PARENTAL AUTHORITY, CIRCUMCISION AND THE CHILD'S RIGHT TO AN OPEN FUTURE

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Parental authority, circumcision and the child’s right to an open future:
Will the real Dena Davis please stand up?

In April 2010 the American Academy of Pediatrics released a new policy on
female circumcision that accepted the right of parents to impose, and
recommended that its members perform, mild forms of genital cutting on girls,
such as a “ritual nick” to the clitoris. The rationale was to show respect for the
beliefs of immigrant parents whose religion or culture required female genital
cutting and to reduce the risk that daughters would be taken back to their home
country for a more severe operation. The suggestion caused some astonishment
among anti-circumcision, women’s rights and, eventually, obstetrical associations,
and it was rapidly withdrawn after widespread protest; but the author of the
policy, Dena Davis, has defended it, arguing that it is very difficult to maintain a
blanket ban on all forms of female genital mutilation (FGC) when the law in the
United States and most other countries is completely silent on circumcision of
boys – a more damaging surgical intervention than a nick – and the practice
remains common. As reported by the Economist, Professor Davis argues that “in
America at least, it is not acceptable to criminalise all female genital cutting (FGC)
while adopting a relaxed stance to the male sort. She suspects that by allowing
male circumcision while forbidding even a symbolic cut on girls, Western
countries show respect for only those religious and cultural practices with which
they are already comfortable.”

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Davis is suggesting that if physicians defer to the wishes of Jewish and Muslim parents to have their boys circumcised, it is discriminatory to refuse the wishes of some African and Muslim parents to have their girls circumcised. This is a controversial position for a bioethicist to adopt, and it raises two obvious questions: First, is it a correct interpretation of bioethics and an appropriate deployment of medical resources for doctors to give the cultural practices of the parents priority over the welfare of the child? Secondly, if Professor Davis is concerned about discrimination and wishes to promote equal treatment on the basis of both gender and religion, one wonders why did she not recommend evening up the scales by reducing the risk to boys – advocating a “ritual nick” on their penis, for example, instead of foreskin amputation. Giving boys a fraction of the protection already given to girls would do more for both children’s rights and gender equity than reducing the protection given to girls. The position Davis adopts is at first surprising, for in previous publications she has shown herself quite sensitive to both the rights of children and the wrongs of circumcised boys, and has warned that the American policy of criminalising all forms of FGC while allowing open slather on all forms of circumcision (male genital cutting) contravenes two clauses of the United States Constitution: the First Amendment, which prohibits Congress from making laws to establish a religion or to prevent the free exercise thereof; and the Fourteenth Amendment, which gives all American citizens equal protection under the law. The former is invoked by Jewish, and increasingly Muslim, citizens as a guarantee of their right to circumcise boys, but why should it not also be invoked by African or Muslim parents whose religion prescribes circumcision of girls? The right to equal protection has been deployed to ensure that women share the rights and
protections enjoyed by men, but it also implies that men should share the rights and protections enjoyed by women. A review of Davis’s publications reveals that the AAP’s short-lived policy on FGC was the culmination of a campaign to change American practice that began in 2001, when she published an article defending the “Seattle compromise”\(^2\) and recommending both the “ritual nick” and some minor regulation of male circumcision.

What is puzzling about these suggestions is that until 2001 Davis was known as an advocate of children’s rights and as the populariser of a principle known as the child’s right to an open future, adapted from the legal philosopher Joel Feinberg. In previous studies she had argued forcefully that parents were not morally entitled to make decisions for children that foreclosed their future options or which sought to force them into roles that were inconsistent with their natural inclinations and potential. Defending the rights of parents to circumcise both boys and girls, however mildly in the latter case, does not sit well with such a liberal perspective. In this paper I wish to describe Davis’s original philosophical position, discuss her writings on circumcision, and evaluate the extent to which her analyses of and recommendations on male and female genital cutting are consistent or inconsistent with the principles she has advanced.

Part I: Dena Davis and the child’s right to an open future

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\(^2\) The Seattle Compromise was a proposal by doctors at the Harborview Medical Center to perform a mild form of genital cutting, referred to as a “ritual nick” or scratch, on girls born to immigrant parents from Somalia, whose home culture prescribes circumcision of both males and females. The stated aim was to protect the girls by forestalling attempts by the parents to take the girls back to Africa for more severe forms of cutting. The plan was abandoned after intense local opposition and warnings that it would breach the new Federal statute prohibiting any form of female genital cutting. The plan is defended and the affair described in detail by Doriane Coleman, The Seattle Compromise: Multicultural Sensitivity and Americanization, 47 DUKE L.J. 717 (1998).
Davis established her reputation as an authority on bioethics with a series of publications on genetic counselling, in which she argued that it was ethically wrong for parents to use new techniques of genetic manipulation to ensure that a child was born with the genetic traits and particular characteristics that they desired (“designer babies”, as they are popularly known).³ This was wrong because it denied autonomy and choice to the child: while genetic counsellors should respect the autonomy of the parents, they should complement this with respect for the potential autonomy of the future child. Davis based her position on the concept of the child’s right to an open future as developed by Joel Feinberg, whose essay on the subject she follows closely. Feinberg proposed that in the family context there were four kinds of rights: rights that adults and children have in common (e.g. the right not to be killed); rights held only by children or dependent adults (e.g. food, shelter, protection); rights that can be exercised only by adults or older children (e.g. to choose or reject a religion); and, the type that matters here, “rights in trust”, defined as rights that should be saved for the child until he is an adult. These rights are fragile, for as Davis comments, they can be “violated by adults now, in ways that cut off the possibility that the child when he or she achieves adulthood, can exercise them.” A striking example is the right to reproduce. Even though a child is not physically capable of exercising this right, or when older not socially capable, it is a right that the child will have as an adult. It follows that “the child now has the right not to be sterilized, so that the child

³ A full list of Professor Davis’s publications is at the Cleveland Marshall College of Law staff pages. As at 24 June 2010 she listed the AAP’s 2010 FGC policy, Policy Statement – American Academy of Pediatrics: Female Genital Mutilation, among her publications: http://www.law.csuohio.edu/faculty/publications/search.php
might exercise the right to reproduce in the future. Rights in this category virtually all the important rights we believe adults have, but which must be protected now to be exercised later."

Davis notes that in a liberal multicultural society there will be conflict between the sub-cultures that impose restrictions on their members and society’s belief in individual rights and equal opportunity. While she believes that communities that deny individual choice must be tolerated, this is on the proviso that society recognises “the right of individuals to choose which communities they wish to join and leave if they have a mind to”. The problem for children is that they have no choice as to what kind of community, or indeed what kind of parents, they are born to; it follows that while society recognises the right of parents to bring up children in accordance with their own values and beliefs, that right is not absolute. Davis follows Feinberg in supporting the United States Supreme Court’s decision that compelled Jehovah’s Witnesses to allow their sick or injured children to receive blood transfusions, even though this violated deeply held religious beliefs and their own wishes. Likewise, she criticises the Court for its decision in the Yoder case (1972) that allowed Amish parents to withdraw their children from school two years earlier than required by State law. Indeed, she goes further than Feinberg, who was inclined to agree with the judgement inasmuch as the harm of the Amish community disappearing would be greater than the harm experienced by the children in missing their final two years of education. Davis criticises the

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4 Dena Davis, Genetic Dilemmas: Reproductive Technology, Parental Choices and Children’s Futures (London and New York: Routledge, 2001), 24
5 Genetic Dilemmas, 30
6 Genetic Dilemmas 24
decision for the same reason as James Dwyer, well known for his sweeping
critique of the very concept of parental rights:\textsuperscript{7} because the decision ignored the
interests of the children: “the justices ducked the question of whether the liberal
democratic state owes all its citizens, especially children, a right to a basic
education that can serve as a building block” for the varied and unpredictable
decisions that a child may wish to make as an adult. Davis is concerned that if the
child misses out on those crucial two years of schooling, he will never be able to
catch up if he later decides that he does not want to follow the Amish lifestyle, but
will be forced to remain there for ever, unhappy and resentful.\textsuperscript{8}

Following Lainie Friedman Ross, Davis makes the obvious point that parental
authority, “the freedom to form and raise a family according to their own
conception of the good”, may conflict with the future autonomy of the children to
“implement their own life plans” when they reach adulthood.\textsuperscript{9} Arranged
marriages, for example, would be a violation of the child’s right to a basic tenet of
adult autonomy: the right to choose whether and whom to marry. Davis
comments that arranged marriages are illegal in the United States, but that even if
they were not “they should still be rejected on ethical grounds.”\textsuperscript{10} But what is less
obvious and perhaps surprising in view of some of her later remarks about
circumcision, is that when it comes to intergenerational conflict she sides with
individual choice and the child’s right to autonomy:

\textsuperscript{7} James Dwyer, Parents’ Religion and Children’s Welfare: Debunking the Doctrine of Parents
Rights, 82 Cal. L. J. 1371 (1994)
\textsuperscript{8} Genetic Dilemmas, 24-7
\textsuperscript{9} Lani Friedman Ross, Children, Families and Health Care Decision Making (New York: Oxford,
1998), 3
\textsuperscript{10} Genetic Dilemmas, 28
I believe the autonomy of the individual is ethically prior to the autonomy of the family. … Where the family exercise of its rights to “form and raise a family according to [its] own conception of the good” threatens to extinguish the abilities of children to choose their own lives when they become adults, I believe that the family behaves wrongly and that liberals ought to support the (future) rights of the children.\textsuperscript{11}

Davis recognises that it is precisely in matters affecting their children that groups are most jealous of their prerogatives. Although she acknowledges their right “to shape the values and lives of their children”, she also maintains that when that shaping takes the form of a radically narrow range of choices available to the child when she grows up – when it impinges substantially and irrevocably on the child’s right to an open future – then … liberalism requires us to intervene to support the child’s future ability to make her own choices about which of the diverse visions of life she wants to embrace.\textsuperscript{12}

In her case studies Davis focuses on the harm done to children when parents limit the range of choices available to them when they become adults, covering both situations where a limitation is due to a physical disability and those where intensified parental expectations made possible by new technologies enable the production of children with specific desired characteristics, such as gender. Thus, she argues that it is wrong for deaf parents to take steps to ensure that they have a deaf child because deafness significantly limits the child’s future options and is thus a harm. On the same basis, she argues that pre-conception selection of the child’s sex may cause harm because it enhances the parents’ gender expectations and makes it more difficult for the child to escape gender stereotypes.\textsuperscript{13}

The example of deaf parents taking deliberate steps to ensure that that have deaf children “because they will be like us” is of particular interest because it is closely

\textsuperscript{11} Genetic Dilemmas, 31
\textsuperscript{12} Genetic Dilemmas, 31-2
\textsuperscript{13} Genetic Dilemmas, 47-8
analogous to the reason why many parents want their children circumcised. The analogy is doubly valid because although most people would regard deafness as a harm (it is recognised as a disability), some deaf people regard their condition as a linguistic identity or minority culture that ought to be accorded the rights and privileges of other minority cultures in accordance with the multicultural promise. Davis is at some pains to combat this argument and to show that deafness really is a harm, and thus that deliberately creating a deaf child is a cruel act that denies autonomy to the future adult (who might well prefer to be able to hear) and deprives him of the many additional opportunities available to people with all five senses. “If deafness is a culture rather than a disability,” she writes, “it is an exceedingly narrow one” that drastically narrows a person’s life options and probably condemns them to low-paid jobs and a limited social life. And she continues:

If deafness is a disability that substantially narrows a child’s career, marriage and cultural options, then deliberately creating a deaf child counts as a moral harm because it so dramatically curtails the child’s right to an open future. … If deafness is a culture … then deliberately creating a deaf child who will have only limited options to move outside of that culture also counts as a moral harm. 14

Davis makes the important point that there is a difference between moral conditioning and physically marking the body. While an individual may never completely throw off the influences of his socialisation and upbringing, many children challenge and reject the values of their parents and set themselves on a very different course in adolescence and adulthood. As she expresses it, although the transformation would never be complete and traces of her childhood experience would always remain, “a person raised as a secular Jew could decide to

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14 Genetic Dilemmas, 64
become a Roman Catholic.” But the situation is quite different when irreversible changes have been made to the body:

When choices are irreversible, such as whether a person will be hearing or deaf, or when they can be postponed until the child is old enough to decide for herself, such as whether or not to be tested for adult onset diseases, then good parenthood consists in allowing the child the greatest possible latitude of choice when that child reaches adulthood.\(^\text{15}\)

While it may very well be possible to change one’s mind about religion or other values, it will not be possible to erase permanent physical marks.

The concept of harm is central to Davis’s discussion of the relation between parental authority and children’s autonomy. Few would agree that parents are entitled to harm their children, but there is much disagreement as to what constitutes harm. Davis offers the paradoxical proposition that to be born with only one arm is not a harm if the alternative is not to be born at all. This is a debatable rather than a self-evident point, and the case might look different if you were born with no legs, but it illustrates her central contention: life is a matter of choices, and, like Jack Aubrey, we should always choose the lesser of two weevils. Thus, if the alternatives are between being born deaf and not being born at all it is better to be born deaf. But this is only true, Davis continues, so long as the outcome is accidental: to be born deaf as the result of deliberate action by one’s parents is certainly a harm, because then the alternatives are between being born deaf and being born with normal hearing. Although they may think they are doing the right thing, the parents have chosen the greater evil, which denies the child the advantages that depend upon the capacity to hear. This is ethically wrong, not primarily because it means a deaf child will be likely to suffer socio-

\(^{15}\) Genetic Dilemmas, 34
economic deprivation, but because it denies choice: “The primary argument against deliberately seeking to produce deaf children is that it violates the child’s own autonomy and narrows the scope of her choices when she grows up; in other words, it violates her right to an ‘open future’.”

The picture that emerges from a study of Davis’s writings on genetic dilemmas is of somebody deeply committed to children’s rights and willing to champion them against both the authority of parents and the unreasonable demands of the culture into which they happened to be born. “When group rights would extinguish the abilities of individuals within them to make their own life choices, liberals ought to support the individual against the group,” she writes. “This is especially crucial when the individual … is a child, who is particularly vulnerable to adult coercion and therefore has special claims on our protection.” Indeed, where there is conflict between cultural diversity and individual choice, “I support the right of individual autonomous choice,” a position Davis underlines with a reference to Martha Nussbaum’s concept of human rights as capabilities, and she quotes her description of Capability No. 10: “Being able to live one’s own life and nobody else’s. This means having certain guarantees of non-interference with certain choices that are especially personal and definitive of selfhood, such as choices regarding marriage, child-rearing, sexual expression, speech and employment.”

In later formulations, Nussbaum’s capabilities also include a right to physical integrity and associated entitlement to the realisation of one’s full sexual potential.

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16 “Genetic dilemmas and the child’s right to an open future”, 27 Hastings Center Report 7, 9 (March 1997)
17 Genetic Dilemmas, 31
18 Genetic Dilemmas, 29
Capability No. 3, “Bodily integrity”, is defined as “Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.” And under capability 7B, “Affiliation”, individuals have the right to “the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others.”

Following this line of thought, Davis endorses the Kantian principle that individuals should always be treated as ends, never as a means to the fulfilment of others, and states explicitly that this principle applies to the relations between parents and children as much as among adults:

Deliberately creating a child who will be forced irreversibly into the parents’ notion of “the good life” violates the Kantian principle of treating each person as an end in herself and never as a means only. … Good parenthood requires a balance between having a child for our own sakes and being open to the moral reality that the child will exist for her own sake, with her own talents and weaknesses, propensities and interests, and with her own life to make. Parental practices that close exits virtually forever are insufficiently attentive to the child as end in herself.

Children should be allowed to make their own lives and fulfil their own dreams.

Concluding her analysis of the child’s right to an open future and its application to the opportunities offered by new techniques of genetic manipulation, Davis proposes the following rule: “Parents ought not deliberately to substantially constrain the ability of children to make a wide variety of life choices when they

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19 Martha Nussbaum, Frontiers of Justice: Disability, Nationality and Species Membership (Cambridge, Mass: Harvard University Press 2006), 76-7
20 Dena Davis, Genetic Dilemmas and the Child’s Right to an Open Future, Hastings Center Report, 9
become adults.” Much disagreement may arise from an adverb such as “substantially”, but having made such a strong case for a child’s right to make his or her own choices Davis would be expected to apply the open future principle to other areas of bioethical debate. It therefore comes as a surprise to find that when she turns her attention to circumcision the concept makes no appearance at all.

Part II: The open future principle, parental authority and physical alterations

The question we must now consider is whether the open future principle is applicable to permanent physical alterations that parents may wish to impose on children – and indeed that children may wish to impose on themselves – such as branding, tattoos, piercing and various forms of genital cutting. In this inquiry it will be helpful to return to Feinberg’s elucidation of the concept and to other scholars who have been inspired by it, such as James Dwyer. Feinberg calls the rights implied by the open future “rights in trust” and defines them as the sort of rights an autonomous adult would have, but which the child is too young to exercise. They are “rights that are to be saved for the child until he is an adult, but which can be violated ‘in advance’ before the child is even in a position to exercise them.” Such violations mean that when the child does grow up he will find that certain options will already be closed to him. An example would be the right to walk down the footpath, certainly held by an infant even though he cannot yet walk, because as an adult he will be able to walk. This right would be violated

21 Genetic Dilemmas, 66
before it could be exercised by cutting off his legs (or, one might add, otherwise crippling him.) Feinberg points out that since children are not capable of defending their own future interests against infringement by their parents, this role must be performed by others, usually the state in its capacity as *parens patriae*. American courts have long held that the state has a “sovereign power” of guardianship over minors and incompetent adults, which gives it the authority to look after the interests of those who are incapable of protecting themselves.²³ Although parents are generally entitled to the custody of their children and to bring them up in accordance with their own values, that right is constrained by limitations relating to physical integrity, medical treatment and education:

> If a parent … has a legally recognised right to the custody of his own child then we should expect courts to infringe that right only with the greatest reluctance and for the most compelling reasons. One such reason would be conflict with an even more important right of the child himself. Parents who beat, torture or mutilate their children, or who wilfully refuse to allow them to be educated, can expect the state … to intervene.²⁴

Elsewhere Feinberg suggests that refusal to provide appropriate medical care, or insistence on providing inappropriate or ineffective medical care would also be grounds for state intervention. On this basis, if circumcision could be considered mutilation or inappropriate medical care, then the state would be entitled to intervene to protect children from parental desires to circumcise them, as indeed it has done in the case of girls.

None of this means that the child must be left completely free to do whatever he likes or that he should be immune from parental discipline and protection.

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²³ Feinberg 79
²⁴ Feinberg 88
Feinberg points out that paternalism in the raising of children is both inevitable and proper because there will always be times when a child, even an adolescent, cannot properly evaluate his long-term interests, and when he must be “protected from his own immature and unformed judgement”. Feinberg notes that every child is a potential adult, and it is precisely that future adult whose autonomy and capacity for later choice must be protected now. Adults are entitled to gratify harmful whims when they affect only themselves, but it will often be necessary to protect children from making rash decisions: “Respect for the child’s future autonomy as an adult often requires preventing his free choice now.” Applying this principle to the real world of childhood, it is perfectly legitimate for parents to prevent children from eating too many sweets or raiding the cocktail cabinet; to make them eat their vegetables and go to the dentist regularly; to refuse requests to get tattoos or nose rings; to refuse a girl’s request for a tubal ligation or a boy’s for a vasectomy; and to refuse a boy’s request to get circumcised because his envious buddies on the swim team tease him about his foreskin. The principle in all such cases is to preserve children’s future options and prevent them from making irreversible decisions they may later regret. The converse does not apply: just because parents have the right to prevent their children from committing follies such as a large tattoo or a permanent genital alteration does not mean that they have the right to impose such alterations themselves.

The position of Davis in Genetic Dilemmas is remarkably similar to the arguments advanced by the legal and bioethics scholar James Dwyer, though he takes the

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25 Feinberg 89
26 Feinberg 78
“open future” principle a good deal further to question the very existence of parental rights over children. There is, however, no need to follow Dwyer all the way in order to agree with his argument that the open future principle restricts the extent to which parents may indoctrinate their children and completely rules out the imposition of permanent physical damage, such as that resulting from non-therapeutic and medically unnecessary surgeries like circumcision. In a paper published in 1994 Dwyer sought to establish the legal principle that nobody has an unfettered right to control the life of another person, no matter how intimate the relationship.27 In making this case, he traverses much of the ground covered by both Feinberg and Davis, and cites the well known judgement in Prince v. Massachusetts – and not only the oft-quoted reference to parents not having the right to martyr their children, but also the more interesting and relevant passage that precedes this: the state’s authority to restrict parental control of children “is not nullified merely because the parent grounds his claim to control the child’s course of conduct on religion or conscience. … The right to practise religion does not include liberty to expose the community or the child to communicable diseases or the latter to ill-health or death.”28 Dwyer also cites the familiar case in which the US Supreme Court held that Jehovahs Witnesses could not prevent hospitals from giving their children life-saving blood transfusions, thereby establishing that while the Free Exercise clause give parents the right to “train and indoctrinate their children in religious matters”, the placing of a child in danger was not a form of training and thus not constitutionally protected. Taken together these cases impose broad limits on the extent of parental authority in religious

27 Dwyer, Parents Religion, 1373
28 Dwyer, Parents Religion, 1380-81
matters: “these rights did not include a right to endanger seriously a child’s physical health or safety”; parental Free Exercise rights were “limited to indoctrinating their children and involving them in [presumably non-dangerous] religious practices.”29 If these principles were taken seriously and applied consistently, they would place a large question mark over any customary ritual that carried a known risk of infecting a child with a disease, or causing other forms of ill-health. Circumcision, like any surgical procedure, does carry such risks.

It will be recognised that these limits are generous and give parents very wide discretion over the raising of their children. Dwyer concedes that American courts have rarely taken the separate interests of children seriously and have confined themselves to preventing only the most serious varieties of ill-treatment, usually involving the risk of death or grave injury, such as the failure to provide needed medical care or insistence on “alternative” treatments. Because of what Dwyer regards as the excessive deference shown to religious belief in the USA, many states exempt even this requirement from their child abuse statutes, and parents who cause the death of their children through refusing valid medical care or insisting on bogus remedies, such as faith healing, must instead be prosecuted under manslaughter or other homicide statutes. Despite this, Dwyer points out in a later paper that

Court's have uniformly found it appropriate to order medical treatment for a child, over parents' objection that doing so violates their First Amendment right to the free exercise of religion, when treatment is necessary to prevent the child from dying.” Most courts have held that intervention is also appropriate when necessary to prevent “grievous

29 Dwyer, Parents Religion, 1382
harm” to a child, which one state court defined as “a significant impairment of vital physical or mental functions, protracted disability, permanent disfigurement, or similar defects or infirmities.”

If circumcision can be regarded as a permanent disfigurement, then it would also be categorised as “grievous harm” and thus a fate from which the state would be entitled to protect a child. Dwyer also cites a rare case in which the court showed a clear awareness of the distinct interests of parents and children and the separate personhood of the latter:

This special protection [in abuse and neglect legislation] should be guaranteed to all such children until they have their own opportunity to make life’s important religious decisions for themselves upon attainment of the age of reason. After all, given the opportunity when grown-up, a child may some day choose to reject the most sincerely held of his parents’ religious beliefs, just as the parents on trial here have apparently grown to reject some beliefs of their parents. Equal protection should not be denied to innocent babies, whether under the label of religious freedom or otherwise.

The case concerned the parents of a baby boy who contracted a bacterial infection for which they refused medical treatment, and from which he died. As Dwyer sums up the implication of this judgement, “the right to hold one’s religious beliefs, and to act in conformity with those beliefs, does not and cannot include the right to endanger the life and health of others, including his or her children.”

An objection sometimes raised to the proposition that children have rights is that they lack power to enforce them. It is true that most children are vulnerable and unable to invoke the institutional mechanisms that could protect them from an unwanted intervention, but this fact highlights the need to give them better protection. Indeed, it seems perverse to deny rights to those who need them most,

for as Michael Ignatieff has observed, a right is an assertion against power by one in a position of weakness.\textsuperscript{32} Recognising this, the state has often stepped in to protect the lives and bodies of incompetent adults and disabled children against family wishes, and if this is legitimate, how much more important must it be to protect those whose whole lives lie before them and whose undamaged bodies require no special care? Dwyer suggests that children should not have fewer rights than or be treated with less consideration than incompetent adults:

As in the case of adults who are mentally retarded or in a persistent vegetative state, courts could employ a substituted judgement procedure for imputing preferences to children. Under this approach the parents, acting as the agents for the child, would have to argue that their judgement is the same as the child would choose for him/herself if rationally able to do so, given the child’s existing desires, values, inclinations an needs, as well as likely future needs.\textsuperscript{33}

Dwyer acknowledges that infants and very young children would not have shown much evidence of preferences on any aspect of their lives, but does not regard this as invalidating the substituted judgement principle so long as there are reasonable grounds for determining what the incompetent person would choose if he or she were competent. This is where the open future principle can help. Whenever a child is too young to express preferences, the imperative is not to do anything irreversible that limits or shuts off future options. This principle would not prevent, say, dental care, since good teeth in adulthood are in the child’s long-term best interests, no matter how great the discomfort at the time or how much resistance he shows. We might also reasonably assume that if a child appreciated the discomfort of tooth decay and the disadvantages of losing teeth, he would choose to have them looked after properly. But the principle would prevent

\textsuperscript{32} Michael Ignatieff, Human Rights as Politics and Idolatry (Princeton University Press, 2001), 68-9

\textsuperscript{33} Dwyer, Parents Religion, 1430
amputation of body parts (unless essential for therapeutic purposes) because it is impossible to put them back later and when the child reaches adulthood, or even before, he may well regret their loss. As Dwyer comments

> It seems unlikely that any individual, upon reaching adulthood, would resent having had a range of options in matters of belief, lifestyle and health preserved for her during childhood. It seems reasonable to believe that she might want to make her own choices as an adult in accordance with the personal attitudes and ambitions she has developed, rather than having almost all options closed off to her just because her parents wished to determine her life for her.  

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Thus, a boy is far more likely to resent having been circumcised than having been left uncircumcised, because if left alone he can always get himself circumcised as an adult if that is what he wants. A boy who has been circumcised by his parents does not have this option and must live for ever with the choice that somebody else has made.

Let us now revisit Davis’s example of a couple who are deaf for non-genetic reasons and want their child also to be deaf. There is no possibility of this happening through the genetic lottery, so the mother exposes herself to an infection known to cause deafness in babies, such as German measles. In this case, Davis writes, it is easy to show that the child has been harmed. “Baby Ann had two possibilities: being born hearing or being born deaf. Her parents deliberately did something to ensure the latter condition. If being deaf is less desirable than being able to hear, then Ann has been harmed.”35 I suggest that this example is directly applicable to circumcision, since all boys are born with foreskins and thus have two possibilities – growing up with a foreskin or growing up without one –

34 Dwyer, Parents Religion, 1434
35 Davis, Genetic Dilemmas, 38
and only deliberate surgical intervention will produce the latter situation. To paraphrase Davis’s words, if being deprived of one’s foreskin is less desirable than having it, and thus preserving the choice of keeping or losing it, then the circumcised boy has been harmed. This point may be more contentious than the example of deafness, since circumcision promoters insist that boys are better off without it, and some men are vehement that they prefer to be circumcised. These considerations are not a problem, however, because whatever the circumcision promoters may claim, all the medical authorities that have issued a policy on routine (non-therapeutic) circumcision of minors agree that the benefits are dubious and, even if they exist, certainly not sufficient to justify imposition of the surgery on non-consenting children.36 Even if the “benefits” were certain rather than speculative, the decision could still safely be left until maturity, since all the significant ones (reduced risk of penile cancer, sexually transmitted infections and HIV) are not relevant until a boy becomes an adult. Even then the protective effect can be achieved by non-surgical means, such as good hygiene, safe sex and condom use. An adult male worried about HIV infection is entitled to reach the conclusion that the 50-60 per cent risk reduction perhaps provided by circumcision is preferable to the 90 per cent risk reduction given by condoms,37 but it is not, on the face of it, a decision that a rational person would be expected to


reach in the absence of pressure or incentives, and it is certainly not one that should be taken on behalf of sexually inactive children.

Respect for the open future principle would thus appear to require parents to leave their boys’ foreskins alone and let them make their own minds up about such an intimate personal choice when they reach the age of consent. Delaying circumcision until the child is mature enough to make an informed decision about it, which in most cases would not be until his mid- to late teens, is not only the soundest policy from an ethical point of view, but also the least-risk approach, in that it avoids the risks of both the surgery and the danger that the adult will regret and resent what was done to him as an infant or boy. The only justification for removing a functional and highly visible part of a sensitive organ such as the penis from a minor would be if there was a high risk that its presence would cause death or serious illness before the boy reached adulthood. No boy has ever died because his parents neglected to circumcise him, though many have died or suffered crippling injuries as a direct consequence of circumcision. If, for any reason, an adult male prefers to have a circumcised penis the open future principle ensures that he is free to make this decision for himself, and also that he will be able to select his own surgeon, style of cut and other details, thus maximising the likelihood that he will be happy with the outcome and reducing the likelihood of regrets.

The fact that very few men seek circumcision in adulthood suggests that if they had been offered the choice in infancy or childhood the vast majority would have
opted to retain their foreskin.\textsuperscript{38} Evidence of this is provided by a recent study of adult men in San Francisco, which found that even if there were proof that it would give them significant protection against AIDS, only 0.7 per cent of the men surveyed said they would agree to get circumcised.\textsuperscript{39} This point is admitted by circumcision promoters and explains why they are so insistent that circumcision must be performed in infancy, when a child is unable to resist. Brian Morris states that if the choice were left to them, many boys would make the “wrong” decision: “Parental responsibility must override arguments based on the rights of the child. Parents have the legal right to authorise surgical procedures in the best interests of their children”. When they are old enough to give legal consent males “are reluctant to confront such issues” and are neither “mature nor well-informed enough” to make the right decision for themselves. In other words, Morris concedes that if doctors waited until boys were mature enough to make up their own mind, most would not consent to the operation.\textsuperscript{40} Using the substituted judgement test, we may conclude that if an infant or child were rationally capable of assessing the relevant information and making a decision about circumcision, the vast majority would say no. Indeed, the Australasian Association of Paediatric Surgeons has stated that it is “opposed to male children being subjected to a procedure, which had they been old enough to consider the advantages and

\textsuperscript{38} The exception to this generalisation is in the unique situation of certain African countries, where the AIDS crisis has led the World Health Organisation to institute a massive campaign to circumcise adult men. Given the resulting saturation propaganda in favour of circumcision, and the fact that it is provided free of charge, often with further financial inducements, it is doubtful if the consent that these men have given was in any sense \textit{informed} consent. It would certainly not meet the standards of disclosure required for a surgical operation in any Western hospital.


\textsuperscript{40} Brian Morris, \textit{In Favour of Circumcision} (Sydney: NSW University Press, 1999), 61-2
disadvantages, may well have opted to reject the operation and retain their prepucce.” 41 The benefits of the foreskin must always be set against the claimed advantages of losing it.

The question of harm is thus central to any discussion as to whether various forms of genital cutting should be regarded as violations of the open future principle. Whether future options are closed to an unacceptable degree comes down to the extent of the harm that is imposed by a particular decision, and that harm can be both physical and psychological. The unexamined assumptions behind the double standard on male and female genital cutting is that the former is usually harmless and the latter always harmful. Davis has criticised the second assumption, but reproduces the first in the AAP’s 2010 FGC policy, where she proposed that a scratch on the clitoris was not harmful, or not harmful enough to warrant its prohibition, adding as proof of this claim that “the ritual nick suggested by some pediatricians is … much less extensive than routine newborn male genital cutting.” 42 Obviously, if RNC is harmless, a mere nick is nothing. But there is much ambiguity here: is the policy setting the threshold of harm at the nick, meaning that anything “more extensive”, including RNC, is harmful? Or is it setting it at the removal of the male prepuce, in which case anything “less extensive” must be harmless and acceptable? If the threshold of harm is prepuce removal, in the interests of gender equity the Bioethics Committee should have recommended that removal of the female prepuce (clitoral hood) be permitted; but if the

42 American Academy of Pediatrics, Committee on Bioethics, Policy Statement: Ritual Genital Cutting of Female Minors, 125 Pediatrics 1088, 1089 (2010)
threshold is the nick, they should have recommended that removal of the male prepuce be prohibited and a ritual nick on the penis substituted. Either way, the Policy is caught in glaring contradictions, though one suspects that the Committee was taking advantage of the popular prejudice that male circumcision is harmless and setting that as the threshold, thus making it very easy to prove that the ritual nick was little more than a tickle. But when the AAP “retired” the new policy on 27 May 2010, it appeared to acknowledge that even the ritual nick was too harmful (or at least too risky) to be permitted:

The American Academy of Pediatrics (AAP) reaffirms its strong opposition to female genital cutting (FGC) and counsels its members not to perform such procedures. As typically practiced, FGC can be life-threatening. Little girls who escape death are still vulnerable to sterility, infection and psychological trauma. The AAP does not endorse the practice of offering a “clitoral nick.” This minimal pinprick is forbidden under federal law and the AAP does not recommend it to its members. The AAP is steadfast in its goal of protecting all young girls from the harms of FGC.  

But if the ritual nick is too harmful or risky to be permitted, where does that leave circumcision of boys?

There is a further unexamined assumption in much of the literature on the “pros and cons” of circumcision that the harm lies only in risks, complications and possible indirect effects, such as long term loss of sexual feeling and functionality. This perspective make it easy for the circumcision promoters and raises the bar very high for their critics, who are constantly asked to provide scientific (i.e.

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43 AAP statement, 27 May 2010, at http://aapnews.aappublications.org/cgi/content/full/aapnews.20100601-2v2?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=fgc+policy&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT
mathematical) proof that loss of the foreskin adversely affects sexual response.\(^4\)

When such proofs are produced they are belittled or ignored.\(^5\) Critics of FGC are rarely asked for proof that the threatened elements of the female genitalia contribute to the sexual response of women, yet even in the absence of compelling scientific proof nobody doubts the importance of the clitoris or labia because it is assumed as a matter of common sense and daily experience that the visible components of the genitals must play a role in sexual response. The only reason the same common sense is not applied to the foreskin is that the pro-circumcision bias within the United States medico-scientific community has reversed the burden of proof: defenders of FGC are forced to prove that excision of parts of the female genitals is not harmful, but critics of male circumcision are required to prove that comparable excisions are harmful. I suggest that all this scrambling for elusive evidence about such a subjective thing as sexual feeling is beside the point. Whatever their role in sexual response, the foreskin, labia and clitoris are integral parts of all male and female bodies and belong to their owners as surely as their liver, eyes or toes.

\(^{44}\) As Abraham Wolbarst put in it his call for universal infant circumcision in 1914: “If there is any objection to circumcision it should be based on valid, scientific grounds.” Abraham Wolbarst, Universal circumcision as a sanitary measure, 62 JAMA 92, 95 (1914)

\(^{45}\) An example of both tendencies is found in the AAP’s 1999 Circumcision Policy Statement, which includes the sentence: “One study suggests that there may be a concentration of specialized sensory cells in specific ridged areas of the foreskin.” But as Fleiss and Hodges point out, “The cautious wording is puzzling. Taylor’s investigation does not “suggest” that there “may be” specialized nerve endings in the ridged band of the foreskin: it conclusively documents this fact. The report also neglects to acknowledge the relevant fact that there additionally exists a large number of anatomical studies on preputial innervation.” See J.R. Taylor et al, The prepuce: Specialized mucosa of the penis and its loss to circumcision. 77 Br I Urol 291 (1996) and Frederick Hodges and Paul Fleiss, Letter, 105 Pediatrics 683 (2000). See also the following recent studies, neither of which has been referred to by authorities advocating widespread circumcision as a tactic for control of HIV in Africa: D.S. Kim and M.-G. Pang, The effect of male circumcision on sexuality, 99 BJU International, 619 (2006); M.L. Sorrells et al, Fine-touch pressure thresholds in the adult penis. 99 BJU International, 864 (2007)
The harm (in both sexes) does not depend on complications or long term adverse effects, but in the mere fact that a normal feature of the body has been removed without permission. The harm of circumcision, experienced by all men circumcised without consent, is that they have been deprived of a visually prominent, psychologically significant and erotically functional element of the penis, which is thereby diminished as a sexual organ. Once upon a time it was argued that circumcision could not be harmful because it did not harm a male’s reproductive capacity; as the British exponent of therapeutic clitoridectomy, Isaac Baker Brown, asserted in the 1860s “Clitoridectomy is neither more nor less than circumcision of the female; and as certainly as that no man who has been circumcised has been injured in his natural functions, so it is equally certain that no woman who has undergone the operation … has lost one particle of the natural function of her organs.”

But even if these self-serving claims were true, the vast majority of sexual experiences, whether with partners or alone, are for the purpose of pleasure rather than reproduction, meaning that it is a very major fact that removal of the foreskin reduces the capacity of the penis to give pleasure, and a very minor fact that it allows him still to produce and ejaculate sperm. The issue is particularly significant in the case of boys and youths, who for physiological or social reasons are too young to reproduce; in their case, the only function of the penis is to give them pleasure, and to deprive them of the fun to be had from playing with their foreskin is a very serious harm indeed. Circumcision as practised in the USA today cannot be understood unless it is appreciated that it was introduced by Anglo-American doctors in the late nineteenth century largely

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46 Isaac Baker Brown, “Replies to the remarks of the council”, Medical Times and Gazette, 13 April 1867, 391
as a measure to control juvenile sexuality and especially to put a stop to that kind of fun.\(^{47}\)

Although Davis does not discuss circumcision in her book, the examples she gives to illustrate her position are quite applicable to such surgeries. According to the open future principle it would be ethically wrong for deaf parents to take deliberate steps to ensure that they have a deaf child because children are entitled to the opportunities that would be available to them if they are able to hear, and she goes to some trouble to show, despite the insistence of some evangelists that deafness is a culture rather than a disability, that it really is a harm. This principle is equally applicable to parents who deliberately remove a boy’s foreskin because they want his penis to be like his father’s (or as prescribed by an ethnic or religious group, or because it is customary in the parents’ community) or for any other reason, since it also violates the open future principle. If the examples chosen were colour blindness or partial deafness, the analogy would be all the more exact, since there is convincing evidence that circumcision reduces the range of sensations capable of being transmitted by the penis, and has indeed been compared to colour blindness by men and youths who have undergone circumcision in maturity.\(^ {48}\) The operation thus closes off options for sexual experience that the child would otherwise have as an adult (and indeed as a child). It also deprives the boy of the choice that should be held for him in trust to exercise in maturity, when he has had the chance to assess the literature on the pros and cons of


\(^{48}\) Ronald Goldman, Circumcision: The Hidden Trauma (Boston: Vanguard Pubns, 1997), 40
circumcision, and to make his own decision about whether to keep his foreskin or to get it removed for medical, cultural, aesthetic or any other reason.

Choice is central to Davis’s conceptual scheme, and she is an ethical realist in arguing that life is usually a matter of choosing the lesser evil. Thus, if the choice is between no cutting of the genitals and minor cutting it is preferable to have no cutting at all, since any cutting is a violation of the child’s physical integrity and dignity. But if the choice is between minor cutting, such as a scratch, and major cutting that removes tissue and permanently alters the appearance and function of the organs, it is preferable to accept minor cutting. When she comes to consider circumcision, Davis claims that FGC in Indonesia has largely been replaced by a symbolic scratch, and if this is true we must acknowledge that it is a great step forward. From this perspective it would appear that the Seattle compromise is consistent with the open future principle, in that it is better for the Somali girls to suffer a small nick from medical professionals than to be taken back to Africa for more extensive procedures at the hands of traditional practitioners. Imposition of a scratch on a girl’s clitoris would not violate the open future principle because it is not a lasting injury and would not damage or restrict her future life options in any significant way, and probably not at all. The AAP’s 2010 policy is thus defensible, in that Davis is not trying to move girls from the position of no cutting to mild cutting, but from severe cutting to mild cutting, which is a step forward.


50 Even so, it is highly probable that such a procedure, even if carried out under analgesia, could be quite traumatic for an infant or child too young to understand what was going on – as any pediatrician who has had to install a urinary catheter in a young girl can attest. This may not be a matter in which authorities on bioethics or law have much personal experience.
The problem with her policy is that she does not apply the same principle to boys: why not a “symbolic nick” to the penis instead of amputation of the foreskin? In other words, despite her admission that MGC is ethically problematic and “more extensive” (equals more harmful) than mild forms of FGC, she is still thinking within USA cultural assumptions about the wickedness of FGC and the neutrality of MGC. Still, on the lesser evil principle, the 2010 policy is not as outrageous as some of her critics have asserted.

This does not necessarily mean that the ritual nick is ethically acceptable, since its consistency with the open future principle hinges on two unknowns: (1) that the girls would be at high risk of a nastier intervention if it was not done; and (2) that the nick will certainly spare them from anything worse. But there is no evidence (or none produced by Davis or Coleman) that unnicked girls are being taken back to Somalia, nor is there anything to prevent the parents getting the nick done in an American hospital, and then deciding later that it was not “extensive” enough and arranging for further surgery. The situation is not comparable with Indonesia or Kenya, where there was an ingrained tradition of FGC from which parents had to be slowly weaned. There is no such tradition in the USA, and the Seattle compromise would appear to be having the reverse effect: introducing medical personnel to a cutting practice formerly unknown. There is, moreover, the question of whether children have an inherent right to their own freedom of religion and physical integrity, as implied by the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the Declaration on the Rights of the Child. As Davis herself acknowledges, opponents of FGC have pointed to the dangers of allowing even mild forms, including the
risk that they will become the proverbial thin end of the wedge or that medicalisation on the Seattle model will lead to the entrenchment of the practice, as has apparently happened in Egypt.\textsuperscript{51}

Nor does consistency with the open future principle imply that the AAP ought to be permitting or encouraging its members to perform a procedure of this kind. This is not only because the scratch poses an unacceptable risk of pain and harm to the girl, but because it confounds the spheres of medicine and religion and confuses the functions of doctors and priests. According to its statement of aims, the mission of the AAP is “to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults.”\textsuperscript{52} There is nothing here about performing religious or cultural functions, such as initiation rites, and it is no more appropriate for pediatricians to perform ritual genital cutting than for baptism to be performed by hydrologists, tooth evulsion by dentists or skin scarification by dermatologists.\textsuperscript{53} Pediatricians will, of course, show respect for the religious and other cultural beliefs of the parents of children brought to their care, but this does not mean that they are obliged to perform any and every function prescribed by those beliefs, and certainly not those of a quasi-surgical nature that intrude on the bodies or minds of children. The only argument in favour of physicians taking charge of these sorts of procedures is that they may otherwise be performed by unskilled “kitchen table” operators, with a


\textsuperscript{53} David Shaw, Cutting Through Red Tape: Non-therapeutic Circumcision and Unethical Guidelines, 4 Clinical Ethics, 181 (2009)
consequent high toll of death and injury. This is a dilemma that must be faced, but one that lies beyond the scope of this paper. One approach might be to establish a suitably trained cadre of paramedicals, similar to mohels, whose surgical competence would be certified by the appropriate regulatory authorities, and whose cultural acceptability would be approved by the relevant sub-culture. This would free pediatricians and other medical personnel from the invidious requirement to ask parents if they want their babies’ genitals cut, and make a clear distinction between medical treatment and cultural rites.

Part III: Davis and male and female genital cutting

Having argued that non-therapeutic genital cutting involving permanent alteration or lasting injury does violate the open future principle, I shall now consider Davis’s writings on circumcision in more detail. Exactly what prompted Davis to turn her mind to male and female genital cutting she does not spell out, though the precipitating events seem to have been the failure of the Seattle compromise and the AAP’s policy on routine male circumcision issued in 1999. The latter concluded that although circumcision might have potential benefits, they were not substantial enough to warrant recommending the procedure as a routine, but that even if the medical (prophylactic) case was not valid, parental wishes, based on religious, ethnic, family or other traditions, would provide

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54 As the Royal Dutch Medical Association warns in a policy that nonetheless takes a very critical stance against non-therapeutic circumcision of minors and suggests that on bioethical and human rights grounds alone it ought to be illegal. Royal Dutch Medical Association, Non-therapeutic Circumcision of Male Minors, Policy Statement, May 2010; at http://knmg.artsennet.nl/Diensten/knmgpublicaties/KNMGpublicatie/Nontherapeutic-circumcision-of-male-minors-2010.htm
sufficient grounds. According to Davis’s interpretation, the new policy meant that circumcision could no longer be regarded as a routine procedure and placed its future in doubt: “Withdrawal of medical support for routine circumcision requires us to face some uncomfortable facts and raises intriguing constitutional questions.” This is an odd comment for two reasons. First, although Davis implies the contrary, neither the AAP nor any other US medical authority has ever issued a policy recommending routine circumcision. There have been many calls from individual doctors for such a policy, beginning with Abraham Wolbarst’s “Universal circumcision as a sanitary measure” in 1914, but it was not until after the Second World War that neonatal circumcision became the American norm, and then as a consequence of unofficial practice by obstetricians, who succeeded in having circumcision incorporated as part of the childbirth process. Far from recommending routine circumcision, all the policies issued by the AAP since 1971 have been intended to show that it is not necessary as a health measure and to discourage the practice. Even the 1989 policy, prepared under the influence of long-time circumcision evangelist Edgar Schoen, while stressing “proven medical benefits”, did not go so far as to recommend circumcision as a routine, much less a universal, intervention. Since there had never been authoritative medical support for routine circumcision, it could hardly be withdrawn. Secondly, it is not entirely clear why the facts raised by the AAP’s more forceful recognition that non-therapeutic circumcision was of minimal medical value were necessarily

56 R.L. Miller and D.C. Snyder, Immediate circumcision of the newborn male, 65 American Journal of Obstetrics and Gynaecology 3 (1953)
57 The policies issued by the AAP have been collected at http://www.cirp.org/library/statements/
uncomfortable. Surely the news would come as a relief to most parents, who would now be spared the anxiety, risks and extra care required by a surgical operation performed so soon after a boy’s birth, as well as being a cause for celebration among the insurance companies and state health providers that paid for the operation on the basis that it was essential medical care.

Davis’s use of the phrase suggests that there is something else at the back of her mind, most probably the outpouring of publications on the ethics of genital cutting that followed the adoption of the United Nations Declaration on the Rights of the Child (1989) and the development of a vigorous anti-circumcision movement in the United States and elsewhere during the 1990s, in which Jewish critics of circumcision within the Jewish community were prominent. Among the many critiques of the legal and ethical tolerance of male genital cutting were several that raised the pertinent question of gender discrimination: if girls have total protection, why don’t boys have any? As early as 1985 William Brigman had suggested that non-therapeutic circumcision of minors satisfied standard definitions of child abuse and ought to be regarded as unlawful under existing statutes covering mayhem, assault and battery. He further argued that neither the doctrine of parental rights nor the right to practice a religion could legitimate the imposition of such a significant and irreparable injury on a child.58 International campaigns against FGC that developed during the 1990s were complemented by a home-grown movement against routine circumcision of boys that soon raised the question of equal protection. In 1997 Abbie Chessler complained that while

opposition to female circumcision was at the forefront of human rights law, male circumcision continued to be ignored, observing that “United States’ criticism of other cultures and religions is self-righteous and ironic [while] it continues to advocate its own abusive ritual.” After a thorough analysis of the legal literature she concluded that

the bifurcation of male circumcision from female circumcision can no longer be tolerated. Claims that the two cannot be linked perpetuates the continued legitimacy of one human rights abuse, male circumcision, through the condemnation of another. An analogy must be made between the two; regardless of whether a child is male or female, neither should be subject to genital mutilation.59

She was followed by Shea Lite Bond’s analysis of the Federal FGC law, which she held to be unconstitutional because it failed to give protection to males,60 and Ross Povenmire’s argument that parents did not have the legal right to consent to the amputation of normal tissue from their infant children. Like Bond, he found more similarities than differences between male and female genital cutting, and similarly contended that the Federal FGC act was inconsistent with the Fourteenth Amendment.61 On top of these came an exhaustive analysis by Van Howe, Dwyer and Svoboda, who identified the legal and ethical requirements for consent that apply when medical professionals treat competent adult patients – full disclosure, adequate capacity to consent, and voluntariness – and analysed how the principles applicable in that context translate into the legal and ethical requirements for consent to treatment of incompetent adults and children. They argued that since medical professionals may not, as a rule remove healthy tissue from even...

59 Abie Chessler, Justifying the Unjustifiable: Rite v. Wrong, 45 Buffalo L. Rev. 555, 612-3 (1997)
61 Ross, Povenmire, Do Parents Have the Legal Authority to Consent to the Surgical Amputation of Normal, Healthy Tissue From Their Infant Children?: The Practice of Circumcision in the United States. 7 Journal of Gender, Social Policy & the Law 87 (1998-1999)
consenting adult patients, it follows *a fortiori* that parents may not authorize such operations on children, and thus that surrogate consent for medically unnecessary procedures was not legally valid.\(^62\)

Quite suddenly there was a substantial body of legal scholarship that cast doubt on the legality of non-therapeutic circumcision of minors, thus calling into question not only its continuation as a routine “health” measure, but also its survival as a religious practice. Davis’s consideration of circumcision took place within this context, and the key to her position is that she focuses on the same paradox, but from the opposite direction: if male circumcision is accepted and boys have no protection, is it necessary for girls to be as heavily protected as they are? Accordingly, having opened her paper with the observation that there was no health case for circumcision of infant boys, Davis might have been expected to apply the open future principle and argue that there was no reason to do it at all in the vast majority of cases, and thus that boys should be left alone to make up their own minds when they reached adulthood. Instead, she changes tack and launches into the real purpose of the paper, which is a defence of the Seattle compromise and a critique of the “wide sweep” of the laws against FGC, which “block the efforts of compassionate and creative physicians who want to offer a compromise to immigrant parents from countries where FGA [female genital alteration] is common.” This would protect girls from being sent back to Africa for nastier operations, and also from the attentions of any traditional practitioners available

locally. Davis is at pains to point out that the mild form of FGC that the Seattle doctors proposed, no more than a slight scratch on the clitoris, performed in sterile conditions under anaesthetic, would be far less “extensive” or “substantial” than the average male circumcision, and would carry far less risk of complications and (additional) harm, and she is manifestly exasperated that people who can blithely accept the surgical removal of an entire structure from a baby boy’s penis are so horrified by the thought of a mere scratch on a girl’s vulva that they sent death threats to the hospital where the idea was mooted. Davis is particularly critical of the Federal US legislation criminalising any form of FGC, no matter how trivial or whatever the sanitary precautions, while male circumcision, “a more substantial procedure than the one contemplated at Seattle, is legal, even when done by a non-medical practitioner in the home.” She is also concerned that the two practices “lack a legally defensible distinction”, and points out that the inconsistency raises worrying questions of discrimination against non-mainstream religions, which may fall foul of the Free Exercise clause of the First Amendment, and of discrimination against males, which may contravene the “Equal Protection” guarantee of the Fourteenth.

As we have seen, Davis was certainly not the first to identify the double standard whereby FGC is regarded as an abomination that must be stamped out, but circumcision of boys as a mild adjustment that should be tolerated or even promoted, but it is to her credit that she was one of the first scholars from within

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63 Davis, Male and Female Genital Mutilation, 488
64 Davis, Male and Female Genital Mutilation, 510
65 Davis, Male and Female Genital Mutilation, 488
the professional bioethical community to criticise the inconsistency in both law and popular attitudes, and to acknowledge that male circumcision was more extensive (that is, harmful) than the most common forms of FGC. She provides a reliable survey of world FGC practices, runs through the arguments for and against routine circumcision of boys quite fairly and gives generous weight to the anti-circumcision side of the debate. Davis even acknowledges the sexual function of the foreskin and prints quite extensive quotes from men who, although they did not suffer surgical complications, have reported severe loss of sensation and functionality following circumcision in adulthood. She further points out that while popular attitudes quarantine male and female circumcision into separate compartments, they should be seen as circles with some overlap:

If we compare the Seattle proposal to the unregulated practice of berit milah (ritual Jewish circumcision of newborn males), it appears that the latter involves more skin removed, with less likelihood of adequate pain control and no systematic reporting system for complications. The Seattle proposal was [as Doriane Coleman comments] “less injurious to the health, welfare and safety of girls than male circumcision is to the health, welfare and safety of boys.” The primary difference between the operation proposed in Seattle … and the one performed daily on newborn males in America is that the first is associated with “bizarre” practices brought to America by strange people practising strange customs, while the other is a Western practice with which we are familiar.” (Coll 564-5)

Some of Davis’s remarks are questionable, such as her assertion that FGC is entirely without “health benefits”. Since her paper, evidence has emerged that female circumcision may offer some such advantages, including a degree of protection from HIV infection, and does not necessarily add to the difficulties of

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66 Davis, Male and Female Genital Mutilation, 520-22
67 Davis, Male and Female Genital Mutilation, 564-5
childbirth or destroy women’s capacity for sexual pleasure.\textsuperscript{68} It should also be remembered that in the late nineteenth century and right up until the 1930s various forms of FGC were widely discussed and regularly performed in the USA as a therapeutic or preventive medical procedure, and for much the same reasons as circumcision of boys at that time: to treat “nervous diseases” and to control sexual irregularities, such as masturbation and frigidity.\textsuperscript{69} The impression that FGC confers no health benefits arises because in the West (the place where most medical research takes place) there is no cultural pressure to perform such procedures, and thus no incentive to fund the research that would demonise the female external genitals as effectively as Anglo-American doctors succeeded in demonising the foreskin.\textsuperscript{70} If the clitoris, clitoral prepuce or labia had been the target of even a fraction of the research effort that has gone into proving the complicity of the foreskin in the generation of disease and disapproved behaviours there would be an abundance of “compelling” evidence as to the health benefits of various forms of FGC. In places where there is a cultural demand for FGC there is just as much insistence on its hygienic advantages as there is on the healthfulness of male circumcision.\textsuperscript{71}


\textsuperscript{70} Darby, A Surgical Temptation

Davis is also on shaky ground when she writes that “MGA is not anywhere close to as mutilating and threatening to life and health as are many forms of FGA.” She admits that data on complications and other adverse sequelae of circumcision are inadequate, but she seems unaware that in places such as South Africa, where ritual circumcision is performed on teenage Xhosa boys, the reported toll of death and injury is far higher than the toll of FGC in places where that is common. Even in the United States, deaths from circumcision are reported regularly, and a recent study has claimed that it causes more than a hundred neonatal fatalities each year. Nor is it true that circumcision is necessarily less mutilating than all forms of FGC: circumcision is a deceptive term, for although it implies a single procedure involving the excision of a particular organic structure, it actually involves a wide range of outcomes, from mild to severe, depending on how much of the dermal tissue of the penis (“foreskin”) is removed. In the United States the “high and tight” look favoured by the obstetricians who perform most of the neonatal operations ensures maximum loss of tissue and a high incidence of complications; as one pediatric surgeon comments:

Unfortunately, 70-80% of neonatal circumcisions are performed by obstetricians, who can neither manage their complications (2-5% incidence) nor obtain proper informed consent (defined as outlining risks and benefits of a procedure, as well as alternatives-including nothing) for neonatal circumcision. Currently, the American College of OB-GYN (ACOG) have no parameters for training (learning and

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72 Davis, Male and Female Genital Mutilation, 566

73 Editorial: Astonishing Indifference to Deaths Due to Botched Ritual Circumcision, 93 South African Medical Journal 545 (2003); Pat Sidley, Botched Circumcisions Kill 14 Boys in a Month, 333 British Medical Journal 62 (2006). As at 30 June, the death toll for 2010 in Eastern Cape Province alone was 40 boys: http://allafrica.com/stories/201006300778.html

74 Dan Bollinger, Lost Boys: An Estimate of U.S. Circumcision-Related Infant Deaths, 4 Jnl Boyhood Studies 78 (2010)
performing neonatal circumcision, managing complications) of residents, who then go out and continue this practice.

In my practice … I manage the complications of neonatal circumcision. For example, in a two year period, I was referred 275 newborns and toddlers with complications of neonatal circumcision. None of these were “revisions” because of appearance, which I do not do. 45% required corrective surgery….

Complications of this unnecessary procedure are often not reported, but of 300 pediatric urologists in this country who have practices similar to mine … well, one can do the math, to understand the scope of this problem … let alone, to understand the adverse cost-benefit aspect of complications (>\$750,000) in this unfortunate group of infants and young children.\textsuperscript{75}

Commenting on the Yoder decision, Brigman noted that the state may interfere with parental discretion “if it appears that parental decisions will jeopardize the health and safety of the child, or have the potential for significant social burdens.”\textsuperscript{76} There is little doubt that genital cutting of minors does impose significant burdens on both the individuals affected and society. The initial cost and risks of the procedure are followed by the burdens of after-care, repair of sloppy surgery and complications, court cases where parents disagree, resentment on the part of many boys, efforts at restoration, psychological disturbance and even suicides. On a cost-benefit basis alone the state would be quite justified in imposing reasonable regulations on a practice with such ramifying social impacts.\textsuperscript{77}

\textsuperscript{75} M. David Gibbons, MD, Associate Professor, Pediatric Urology, Georgetown University School of Medicine and George Washington School of Medicine. Posted at Men’s Health Magazine, 2009, in response to the article “The debate over circumcision: Should all males be circumcised?” (http://www.menshealth.com/men/health/other-diseases-ailments/the-debate-over-circumcision/article/6a8cd36265f1f110VgnVCM10000013281eac#readerComments)

\textsuperscript{76} Brigman, Circumcision as child abuse, 354-5

Despite these flaws, Davis provides a comprehensive and fair-minded account of both MGC and FGC, recognises that they cannot be considered in isolation, acknowledges that they may be performed for similar reasons and may have comparably harmful outcomes, highlights the legal and ethical problems arising from these facts, and recommends limited regulation of MGC. It is on the basis of the last point that Davis claims that her proposals are intended both to “offer increasing protection to all children and treat different religious traditions with equal respect.” The question here is which of these aims is predominant. It is apparent from her focus on the Free Exercise clause that Davis’s primary concern is respect for religion, not protection of children. She states that that she will focus entirely on First Amendment issues while referring readers interested in the Equal Protection problem to Bond’s paper, which she does not discuss at all. Thus, although the stated aim is to increase protection for all children, her principal proposal for reducing inconsistency in the law’s differing attitude to FGC and MGC is to reduce the level of protection given to girls while giving only token protection to boys. Her two proposals are that legislation should be rewritten to allow the “ritual nick” on girls as proposed by the Harborview Medical Center in the Seattle compromise, and that states should exercise “some control” over medically unnecessary circumcision of male minors. This would entail collection of data on complications, certification of non-physician practitioners, and a legal requirement for adequate pain control.

78 Davis, Male and Female Genital Mutilation, 489
80 Davis, Male and Female Genital Mutilation, 568-9
It is obvious that the only proposal here that would be likely to have any practical effect is the first, and this is the one that Davis has evidently continued to advocate, achieving success in the AAP’s short lived FGC policy of April 2010, which embodied precisely this idea. The recommendations for increased protection of boys are so trivial as to be insulting, since girls retain blanket protection against any form of genital cutting that involves removal of tissue or the imposition of a prominent scar, while boys must be content with the collection of statistics on their injuries. Even if these proposals had made headway there is little reason to think that they would have made any difference to the practice of routine circumcision. The really nagging question, if Davis is truly interested in both respect for religion and protection of children’s physical integrity, is why she did not propose a compromise operation for boys.

It does appear as though Davis’s concern that all religions be accorded equal respect runs deeper than her concern for children. More disturbing than the content of her recommendations on FGC and the tokenism of her suggestions for regulation of MGC is the rationale for these proposals. As she summarises it later in her contribution to David Benatar’s collection, *Cutting to the Core*, it was to acknowledge that “the fuzzy reasons why a secular Jew would alter her son are no more or less worthy of respect than the complex, fuzzy reasons why a Somali mother would alter her daughter;” to respect the “important motivations” that underlie both FGA and MGA; by narrowing the gap between criminalisation of any form of FGA and “the complete legal indifference to MGA” to show “respect for immigrants from cultures that practise FGA and remove the taint of religious
This is to elevate the principle of respect for religion to the point where it flies free from nearly all restrictions, and to do so at the expense of children’s physical integrity. At the very least, we might have expected Davis to consider whether these proposals and their rationale infringed the open future to which, in her previous writings, she has insisted that they have fundamental right, and to argue either that they do not infringe this principle, or if they do, that the departure from it is justified in the name of a greater good. No such argument is offered.

It is possible to detect a deeper strategy here, and that is to deflect attacks on ritual and routine circumcision from critics who point to the legal disparities identified by Davis and demand that the laws be rewritten to give boys and girls the equal protection seemingly promised by the Fourteenth Amendment. Davis’s recommendations could be seen as an attempt to neutralise this argument by a moderate reduction in the inequality of treatment: slightly reducing the protection given to girls and slightly increasing the protection given to boys. It may be that an incentive for Davis’s interest in the circumcision question were the efforts of anti-circumcision campaigners in North Dakota in the mid-1990s to persuade the state legislature to enact a gender neutral law against genital mutilation. When this initiative failed and the resulting legislation covered girls only they sought to have it invalidated on the ground that it violated the Fourteenth Amendment. Because the plaintiffs were denied standing, this case never came to trial, and the question of whether laws protecting females only are discriminatory and invalid.

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81 Dena Davis, Genital Alteration of Female Minors, in David Benatar (ed), Cutting to the Core: Exploring the Ethics of Contested Surgeries (Rowman and Littlefield, 2006), 72; Davis, Male and Female Genital Mutilation, 568-9
remains untested. But the possibility remains, and provides the key to Davis’s concerns and the otherwise puzzling elements of her position on circumcision. The most telling evidence of this is a quotation she includes from the champion of the Seattle compromise, Doriane Coleman:

Washington has two options. It can begin performing symbolic female circumcisions, or it can stop circumcising or condoning the circumcision of boys. While the latter option would immediately raise substantial and very legitimate First Amendment concerns for parents whose religion requires circumcision — concerns that could be articulated just as easily by parents of boys and girls — it is clear that the choice must be made one way or the other. The bottom line is that the state cannot treat parents differently on the basis of their child’s gender.

Nor, Davis adds, “can a state or the federal government treat parents differently on the basis of their differing religious beliefs.” What she means here is that if the symbolic cut or “ritual nick” is accepted, it will be easier to secure the future of conventional circumcision of boys, since arguments against it based on the principle of equal treatment will have been neutralized. But if the compromise is rejected, there is the danger that the weight of the inconsistency and resulting sense of injustice will eventually bring down circumcision of boys as well. In effect, the overriding purpose of the “ritual nick” was not to show respect for the culture of the parents, but to preserve circumcision of male infants. On the evidence so far, however, it must be said that most Americans seem perfectly happy to live with the contradiction.

The orderly retreat from the principles of the open future that was evident in Davis’s discussion of the Seattle compromise becomes a chaotic rout when she turns to consider the Boldt case. Like all custody battles, this is a complex story,

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82 Described in Bond, *Female Circumcision and the Equal Protection Clause*
but the basic facts are that the Boldts were adherents of the Russian Orthodox Church and had one child, Misha; after a bitter divorce, custody of the boy was eventually given to the father. Some time after this the father decided to convert to Judaism and tried to take Misha (then aged 9) with him, a transition that necessarily entailed arranging for him to be circumcised. The boy’s mother obtained a temporary court injunction prohibiting the circumcision, and filed an application for custody. The father testified that Misha himself wished to convert and undergo the operation, but that even if he did not his wishes were irrelevant because the custodial parent had complete authority to make what he called “medical decisions” for a child. The mother testified that Misha did not want to be circumcised and was afraid to contradict his father. After a series of hearings and appeals, the Oregon Supreme Court decided that “although circumcision is an invasive medical procedure that results in permanent alteration of a body part and has attendant medical risks, the decision to have a male child circumcised for medical or religious reasons is one that is commonly and historically made by parents,” and it concluded that the custodial parent’s rights in this respect were not fettered by the views of the non-custodial parent. But because this was a custody, rather than a right to circumcise, case, the court ruled that forcing the boy to get circumcised would damage his relationship with his father, and sent the case back to the trial court to determine the boy’s own views. When Misha, by now aged 12, finally got the opportunity to express his own opinion (at a hearing in judges’ chambers in April 2009) he made it clear that he wished neither to remain Russian Orthodox nor to convert to Judaism, and he most definitely did not want to get circumcised or to remain with his father. Accordingly, the court issued an order that he was not to be circumcised and returned him temporarily to
his father while child custody officials worked out the details of how to return him to his mother.\(^{84}\)

Despite the Supreme Court’s remark about the decision to circumcise a child being “commonly and historically made by parents”, the case remained a custody battle throughout, and no determination was ever made as to whether parents did in fact have the right to make such a decision, and if so with what qualifications. Since the question does not seem be as settled in law as the court’s confident words suggest, the observation may be regarded as no more than an *obiter dictum*.

In a similar case a divorced mother having custody of a nine year old son remarried, this time to a Jewish man, and sought to have the boy circumcised at the behest of her new husband. The father objected, and when the matter came to court the judge dismissed the mother’s claim of medical necessity and ordered that the boy be protected from circumcision until his 18th birthday, at which point he would be free to make his own decision.\(^{85}\) In denying that the non-custodial parent had no prerogatives with respect to medical decisions about a child, the Oregon Supreme Court certainly did not mean that the child had no say in the matter; indeed, in directing that the trial court discover Misha’s own views it implied quite the contrary.

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\(^{85}\) Schmidt vs. Niznick, Cook County Illinois, 00D18272, cited in Doctors’ Opposing Circumcision, Amicus Curiae Brief on Boldt, 26;
You would expect an adherent of the principle that a child of whatever age had a right to an open future would take a lively interest in this case, touching as it does on so many sensitive issues of bodily integrity, parental authority and children’s rights as future adults, and we find that Davis has published two commentaries on the affair, one while it was still undecided and the other in retrospect. You would also expect somebody who, in previous writings, has championed the principle of the child’s right to choose against both parental and group authority to be at least mildly critical of the father’s dictatorial attitude and of the Jewish organisations that supported him, and to show some sympathy for the boy. Not a bit of it! Although Davis defends the court’s final decision to respect his wish not to get circumcised, she does so in a grudging tone, and in terms that offer no comfort at all to children at younger ages.

Davis defines the issues raised by the case as (1) whether there are any circumstances in which a physician should perform cosmetic surgery on a minor; and (2) whether a physician should take into account conflict between divorced parents as to the child’s best interests. Ignoring the possibility that a physician might also take into account the wishes and preferences of a child on such a personal matter, she then outlines a “purist stance”, which would refuse to perform any medically unnecessary procedure on a minor, from ear piercing to rhinoplasty. One could argue that these are non-reversible procedures that only a competent adult (or mature adolescent) should be permitted to make, and that there is little harm in waiting until the child is 18. … That position would rule out even routine newborn circumcision.  

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86 Davis, Fathers, Foreskins and Family Law, 4
This position seems to be intended as a straw man, for no serious critic of circumcision has ever advocated such an extreme position, and Davis rejects it unargued; the fact that it would rule out RNC seems sufficient to make it not worth taking seriously.\(^\text{87}\) She then goes on to make the evasive statement that “most pediatricians would attempt to balance the pros and cons of the procedure, the best interests of the child and deference to parental decision-making authority”, followed by some highly contentious claims that beg all the key questions:

The law invests parents with this authority because parents are believed to act in the best interests of their children, and because parents have the right to raise children in their own religion and culture. … Taking all this into account performing circumcision on a newborn at the parent’s behest seems ethically acceptable, despite the fact that it deprives children of the freedom to make this important decision for themselves at a later time.

Or despite the fact that violates the open future principle; and one is staggered by how much work a poor old word like “seems” is doing here. It may “seem” that way to Davis, but this is precisely the case she has to argue. She then goes on:

“When parents choose circumcision out of religious conviction, the procedure provides the added benefit of allowing the child to feel like a full member of the group, and in the Jewish context to become bar mitzvah at age 13.”\(^\text{88}\) But no benefits have been mentioned previously: the only antecedent to which the words “added benefit” could refer is the denial of the child’s right to an open future. This

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\(^\text{87}\) In fact, the position rejected is far from indefensible, since the types of interventions envisaged are non-urgent and thus reasonably delayed until the child is old enough to decide whether he/she really wants them. One can understand a parent of a child with facial abnormalities or deformities wishing to correct them through surgery in order to spare the child the discrimination and rejection he/she would be likely to suffer, and in such cases the substituted judgement test might well conclude that they were procedures that a competent child would choose for him/herself. But procedures of this type are the polar opposite of genital cutting, which is the artificial imposition of a deformation.

\(^\text{88}\) Davis, Fathers, Foreskins and Family Law, 4, 7; emphasis added
can hardly be what Davis means, but it is the sort of mishap that can occur when stock expressions are used to cover up sloppy thinking. Aside from this slippery word use, the benefits identified here seem to belong entirely to the group: what has happened to the child’s right to make his own decisions about such personal matters?

Davis then dodges the crucial ethical issue here by commenting that it is “difficult to imagine a doctor who would perform elective surgery on a protesting or even an unenthusiastic pre-teen” without attempting to establish the conditions in which it would be ethical or otherwise, without mentioning the fact that this was precisely what was demanded by the father and the Jewish organisations that supported him, and without revealing that the father had lined up a compliant surgeon prepared to testify that the boy “needed” circumcision for “medical reasons”.

89 Most significantly she fails to explain why a pre-teen or a 12-year old has the right to reject medically unnecessary circumcision, but not a boy of 8 years, four years, six weeks or two days.90 She then deepens the muddle by misrepresenting the principle of respect for autonomy by defining it as requiring that “persons with the mental capacity to make certain medical decisions have these decisions respected.” But this leads to the absurd situation in which a 12-year old may be judged mature enough to reject circumcision, while an infant or young child must accept whatever his parents think best for him. This proposition will be a great comfort to anybody who wants to perform genital cutting in children: all they have to do is make sure they get in good and early, before the

89 Jewish organisations’ brief; father’s petition for writ of certiori
90 Davis, Fathers, Foreskins and Family Law, 7
child develops any capacity for resistance and before interfering busybodies such as Doctors Opposing Circumcision have the chance to intervene in its defence. Which is, indeed, what usually happens.

The muddle arises because Davis mixes up two quite different kinds of competence: to consent to something desired and to refuse consent to something not desired. Contemporary controversies over teenagers and medical treatment centre on whether they are competent to consent to medical treatments such as contraception and quasi-surgical interventions such as piercings that they themselves are seeking, and whether parental authority may legitimately invoked to stop them. This is the complete reverse of the situation in the Boldt case, where the father sought to impose a quasi-surgical but medically unnecessary procedure on a boy, and not for the boy’s benefit, either physical or spiritual, but merely to ensure that the boy followed him into fresh pathways of religious experience. There is no question of the boy’s competence to refuse such medical treatment, since there was no medical treatment of a therapeutically nature offered; circumcision as an initiatory rite is not a medical procedure at all. Had Davis applied the open future principle here it would have been perfectly clear that the father had the right to prevent the boy from getting a nose or eyebrow piercing, or from getting circumcised, but not to impose such interventions. Equally, it would have shown that a minor does not have an automatic right to any medical treatment or bodily modification that takes his passing fancy, but must be guided by adult wisdom;

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91 Leanne Bunney, The capacity of competent minors to consent to and refuse medical treatment, 5 J Law Med 52 (1997)
but that he does have the right to reject and refuse interventions of this kind if his parents seek to impose them on him.

As to the startling suggestion that a child must have attained a certain (though undefined) degree of maturity before he or she becomes competent to reject contested surgical interventions such as circumcision, the ethical position was put by a writer in the *Canadian Medical Association Journal* in a passage that Davis herself quoted in her paper on the Seattle compromise:

> The performance of unnecessary surgery on minors who have no say in the matter does not sit well with many people who consider circumcision a denial of basic human rights specifically an infant’s right to the respect and autonomy fundamental to Canadian law. ... Removal of a normally function healthy body part without medical indication has also been viewed as a violation of the Hippocratic oath, falling under the United Nations’ definition of genital mutilation. As such, circumcision is seen as being against the Universal Declaration of Human Rights and the UN Convention on the Rights of the Child. ... In BC [British Columbia], the Infants Act stipulates that a child should be accorded the same protection under law as adults: if an adult male cannot be forced to undergo circumcision in adulthood, it follows that he shouldn’t be forced to have it in infancy simply because he is too small to resist.⁹²

The problem with the idea that circumcision of an adult requires informed consent but circumcision of a minor can be accomplished at the wish of a parent is that childhood is a temporary condition but circumcision a permanent one. A person soon ceases to be a child, but no matter how old he gets he will not get back what has been taken away; as an adult the person has the same mark or absence that his parents were entitled to effect by the mere fact of his being a minor. There is thus no significant difference between forcible circumcision of an adult (which is illegal) and circumcision of a minor, since the result in adulthood, when the parts affected are most needed, is the same in each case. To make an adult’s right to

⁹² Eleanor LeBourdais, *Circumcision No Longer a “Routine” Surgical Procedure*, 152 CANADIAN MED. ASS’N. J. 1873, 1874 (1995); part quoted in Davis, *Male and Female Genital Mutilation*, 515
The child’s right to an open future

Physical integrity meaningful it must be respected in infancy and childhood, implying that irreversible bodily alterations should not be performed. By defining respect for autonomy as “requiring that persons with the mental capacity to make certain medical decisions have these decisions respected”, Davis drastically reduces the scope of autonomy and effectively denies it to children and incompetent adults. This is a radical departure from accepted principles of bioethics and a succession of legal judgements in the USA, Britain and Australia that restrict the power of adults to make medical decisions on behalf of incompetent family members. Lack of mental capacity, neither in infancy nor in adulthood, does not negate a person’s right to physical integrity; if parents are determined to violate this right, the state is entitled to intervene in defence of those who lack the capacity to defend their own interests.

This is precisely what Davis wants to deny. Continuing her commentary on the Boldt case, she remarks that in the United States “many boys are circumcised for purely secular reasons, and it hardly seems to make a difference to their future lives”, and adds that this should be “reason enough to allow parents great latitude in making this decision for newborns” – that is, to have baby boys circumcised if they so desire. Once again we find a breathtaking assertion of parental power hinging on that small word “seems”. Davis produces no evidence in support of the impression that most men circumcised in infancy “don’t mind” or “get along

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93 Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics (Oxford University Press, 1977)


95 Davis, Boldt v. Boldt, 3
fine”, which is contradicted by the very existence of an anti-circumcision movement and the thousands of men in the USA, Canada, Britain, Australia and New Zealand who are attempting foreskin restoration, as well as the considerable evidence from personal testimony that, for many men, the pain of circumcision is not a momentary thing, but a life-long torment from which there is no release, sometimes leading to severe psychological disturbance, even when the physical damage is within the normal range.6 The kindest thing one can say about Davis’s remarks here is that they are callous, as is her following comment that being circumcised for religious reasons does not prevent a boy from changing his religion later. That may be true, but since most circumcision procedures in the USA are not performed for religious reasons, that small consolation (if consolation it be) is not available to the vast majority; and even if a boy does change his religious adherence later, he must still carry the mark of his initiation with him for the rest of his life: he does not get his foreskin back when he exits. Circumcision, it must be emphasised, is an irreversible marking of the body; even a tattoo as a sign of religious affiliation would be easier to erase if a person wished to move away from all that. Davis’s position is that so long as any circumcised boy retained the mental capacity to abandon the religion of his parents, the condition of his anatomy does not matter, since the absence of his foreskin would not prevent him from becoming an atheist, Christian, Buddhist or whatever. This argument is not only insensitive to human suffering, but treats mental states as all important and

the body as of no account. According to this theory, a boy would not be harmed or have his future options closed off even if his entire penis were lost – as happens to quite a few of the Xhosa teenagers in their sacred rite.

Davis observes that the Boldt affair is “eerily reminiscent” of the Yoder case, seeming to forget that in that instance she criticised the court for ignoring the interests of the children and considering only the wishes of the parents. She hastens to assure us that “circumcision is hardly as dramatic as being denied a high school education”, but like many of the confident assertions in her paper for Journal of Clinical Ethics, the claim is far from self-evident and highly debatable. In the modern world it is actually not so difficult for young people who missed out on the last two years of school to make good the gap if they have the will; they can go back to school after they have earned some money, or take advantage of early school leaver programs to enter tertiary education and acquire the qualifications that will lead to expanded career options. As Brigman points out, a boy who has been deprived of his foreskin has no such opportunities:

There are two significant differences between the denial of education by parents on religious grounds and the religious rite of circumcision: (1) denial of education is at least partly reversible, whereas the disfigurement caused by removal of a body part is not, and (2) the physical pain and suffering, with potentially significant surgical and general health complications, inflicted on infants by circumcision is not found in parents’ denial of education to their adolescent children.

It bears repeating that few bodily alterations are as irreversible as circumcision.

Part IV: Why does Davis not apply the open future principle to circumcision?

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97 Boldt v. Boldt 3
98 Brigman, Circumcision as child abuse, 354-5
It is clear from an analysis of her writings that there are two Dena Davises. One of them defends children’s right to an open future against parental expectations and their mental and physical integrity against parental “shaping”; defends the autonomy of the individual against demands of the group and insists that individuals must be treated as ends in themselves, with their own goals and values, and not as means to the goals and values of others. The other Professor Davis rejects these principles and considers that when it comes to genital surgeries and other quasi-medical procedures, the child’s right to an open future is trumped by parental wishes (since parents are “presumed” to know what’s best for a child), the individual is subordinated to the group, and it is acceptable to treat people as means to the goals of others, such as the cohesiveness of collective entities. We can be sure that Davis has not abandoned the open future principle in relation to the issues she has discussed in her writings on genetic dilemmas, for she has reiterated it as recently as 2009,\textsuperscript{99} long after she began to study genital cutting, and at the same time as she must have been observing the Boldt case and drafting the AAP’s short-lived policy on FGC issued in April 2010. It seems that she just does not apply the open future principle to genital cutting.

This failure is paradoxical, for there could hardly be any parental intervention to which the principle of the open future is more obviously applicable. It may not always be easy for individuals to overcome childhood mental conditioning such as indoctrination in religious values or gender roles, but it is far easier than restoring

\textsuperscript{99} The parental investment factor and the child’s right to an open future, 39 Hastings Centre Report, 24 (March 2009)
missing parts of their genitals. As Davis herself remarks, a girl raised as a Jew can become a Catholic, and the Bold case shows that a man can throw off his Russian Orthodox upbringing and convert to Judaism. If in the process he wishes to discard his foreskin that is his privilege. It is not so easy in the other direction: a man raised as a Jew or Muslim does not get his foreskin back if he decides to convert to Russian Orthodoxy. Nor does it follow that an adult’s change of heart means that any children they may have should be required to follow suit. When Davis turned her mind to ritual and other forms of genital cutting, she could have argued (and in view of her previous work would have been expected to argue) that she wanted MGC to be treated more like FGC in the interests of respect for children’s physical integrity and the open future principle; instead, she has argued that FGC should be treated more like MGC in the interests of respect for religion.

In concluding this paper I wish to suggest that there are five main reasons why she has confounded expectations so dramatically: (1) inattention to the context of male circumcision; (2) an unstable and none too robust concept of harm; (3) insufficient attention to human rights and bioethics; (4) a corresponding deference to religious belief and practice; (5) an obsessive focus on the needs of particular ethnic/religious minorities. I shall consider each of these points in turn.

1. Inattention to context of circumcision

Davis acknowledges the distinction between religious and secular motivations for non-therapeutic circumcision, but does not give sufficient attention to the question of purpose, consent and competence to consent. The blanket term “male circumcision” is deceptive because it ignores the context in which the procedure is
performed. The two principal forms of circumcision are therapeutic and non-therapeutic, and the latter may be divided further into prophylactic, ritual/religious/cultural, and owner preference. Therapeutic circumcision is to treat an injury, deformity or disease (as when an incurably gangrened finger is amputated); secular “prophylactic” circumcision (the most common form of non-ritual circumcision practiced in the USA today) is performed for a variety of reasons, but most often justified (especially when challenged) on the basis that it will reduce the subject’s risk of contracting certain diseases to which he may be exposed at some future time. Ritual circumcision should be grouped with other initiatory rites involving bodily alteration, such as all forms of FGC, tooth evulsion, scarification, ear-lobe elongation, neck stretching, cranial deformation etc. Prophylactic circumcision should be grouped with other convenience and cosmetic surgeries such as precautionary removal of appendix, adenoids or tonsils; sterilisation and castration; docking the tails of lambs or dogs; and the various cosmetic surgeries to alter a person’s appearance. Owner preference comes under the rubric of informed consent and poses no problem, except in cases

100 “Non-therapeutic” is defined by the Australian Commonwealth Family Law Rules 2004 (Medical Procedure Applications) as any procedure “not for the purpose of treating a bodily malfunction or disease”. A similar definition is used by the Tasmania Law Reform Institute: “circumcision is non-therapeutic if it is performed for any reason other than remedying or treating an existing disease, illness or deformity of the body. … A circumcision performed for the purpose of preventing or reducing the likelihood of possible future disease, illness or deformity of the body (a prophylactic circumcision) is a non-therapeutic circumcision.” TLRI, Non-therapeutic Male Circumcision, Issues Paper No. 14, June 2009, para. 1.3.5

101 It has been repeatedly shown that most American parents seek to have their boys circumcised for broadly social reasons that have little to do with “health prophylaxis”. Like circumcision performed for religious reasons, it is most often a cultural ritual. See Sharon L. Binner, Effect of Parental Education on Decision-Making About Neonatal Circumcision, 95 SO. MED. J. 457, 459 (2002); Mark S. Brown & Cheryl A. Brown, Circumcision Decision: Prominence of Social Concerns, 80 PEDIATRICS 215, 216 (1987). This does not prevent the practice from being defended in the rhetoric of science and bio-medicine, and even the Jewish organisations that supported Mr Boldt devoted much space in their Amicus Curiae brief to a rehearsal of the alleged benefits of circumcision (especially in relation to penile cancer and HIV), as though such temporal utility strengthened their case for circumcision as a religious obligation. See also Geoffrey P. Miller, Circumcision: Cultural-Legal Analysis. 9 Va. J. Social Policy & the Law. 497 (2002)
where an under-age boy wants to get himself circumcised for some reason, in which case it is perfectly correct for parental authority to prevent it until he is old enough to make a more mature and informed decision. Not that all these surgeries are of the same kind. Few people would care if their appendix or tonsils were removed, since they are invisible and have little or no function. Some children with facial abnormalities or deformities might well wish for cosmetic surgery to make them look more normal and attractive. The penis, however, is a central fact in the life of most males, and they are understandably very touchy about anything affecting its appearance and functionality. On top of these distinctions there is the issue of informed consent – an absolute requirement for all other medical procedures – but which of course cannot be given by minors.

To talk about the ethics and acceptability of circumcision in general makes as little sense as to ask whether sexual intercourse is acceptable: it depends on the circumstances. Sexual intercourse with consent is legitimate; sexual intercourse without consent is rape. It is no different in the case circumcision: with the informed consent of the subject or (in cases of genuine medical necessity) with surrogate consent it is legitimate; without such consent it is assault. The principles of the “parents can be trusted to know the best interests of their children” school, whether valid or not, would be applicable only to situations where treatment was medically required, that is, where there was a pathological condition affecting a child’s health. The principles could be debated in relation to therapeutic circumcision (for example, to treat BXO, persistent severe phimosis or recurrent
UTIs that have not responded to conservative treatment), but they have no relevance to non-therapeutic circumcision, whether ritual or prophylactic, since this is an operation to remove a healthy and normal structure. Non-therapeutic circumcision is not medical treatment at all.\(^{103}\)

2. An inadequate concept of harm

Secondly, Davis operates with an inadequate and unstable concept of harm, tending to rely on her gut feeling (that word *seems*) rather than any sort of objective scale, which means that she is subject to the prejudices of her socialisation and the culture that surrounds her: hence her erroneous assumptions that male circumcision (even in the USA) is both accepted, when it is really a “contested surgery”, and harmless, which it certainly is not. It is relatively easy to make choices among greater and lesser evils with respect to FGC, since the World Health Organisation has kindly provided a typology of the various cutting operations, running from mild to severe. No such scale exists for MGC, and she assumes that all circumcisions are the same, even though MGC, like FGC, can vary through a similar spectrum of organic damage.\(^{104}\) In another paper J. Steven Svoboda and I have argued that one of the principal reasons FGC is widely perceived as always more harmful than MGC is that the former term covers a

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\(^{102}\) See British Association of Paediatric Urologists, Management of Foreskin Conditions, at http://baps.org.uk/page14/page14.html

\(^{103}\) Little v. Little 576 S.W. 2d 493 (Tex. Civ. App. 1979), cited in Svoboda et al, Informed Consent for Neonatal Circumcision, 89-90. See also Tasmania Law Reform Institute, Non-therapeutic Male Circumcision

\(^{104}\) R.S. Van Howe, Variability in penile appearance and penile findings: A prospective study, 80 Brit J Urol, 776 (1997)
range of procedures, while male circumcision is thought to involve only one. We argue that this idea is mistaken and have proposed a scale of physical damage to complement the WHO’s classification of FGC. It is also necessary to consider the exact nature of the circumcision operation, since it may take many different forms, and cause more or less physical damage, depending on the instruments used, the skills of the operator, and the sophistication of the medical setting. The spiritual objects of ritual circumcision may be satisfied by a symbolic cut and the shedding of blood; prophylactic circumcision, on the other hand, may require the removal of as much tissue as possible, since the theory is that the loss of the genital mucosa and resulting scar tissue makes the penis less vulnerable to penetration by microorganisms.\textsuperscript{105}

Davis also tends to regard psychological harm as more serious than physical damage. In her writings on genetic dilemmas she argues forcefully that it is wrong for parents to pre-select a child’s gender because parents who do so are likely to want the child to live up to strongly held expectations (butch, football-playing boys; demure, feminine girls) that will make it difficult for the child to escape “gender stereotypes” later.\textsuperscript{106} But is this really worse and more irreversible than being permanently physically disfigured? Or is the open future principle applicable only to mental and behavioural shaping? The question of harm hinges on whether a permanent mark is left on the body, and how prominent it is, and whether any tissue or anatomical feature is removed. A nick or scratch that left no

\textsuperscript{105} Though this has not been proved, and keratinisation (despite assumptions) has been found not to help: M.H. Dinh et al, Keratinization of the adult male foreskin and implications for male circumcision, 24 AIDS 899 (2010)

\textsuperscript{106} Davis, Genetic Dilemmas, chap. 5
permanent mark, or only an insignificant one, is harmless; a nick or scratch that leaves a prominent scar is mildly harmful, but only mildly so long as no tissue is removed, no nerves are damaged and organic function is not affected. Any cutting that removes tissue or severs nerves is *ipso facto* harmful because it deprives a person of part of his/her body and because it alters both the appearance and functionality of the organs.

3. Inattention to human rights and bioethics

Thirdly, Davis fails to take human rights and bioethics as seriously as they deserve. Although she acknowledges the child’s right to an open future, and that this includes the right not to be harmed and to be protected from interventions that permanently and substantially limit his/her future options, there are no references to the Universal Declaration of Human Rights, the International Convention on Civil and Political Rights or the Convention on the Rights of the Child, and thus no acknowledgement that all humans have certain rights that pre-exist their entry to any particular cultural or family context.\(^\text{107}\) The rights accorded by these instruments include both freedom of religion and physical integrity, accorded to “everyone” without exception; there is nothing to suggest that only adults have these rights or that they are not held by infants or children merely

because the latter lack the resources to claim or exercise them. Although it is permissible for a child’s physical integrity to be breached to a certain extent and for certain beneficial purposes, there should be some discussion of what the extent and purposes are. Because the UDHR and the ICCPR gives freedom of religion to everybody, even babies have this right independently of their parents. They may not be able to exercise it until they are much older, but under the open future principle it is a perfect example of a right-in-trust that must be preserved until they develop the capacity. Both instruments, furthermore, specifically prohibit anybody from exercising their rights in such a way as to abridge the rights of others: if it is both illegal and a violation of human rights principles for an adult to forcibly circumcise another adult, how could it be either legal or in accordance with human rights principles to forcibly circumcise a potential adult? There is no meaningful difference between circumcision a minor without consent and forcibly circumcision an adult.

Article 24 (3) of the CRC prohibits “traditional practices prejudicial to the health of children”. Although there has always been uncertainty as to whether this refers to FGC, MGC, both, or neither, it is apparent from the working group debate that the intended target was FGC. Several delegations, led by the United States, wanted female genital mutilation to be specifically referred to in order “to ensure that the Group would explicitly address the traditional practices of greatest concern” and to “give greater content to the phrase ‘traditional practices.’” This proposal alarmed delegations from countries where female genital mutilation was widely practiced, and Senegal responded by urging the Working Group to exercise restraint. According to Sonia Harris-Short, the Senegalese delegation then took a
leading role in the drafting of the proposed article, and it was largely due to its resistance that the USA proposal to name FGC as a practice “prejudicial to the health of children” was defeated. The term “traditional practices” was thus undefined in the final text, leaving it open to argument as to whether FGC falls foul of its provisions. 108 But of course the wording also left room for argument as to whether the term referred to MGC, 109 and one wonders whether the US delegation’s determination to name FGC specifically was also intended to ensure that it could not be interpreted as referring to boys, as the algebraic wording allows, and as it has in fact been interpreted on more than a few occasions. 110 It is true that the USA (alone with Somalia) has not ratified the CRC, but whether this failure reflects lack of support for its principles or a traditional American exceptionalism that regards international treaties of this sort as infringing popular democracy and national sovereignty, 111 is a question that cannot be pursued here.

109 Peter Newell, The child’s right to physical integrity, 1 Int. J. Childrens Rights 101 (1993)
111 Ignatieff, Human Rights as Politics and Idolatry, 13, 83; American Exceptionalism and Human Rights (Princeton 2005); Susan Kilbourne, The wayward Americans: Why the USA has not ratified the UN Convention on the Rights of the Child, 10 Child and Fam Law Quarterly 243 (1998)
Davis is also surprisingly weak on bioethics. No critic of circumcision objects to the imposition of necessary or desirable therapeutic procedures on non-consenting minors, since such interventions are for the child’s benefit, do not cause disproportionate harm, and would normally satisfy both the best interests and the substituted judgement tests. But they do insist on scrupulous ethical inquiry into all non-therapeutic and unnecessary surgeries, especially when they result in lifelong bodily alterations, whether the motivation is religious or secular. Contrary to Mr Boldt’s claim, parents do not have an unfettered right to make medical decisions for their children: what they have is the duty to provide approved medical treatments when needed for the child’s well-being. They do not have the right to subject a child to bogus treatments (such as faith healing) or to withhold valid treatments (blood transfusions, chemotherapy, vaccination against serious diseases) when necessary, nor to impose valid treatments when not necessary.

Davis is equally in error when she asserts that because circumcision makes little or no difference to the future lives of boys circumcised for secular reasons, parents should be allowed “great latitude in making this decision for newborns”. This position not only embodies a non-sequitur and violates the open future principle, but contradicts the AAP’s policy on informed consent and parental permission: “[P]roviders have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses. … The pediatrician’s responsibilities to his or her patient exist independent of parental desires or proxy consent.”

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inconsistent with the four fundamental principles of bioethics as set out in standard texts such as Beauchamp and Childress:

Beneficence — Does the proposed procedure provide a net therapeutic benefit to the patient, considering the risk, pain, and loss of normal function?

Non-maleficence — Does the procedure avoid permanently diminishing the patient in any way that could be avoided?

Proportionality — Will the final result provide a significant net benefit to the patient in proportion to the risk undertaken and the losses sustained?

Justice — Will the patient be treated as fairly as we would all wish to be treated?

Autonomy — Lacking life-threatening urgency, will the procedure honor the patient’s right to his or her own likely choice? Could it wait for the patient’s assent? Non-therapeutic genital cutting of children violates every one of these principles.

4. Deference towards religious belief and practice

It is significant that Davis concentrates on the Amendment that would allow religiously-motivated circumcision of girls, not on the Amendment that would appear to require any legislation on genital cutting to be gender neutral and thus protect both girls and boys. It is also significant that she proposes to make progress towards evening up the double standard by reducing the protection given to girls, not by increasing the protection given to boys (or not to any meaningful degree). It can thus be seen that her primary object throughout is to show respect for religious belief, not children’s bodies. It is also clear that she accepts circumcision of boys, especially when religiously motivated, as a given and expects it to continue. If her principal aim had been to promote equality of

113 Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics (1977; 6th edn, Oxford University Press, 2009), Part II
treatment, she could have focused on the Fourteenth Amendment and argued, not that the Federal law criminalising any form of FGC should be watered down, but that it should be expanded in scope so as to protect boys – not necessarily to give them as total a degree of protection as the current statute gives girls, but something to protect them from parental whim. Indeed, the legislation could even include a clause allowing an exemption for parents who belong to a recognised religion that practises circumcision and who conscientiously believe that circumcising their children is a requirement of their faith. Such a law would give protection to the vast majority of American boys who are circumcised for non-religious reasons, while allowing ethnic and religious minorities to follow their traditional customs. Her next step would be to work towards devising a less harmful alternative procedure for boys, involving something less than radical amputation of their foreskin.

Reviewing Davis’s writings on circumcision it does seem as though her attitude had shifted in the decade since 2001 and that she is now far less committed to children’s rights than she was then, and less objective about circumcision. In her discussion of the Seattle compromise she points out that although religious Jews regard circumcision as “an obligation of the highest order”, most American Jews do not have their sons’ genital alteration performed in a ritually correct manner. The procedure can be understood as deeply sexist, as a celebration of group identity and cultural survival, as anti-erotic, and as a rite of passage. The reasons why parents subject their sons to MGA include religion, custom, group cohesion, family pressure, a misunderstanding of medical benefits, and economic motivations from those who perform circumcisions.114

114 Davis, Male and Female Circumcision, 562. Leonard Glick argues that many American Jews are more likely to circumcise their boys because they are American than because they are Jews:
But when Davis discusses the Boldt case this fair-minded assessment is replaced by what seems like special pleading. Making her unsubstantiated assertion that most circumcised men seem to manage OK in later life, she cites this as a reason why it is especially important to allow parents “great latitude in making this decision for newborns when the parents have grave religious reasons. A newborn, circumcised at eight days and welcomed into the Jewish covenantal community, is free to leave it as an adult, and being circumcised will not stand in his way.” All of Davis’s sympathies here are with the rules of the community, and she appears to have no feelings at all for the boy/adolescent/adult who might prefer not to remain physically scarred for the rest of his life, or who, on the contrary, might want to retain both his faith and his foreskin. What Davis appears to be doing is applying the rules of a priest-dominated monoculture in which a person conformed to group norms or died in the wilderness, to a modern, secular, multicultural society where there are many cultural choices available to individuals and everybody has the potential to reinvent themselves, and in which the state must be neutral with respect to sub-cultures and give all individuals the same protection under the laws of the nation.

(5) A focus on the needs of minorities
It is evident from both the content and the tone of Davis’s own writings, especially when she comes to the Boldt case, that she is more interested in preserving religiously-motivated circumcision than routine circumcision for secular reasons. But since she formulates her defence of the former in broad terms that encompass the latter, her arguments apply not only to children of Jewish, Muslim and Somali parents, but to children whose parents have no cultural reason to circumcise, thus placing all children (though in practice only boys) at risk. This tendency to cast the defence of a traditional practice confined to sub-cultures in terms that apply to everybody has been a feature of American debate over circumcision for at least a century, for it was on the eve of the First World War that the American-Jewish physician Abraham Wolbarst issued his call for “universal circumcision as a sanitary measure”. Confronted with evidence that ritual circumcision was infecting many babies with serious diseases (including diphtheria, tuberculosis and syphilis), and with a consequent campaign by pediatricians to restrict or at least regulate the procedure,117 Wolbarst perceived that the surest way to preserve circumcision within the Jewish community was to generalize it throughout the whole of society as a necessary health precaution. Accordingly, he did not try to justify it on the culturally relativist ground of ethnic particularity, but on the scientific ground that it was a valid measure of preventive health that should be imposed on every male. Taking advantage of the then health scares, syphilis and masturbation, he argued that male circumcision conferred high resistance, if not immunity, to syphilis, discouraged masturbation, and prevented or cured a great

117 L. Emmett Holt, Tuberculosis acquired through ritual circumcision, 61 JAMA, 99 (1913)
many other problems, including herpes and cancer. There is no reason to think that Wolbarst was insincere in his belief that circumcision did confer “health benefits”: like the conservative rabbis in nineteenth century Germany who defeated the reformers who wanted to extend the reform of Jewish law to outdated practices such as circumcision, he cited the “discoveries” of British and American doctors to prove that modern medicine was confirming the wisdom of Jewish tradition. This litany became the script for many who followed.

The situation in the USA is not so different today: circumcision is under attack and on the decline both within the Jewish and among the general community, and religious conservatives are worried. Davis does not base her defence of such practices on medical grounds, but the grounds she has chosen – bioethics, human rights, parental authority, law – are equally unstable. As I have attempted to show, non-therapeutic circumcision of minors cannot be justified within the principles of bioethics or human rights; violates the open future principle that Davis advocates in other contexts; and is probably unlawful even without a specific statute. Ritual and culturally-based genital cutting may be defensible

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118 Wolbarst, Universal circumcision as a sanitary measure; for further discussion, see Robert Darby, Where doctors differ: The debate on circumcision as a protection against syphilis, 1855-1914, 16 Social History of Medicine, 57 (2003)

119 Glick, Marked in Your Flesh, 121-23, 183-88

120 The latest statistics on neonatal circumcision in the USA show a dramatic decline over the past four years, from 56 per cent of boys in 2006 to only 33 per cent in 2010 – an astonishing drop in view of the massive media coverage given to the claimed efficacy of circumcision as a protection against HIV. Even if these figures require revision, we can confidently say that the incidence of circumcision is now well below 50 per cent, meaning that it is unequivocally a minority practice. For the latest figures, see paper by Charbel El Bcheraoui at the Vienna AIDS Conference, http://www.acep.org/MobileArticle.aspx?parentfeedid=4&feed_id=imn080420101635228885&parentid=742

121 As the Queensland Law Reform Commission found in 1991, and as Shaw, Cutting through red tape, argues.
within the principles of cultural pluralism and the rules of the multicultural, multi-ethnic state, but that is not an argument that Davis advances, and not one that I can pursue here. The point I want to stress is that defending the controversial ritual practices of cultural minorities in terms that apply to everybody distorts the debate over circumcision and causes difficulties for medical bodies such as the AAP, whose members are then expected to perform religious functions because they have a quasi-surgical nature and require considerable skill. The result is that when such bodies come to formulate policy on circumcision, it is biased towards accommodating the needs of the minorities that practise it for cultural reasons, thus allowing (and indeed encouraging) all parents to do it, and putting all children at risk. This is a case of the ethnic/religious tail wagging the secular dog. It would be more logical, simpler and fairer if such policies were written the other way round: making the needs of the majority the general rule and accommodating the needs of specific minorities as an allowable exception.

V: Summary and conclusion

In this paper I have attempted to show the following.

- International treaties in the human rights field give people the right to bodily integrity and freedom of religion without discrimination as to age or gender.

- Many human rights authorities and bioethics experts consider non-therapeutic circumcision of minors to be a human rights violation. Some legal authorities consider it to be unlawful, even without a specific statute.

- Circumcision causes physical and psychological harm and is often resented by those who have been subjected to it.
• Medical authorities do not consider circumcision a desirable routine measure for child health.

• There are no “compelling” public health arguments that would justify circumcision of non-consenting minors in the United States or other developed nations.

• Boys in the United States are at far greater risk of genital mutilation than girls.

• Ritual genital cutting cannot be defended in terms of bioethics, human rights or law.

• The principle of the child’s right to an open future is applicable to genital cutting.

It is, however, difficult to suggest an effective and widely acceptable means of protecting boys from adults (usually their parents) who want to get them circumcised. The issue is a highly emotional one, touching on both the relations between parents and their children and the sensibilities of ethnic/religious minorities that regard circumcision as a requirement of their faith or a necessary mark of their tribal identity. Previous attempts to take action in other countries have foundered on precisely this rock. When, in 1986, the Australian government dropped circumcision from the national health scheme (Medicare), the decision aroused protests from Jewish religious leaders, who considered the reform discriminatory in that it applied to circumcision only of boys under six months, and the decision was reversed without a fight. In the early 1990s the Queensland Law Reform Commission found that non-therapeutic circumcision of minors was probably in breach of the State crimes act and was considering the possibility of specific legislation that would give boys protection similar to that already accorded to girls. In response to a discussion paper it received such a flood of contradictory submissions that it was unable to reach a firm conclusion, and
nothing was done. Many of the submissions were from Jewish and Muslim organisations which insisted that any restriction on their right to circumcise boys would be an infringement of their religious freedom and thus a breach of Australia’s human rights obligations. Interestingly, however, most of their submissions did not try to justify circumcision on culturally relativist grounds, but in terms of an old fashioned set of health benefits, the validity of which had already been rejected by medical authorities, but which were applicable to everybody. Such reliance on medico-scientific arguments to defend a traditional cultural practice was not a new strategy, and it would become more pronounced as the 1990s wore on. I have argued elsewhere that the revival of old claims for the “health benefits” of circumcision that became apparent in the mid-1990s is largely a response by traditional circumcising cultures to developments in human rights, law and medical ethics that were threatening to outlaw their practices. The problem for critics of circumcision was that any general ethical or human rights argument against circumcision could not avoid applying to the cultural and religious groups that were most committed to the practice, and most loath to give it up, who naturally reacted fiercely. They, in turn, formulated their arguments in favour of circumcision in terms that applied to all boys, not just their own sub-culture. The result has been that in order to preserve circumcision among the ethnic/religious groups that traditionally practise it, all other boys have been placed at risk of a needless and cruel operation.


Is there no way out of this dilemma? At least for the foreseeable future there is unlikely to be any legislation similar to the federal FGM Act to protect boys from circumcision. In this environment, the emphasis should be on making a clear demarcation between ritual genital cutting and secular routine circumcision; discouraging medical personnel from performing either as part of their normal duties; better education of parents as to the harm of circumcision and its non-necessity for health; and the cessation of signals that it is a medically approved or socially expected procedure.