic orthodontia, participating in sports), are also usually permissible. However, the mere fact that children are pre-autonomous and cannot validly consent to most interventions, "medical" or otherwise, that affect their bodies (for example, being forced to eat their vegetables) does not entail that parents have an unfettered right to authorize all such interventions (for example, child sexual abuse). The less clear it is that a bodily encroachment is, all things considered, in the child's best interests (taking into account the child's interest in being able to autonomously make important self-affecting decisions in the future), the more likely it is that the child's bodily integrity rights are being impermissibly violated.

NOTES

Some material in this box is adapted from B.D. Earp, "The AAP Report on Circumcision: Bad Science + Bad Ethics = Bad Medicine," *Practical Ethics*, 29 August 2012, *http://blog.practicalethics.ox.ac.uk/2012/08/the-aap-report-on-circumcision-bad-science-bad-ethics-bad-medicine/*.