THE MEDICAL DIRECTOR'S GUIDE TO MALE CIRCUMCISION

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in close cooperation with ***NORM-SA*** *(National Organisation of Restoring Men – South Africa),*
and ***ICGI*** *(International Coalition of Genital Integrity).*

Medical expenses are rising faster than available resources. Consequently, there is great interest in reducing unnecessary expenses. We offer this information regarding male circumcision so that medical directors and private hospitals may have full information about the advisability of discontinuing coverage of male circumcision, especially that of the newborn. This communication also serves to publicly inform appropriate institutions of current medical trends regarding circumcision within the medical system in South Africa and the ethical, legal and human rights implications thereof.

There are no medical indications for circumcision of newborn infants[1] [2] and neonatal male circumcision is classified as a *non-therapeutic* procedure.[3] No disease is present in newborn male infants, so no therapeutic action is required. Neonatal circumcision has thus been re-classified as an "*elective procedure to be performed at the discretion of the parents*," according to Paediatric, Obstetric and Gynecological Associations worldwide.[4] [5] This re-classification removes any suggestion that newborn circumcision is a normal part of hospital routine or a medically recommended procedure. Non-therapeutic infant circumcision, therefore, is not presently the South African, nor the worldwide, standard of care.

A few doctors have expressed the *opinion* that there are medical or prophylactic benefits from circumcision. The medical *evidence*, however, does not support these claims. Recent evidence-based statements from several medical associations[6] [7] [8] [9] firmly establish that circumcision is *not* medically necessary. All decline to recommend the procedure. All make emphasis that circumcision is an *elective* procedure.

Medical societies worldwide, including South Africa, find that the *alleged* benefits do *not* exceed the *known* risks.[10] [11] They counsel that circumcision should *not* be routinely performed, meaning that circumcision should *not* be performed without a specific medical indication. The South African Medical Association's (SAMA) position statement on non-medical circumcision of children reflected that, *"from a medical point of view, there was no medical justification for routine circumcision in neonates and children."*

Therefore medical studies support the removal of non-therapeutic neonatal circumcision from the schedule of covered procedures. Cadman *et al.* studied the economics of elective neonatal non-therapeutic circumcision. They

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[1] Foetus and Newborn Committee. FN 75-01 Circumcision in the Newborn Period. *Canadian Paediatric Society News Bulletin Supplement* 1975;8(2):1-2.

[2] Committee on Fetus and Newborn: *Standards and Recommendations for Hospital Care of Newborn Infants*. Sixth Edition. American Academy of Pediatrics; Evanston, IL, 1977: 66-7.

[3] Council on Scientific Affairs, American Medical Association. Report 10: Neonatal circumcision. Chicago: American Medical Association, 1999. Available at URL: http://www.ama-assn.org/ama/pub/article/2036-2511.html

[4] American Academy of Pediatrics & American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*, Fourth Edition, 1997.

[5] American Academy of Pediatrics & American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*, Fifth Edition, 2002.

[6] American Academy of Pediatrics Task Force on Circumcision. Circumcision Policy Statement. *Pediatrics* 1999;103(3):686-93. URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;103/3/686

[7] Council on Scientific Affairs, American Medical Association. Report 10: Neonatal circumcision. Chicago: American Medical Association, 1999. Available at URL: http://www.ama-assn.org/ama/pub/article/2036-2511.html

[8] Commission on Clinical Policies and Research. *Position Paper on Neonatal Circumcision*. Leawood, KS. American Academy of Family Physicians, 2002. URL: http://www.aafp.org/policy/camp/4.html

[9] ACOG Committee Opinion Number 260: Circumcision. *Obstetrics & Gynecology* 2001; 98(4):707-8.

[10] Fetus and Newborn Committee, Canadian Paediatric Society. Neonatal circumcision revisited. (CPS) *Can Med Assoc J* 1996; 154(6): 769-780. URL: http://www.cps.ca/english/statements/FN/fn96-01.htm

[11] Beasley S, Darlow B, Craig J, *et al.* Position statement on circumcision. Sydney: Royal Australasian College of Physicians, 2002. URL: http://www.racp.edu.au/hpu/paed/circumcision/

found it to be uneconomic and recommend that public health care funds not be expended on neonatal circumcision.[12] They argue that funds spent on this wasteful procedure should be spent on medically useful services. They recommend that parents bear the cost of this unnecessary elective surgery. Spilsbury *et al.* have studied the effects of insurance coverage of elective non-therapeutic circumcision.[13] They find that coverage of non-therapeutic circumcision should be discontinued to encourage parents to elect the medically preferred option of non-circumcision.

The British National Health Service stopped payment for circumcision in 1950. Canada has 13 provincial and territorial health insurance plans, twelve of which (92%) have dropped coverage of circumcision. New Zealand's health plan discontinued coverage over 40 years ago. American medical aids have followed the same downward trend by discontinuing coverage of unnecessary non-therapeutic circumcision.

A growing number of private insurers decline to reimburse for medically unnecessary procedures such as non-therapeutic circumcision.

Based on the above, we believe that deleting coverage of non-therapeutic circumcision is a responsible and reasonable action to reduce costs. It is appropriate to shift the cost of this *elective* medically unnecessary non-therapeutic surgery and its complications to those who *elect* to have a circumcision performed. Cosmetic procedures on non-consenting infants also have potential ethical, legal and constitutional ramifications particularly with regard to gender inequality implied by the legal protection of female genitalia from non-consenting surgical alteration.

Additional Costs

The total cost for circumcision is likely to be much higher than one would expect because, if circumcision is performed, both mother and baby tend to remain in hospital longer and consume more services.[14]

When circumcisions are performed, complications frequently occur and must be treated at additional expense. The most common complications of circumcision are bleeding and infection. Infection may be minor or major. Major infections include meningitis,[15] tuberculosis,[16] and necrotizing fasciitis requiring extensive surgical debridement of infected tissue.[17] Some examples are: Van Howe reported a case in which the baby was unable to nurse after circumcision, resulting in a four-day hospital stay,[18] and Connelly *et al*. reported a case of gastric rupture secondary to neo-natal circumcision, which resulted in a 25-day hospital stay.[19] Botched circumcisions sometimes result in cases of inconspicuous penis that require surgical attention.[20] Penile ablation is a complication of circumcision, usually treated by costly surgical reconstruction of a phallus[21] or a sex change operation with psychosexual follow-up.[22] Unfortunately, there are no data to indicate the total cost of treatment for complications of circumcision.

Meatitis, meatal ulceration, and meatal stenosis occur *only* in circumcised boys who lack the protection of the foreskin. Meatal stenosis usually requires a meatotomy. Circumcised boys also tend to be troubled with adhesions – caused by the raw residual foreskin healing to the raw glans penis – which may require a lysing.[23]

When circumcisions are avoided, these additional costs, which fall on the health insurance provider, also are avoided.

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[12] Cadman D, Gafni A, McNamee J. Newborn circumcision: an economic perspective. *Can Med Assoc J* 1984;131:1353-5.
[13] Spilsbury K, Semmons JB, Wisniewski ZS, Holman CD. Routine circumcision practice in Western Australia 1981–1999. *ANZ J Surg* 2003;73(8):610-4.
[14] Mansfield CJ, Hueston WJ, Rudy M. Neonatal circumcision: associated factors and length of hospital stay. *J Fam Pract* 1995;41(4):370-6.
[15] Scurlock JM, Pemberton PJ. Neonatal meningitis and circumcision. *Med J Aust* 1977;1(10):332-4.
[16] Holt LE. Tuberculosis acquired through ritual circumcision. *JAMA* 1913;LXI(2):99-102.
[17] Bliss Jr DP. Healey PJ, Waldhausen JHT. Necrotizing fasciitis after Plastibell circumcision. *J Pediatr* 1997;31:459-62.
[18] Van Howe RS. Neonatal circumcision: associated factors and length of hospital stay (letter). *J Fam Pract* 1996;43(5):431.
[19] Connelly KC, Shropshire LC, Salzberg A. Gastric rupture associated with circumcision. *Clinical Pediatrics* 1992;31(9):560-1.
[20] Bergeson PS, Hopkin RJ, Bailey RB, *et al.* The inconspicious penis. *Pediatrics* 1993; 92:794-7.
[21] Pearlman CK. Reconstruction following iatrogenic burn of the penis. *J Pediatr Surg* 1976; 11: 121-2.
[22] Bradley SJ, Oliver GD, Chernick AB. Experiment of Nurture: Ablatio Penis at 2 Months, Sex Reassignment at 7 Months, and a Psychosexual Follow-up in Young Adulthood. *Pediatrics* 1998;102(1):e9.
[23] Gracely-Kilgore KA. Penile adhesion: the hidden complication of circumcision. *Nurse Pract* 1984; 9: 22-4.

The Normal Foreskin in the Child

Many doctors in certain cultures see only circumcised boys and may therefore not be familiar with the normal intact foreskin.

The prepuce of infants and children is quite different from that of adults because the penis is developmentally *immature* at birth. The inner surface of the prepuce is attached to the underlying glans penis.[24] The foreskin often extends well beyond the tip of the glans penis of the infant.[25] [26] The opening of the foreskin usually is narrower than the glans penis, so the foreskin cannot be retracted. The long narrow non-retractile foreskin provides certain health benefits.[27] It protects the glans penis from contact with the ammonia from urine and prevents meatitis, meatal ulceration, and meatal stenosis—conditions seen only in circumcised boys. Furthermore, the narrow sphincter-like foreskin opening prevents admission of faecal material with bacteria to the vicinity of the urethra and helps to prevent urinary tract infection. *A long, narrow non-retractile foreskin, therefore, is completely normal, healthy, and advantageous in infants and children.*

The penis matures during the childhood and pubertal years. The inner surface of the foreskin gradually separates from the glans penis; the shaft of the penis lengthens, and the apparently excessive foreskin ceases to exist; the opening of the foreskin widens; and the foreskin becomes retractable.[28] The rule of thumb is that 50 percent of boys have a retractile foreskin by puberty, and the hormones of puberty complete the process for the majority of others. After puberty, the penis assumes its adult appearance without the need for surgery.

Redundant prepuce refers to a prepuce that someone thinks is too long. However, there is no objective standard to determine how much is too long, just as there is no objective standard to determine whether someone's nose is too long. So-called "redundant prepuce" is not a medical problem.[29]

Code Information

The South African medical industry has recently implemented the ICD-10 coding system.

ICD-10 Code Z41.2, described as *Routine and Ritual Circumcision,* is used to obtain payment for circumcision. Code Z41.2 is used for elective circumcision at parental request, which denotes a circumcision in the *absence* of any medical indication. In fact circumcision falls under the section headed *"Procedures for purposes other than remedying health state"* with the ICD-10 coding system along with other cosmetic procedures such as *"Ear piercing Z41.3"* and *"Other plastic surgery for unacceptable appearance Z41.1".*

ICD-10 Code N47 denotes *redundant prepuce, phimosis and paraphimosis*. Redundant prepuce and phimosis as, indicated above, are *normal* conditions in the physiology of a male infant, child and youth, and therefore *do not* indicate pathology or disease. There is no medical purpose for these procedures at these ages and when performed, create an abnormal physical appearance. Neonatal circumcision is thus classified as an unnecessary "cosmetic" procedure[30].

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[24] Deibert, GA. The separation of the prepuce in the human penis. *Anat Rec* 1933;57:387-99.
[25] Davenport M. ABC of General Surgery in Children: Problems with the penis and prepuce *BMJ* 1996;312:299-301.
[26] Camille CJ, Kuo RL, Wiener JS. Caring for the uncircumcised penis: What parents (and you) need to know. *Contemp Pediatr* 2002;11:61.
[27] Fleiss P, Hodges F, Van Howe RS. Immunological functions of the human prepuce. *Sex Trans Inf* 1998;74:364-7.
[28] Kayaba H, Tamura H, Kitajima S, *et al.* Analysis of shape and retractability of the prepuce in 603 Japanese boys. *J Urol* 1996;156(5):1813-5.
[29] Fleiss PM, Hodges FM. *What your doctors may not tell you about circumcision*. New York: Warner, 2002: 171, 199.
[30] Commission on Clinical Policies and Research. *Position Paper on Neonatal Circumcision*. Leawood, KS. American Academy of Family Physicians, 2002. Available at URL: http://www.aafp.org/policy/camp/4.html

Recommendations

We make the following recommendations:

1. No payment should be made for non-therapeutic neonatal circumcision for which there is never a medical indication. (Medical associations worldwide describe neonatal circumcision as a 'non-therapeutic' procedure.[31]) - Using ICD-10 code Z41.2 should not be recognised as a valid diagnostic code because this is for *non-therapeutic* circumcision at parental request.

2. ICD Code N47 denotes *redundant prepuce, phimosis and paraphimosis*. Of these conditions both redundant prepuce and phimosis are normal within the physiology of a male infant, and *do not* indicate pathology or disease. Thus it can not be recognised as a valid diagnostic code in children because this code describes conditions that are normal prior to the completion of puberty, and which are pathological only in adults. The continued use of these terms indicating a pathological diagnosis for normal anatomy in infants is therefore fraudulent.

3. Conservative treatment should always be required prior to approval of a request for therapeutic circumcision.[32]

4. Pre-approval for coverage of a therapeutic circumcision should be required. Evidence of need must be submitted with the application. Such evidence should include a complaint, diagnosis of a disease, and a pathologist's report on the actual existence of preputial disease (usually balanitis xerotica obliterans or BXO[33 34]). In the absence of documented evidence of disease, requests for circumcision payments should be refused.

5. In the alternative, claims for payment for a therapeutic circumcision must be accompanied by a pathologist's report showing disease for which circumcision is the treatment of choice, or payment should be refused in the absence of the pathologist's report of disease (BXO).

6. Non-therapeutic circumcision be considered a total scheme exclusion

7. Pre-approval be required for infant circumcision, or circumcision of minors, as some local Medical aids currently DO NOT require such pre-authorisation for non-therapeutic infant circumcision.

Implementation of these measures should greatly reduce the number of payments for circumcision procedures, the vast majority of which are medically unnecessary.

Conclusion

The medical literature shows there are no substantial benefits to the surgery and the risks and disadvantages of circumcision far outweigh any slight, potential benefit. It is therefore reasonable and prudent to stop covering the circumcision of infant boys until evidence-based medical principles are applied to this surgery and issues about patient autonomy, performing elective surgery on a non-consenting minor, informed consent, sexual privacy, adverse neurological development, post-traumatic shock, and surgical necessity criteria are answered. Infant circumcision is currently being spotlighted as an international human rights issue,[35 36] and when performed within medical establishments on a non-therapeutic basis has impending ethical and legal ramifications.

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[31] Council on Scientific Affairs, American Medical Association. Report 10: Neonatal circumcision. Chicago: American Medical Association, 1999. Available at URL: http://www.ama-assn.org/ama/pub/article/2036-2511.htm

[32] Committee on Medical Ethics. *The law & ethics of male circumcision - guidance for doctors*. London: British Medical Association, 2003. URL: http://www.bma.org.uk/ap.nsf/Content/malecircumcision2003

[33] Rickwood AMK, Kenny SE, Donnell SC. Towards evidence based circumcision of English boys: survey of trends in practice. *BMJ* 2000;321:792-3. URL: http://bmj.bmjjournals.com/cgi/content/full/321/7264/792

[34] Spilsbury K, Semmens JB, Wisniewski ZS. *et al.* Circumcision for phimosis and other medical indications in Western Australian boys. *Med J Aust* 2003 178 (4): 155-158. URL: http://www.mja.com.au/public/issues/178_04_170203/spi10278_fm.html

[35] Committee on Medical Ethics. The law & ethics of male circumcision - guidance for doctors. London: British Medical Association, 2003. URL: http://www.bma.org.uk/ap.nsf/Content/malecircumcision2003

[36] College of Physicians and Surgeons of British Columbia. Policy Manual: Infant Male Circumcision. Vancouver, BC: College of Physicians and Surgeons of British Columbia, 2004. URL: http://www.cpsbc.bc.ca/policymanual/c/c13.htm

Due to its non-therapeutic, cosmetic and irreversible effect, circumcision of non-consenting minors is a violation of the legal right to bodily integrity. Human rights documents such as the Universal Declaration on Human Rights (1948) and the Convention on the Rights of the Child (1989), to which South Africa is a *state-party*, imply that non-therapeutic infant male circumcision be forbidden, based on such important principles as: the right to physical integrity, the right to freedom of religion, the right to the highest attainable standard of health, the right to protection from "traditional practices prejudicial to the health of children", and the right to protection against torture. South Africa is thus bound, either through our direct ratification of the treaty or under principles of customary international law. Section 12, point 2, of the South African Constitution's Bill of Rights, details that, "Everyone has the right to bodily and psychological integrity, which includes the right…to security in and control over their body; and not to be subjected to medical or scientific experiments without their informed consent." These principles are clearly violated during the non-therapeutic circumcision of male infants and minors.

Follow Up

This publication is being sent to Private Hospitals and Medical aids within South Africa to promote compliance with international medical trends and current good medical practice. Kindly reply to this communication, via e-mail or post, so as to indicate in writing what the current position of your institution, with regard to the non-therapeutic circumcision of neonates and minors, is. The NOCIRC-SA website will begin to display such information for public interest and awareness. With this in mind, a press release detailing this document is being forwarded to all regional newspapers and the document itself is available on the NOCIRC-SA website (www.nocirc-sa.co.za).

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