

Male circumcision: ritual, science and responsibility

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Abstract

Introduction and objectives. In Italy, four minors have died in the last year as a result of male circumcision (MC) procedures performed for cultural and religious reasons by unqualified persons in unhygienic conditions.

Results and discussion. After illustrating the historical and ethical outlines of the moral admissibility of MC within a comparative perspective, we examine the features of the Italian healthcare system with particular regard both to the heterogeneity of services available in the various Regions and to the risks engendered by excluding MC from the public health setting.

Conclusion. In order to adequately safeguard public health, particularly that of minors, there is a pressing need for thorough discussion of whether the National Health Service should perform MC on minors free of charge or, at least, for a reduced fee. The implementation of targeted campaigns may raise awareness of the importance of proper safety measures in MC.

Key words

- male circumcision
- infants
- adverse events
- parental decision-making
- ethics

INTRODUCTION

Male circumcision (MC) is both an ancient procedure and one of the most widespread practices in the world [1]. Indeed, it is estimated that one out of three men has been circumcised [2]. The procedure is especially common in the Muslim world and in Israel (where it is almost universal) for religious reasons, in the United States and parts of South-east Asia and Africa. Its prevalence is almost universal in the Middle East and in central Asia. Worldwide, the prevalence is estimated to be about 37.7%, while in Italy it is 2.6% [3].

Male circumcision (from the Latin *circumcidere*: *circum* = around and *caedere* = cut) consists of excising the prepuce so that the gland is always free from its hood of skin. In the first phase of the procedure, the amount of foreskin to be removed is quantified on the basis of its elasticity and the length that it reaches.

Topical or local anaesthetics are normally utilised in order to alleviate the pain and physiological stress [4]. However, the procedure is contraindicated in individuals with penile defects, such as congenital penile curvature, penoscrotal fusion, sunken penis (buried penis), concealed penis (concealed penis), micropenis, obesity, and urethral abnormalities.

Generally speaking, MC can be classified according to four possible categories:

- 1) therapeutic circumcision (resolution of phimosis,

chronic irritation of the glans, refractory balanoposthitis, etc.);

- 2) prophylactic circumcision (e.g. in newborns to prevent urinary tract infections in infancy);

- 3) ritual circumcision (typical of Judaism and Islam);

- 4) circumcision for other, personal reasons (imitation, reasons unexplained by the requester).

In Italy, four deaths connected with ritual male circumcision carried out by unqualified operators in unhygienic conditions have recently been recorded: one in Rome, two in the Province of Reggio Emilia and, the most recent, in Genoa.

In December 2018, in the Monterotondo area of Rome, a 2-year-old child of Nigerian origin underwent circumcision at home and died of serious complications. His twin brother, who underwent the same procedure, was hospitalized in the intensive care unit at the Policlinico Gemelli in Rome and was saved. The 35-year-old Nigerian mother, before subjecting her twins to circumcision, had requested information from her paediatrician, who had refused to perform the surgery. Therefore, the woman had turned to a US citizen of Libyan origin known to carry out such interventions. The man was arrested for involuntary manslaughter, unauthorised practice of the medical profession and causing very serious injuries.

In March 2019, a 5-month-old child of Ghanaian

origin, who had been admitted to Santa Maria Nuova Hospital in Reggio Emilia, died as a result of very serious complications following ritual circumcision. The procedure had been performed by a practitioner of African origin who used to carry out this type of intervention in African communities in Emilia.

A few months later (November 2019), another death involved a 5-month-old child of Ghanaian origin, who was resident in Scandiano (Reggio Emilia). The child was urgently hospitalized for cardiac arrest at Sant'Orsola Hospital in Bologna, where he arrived in a desperate condition following a circumcision procedure performed at home. The ongoing investigations focus on a "holy man", who is a compatriot of the parents and is known within the African community to be willing to carry out this kind of intervention. The man, who is a resident of Modena, is currently under investigation for involuntary manslaughter.

The most recent case concerns a newborn of Nigerian origin who died in Genoa (April 2019) following circumcision performed at home. Following the child's death, his mother and grandmother, aged 25 and 50 years, both of Nigerian origin, were arrested on charges of involuntary manslaughter. A 34-year-old Nigerian man, known within the community as a subject capable of carrying out circumcision, is accused of being the material perpetrator of the intervention. He was arrested by the judicial police while trying to flee the country, having learned of the child's death.

In all four cases, death was due to severe haemorrhage after the procedure. In all cases, circumcision was carried out by foreign nationals who did not possess the necessary skills.

These events have prompted debate, not least within the medical community, as to whether MC should be made available by the National Health Service (NHS).

HISTORY AND ETHICAL CONSIDERATIONS

Therapeutic MC was regarded as a common medical procedure up to the late Victorian period. In 1870, the orthopaedic surgeon Lewis Albert Sayre, one of the founders of the American Medical Association, started practising it in order to treat serious motor difficulties [5].

From the ethical standpoint, circumcision for therapeutic reasons does not raise issues that are any different from those connected with any other therapeutic intervention. It is therefore subject to the ethical principles of both "non-maleficity" (which mandates respect for good medical practice) and autonomy, which is expressed through respect for both the free and responsible self-determination of the individual and for individual privacy. Moreover, when it is performed for therapeutic reasons, circumcision, like any other healthcare procedure, must necessarily be carried out by a qualified operator.

MC for prophylactic purposes is more debatable. This practice arose in the 19th century, when the aetiology of most diseases was still unknown [6]. The assumption that a tight foreskin would inflame the nerves and cause systemic disorders prompted the adoption of prophylactic MC for the prevention of a wide range of

problems, including masturbation [7]. The cultural and social climate in which the procedure arose and spread in the second half of the 19th century, in English-speaking countries, is described by the medical historian Edward Wallerstein, who asserts that, "within the miasma of myth and ignorance, there emerged the theory that masturbation caused many and various disorders. It therefore seemed logical to some doctors to perform genital surgery on both sexes, in order to prevent masturbation; the main technique implemented in males was circumcision. This was especially true in English-speaking countries, as it was in line with the mid-Victorian attitude to sex, which was considered sinful and debilitating" [6]. As medical knowledge increased, however, the rationale behind preventing masturbation was questioned and, subsequently, abandoned.

In 2007, on the basis of scientific evidence, the international community recommended that "male circumcision now be recognized as an additional important intervention to reduce the risk of heterosexually acquired HIV infection in men" [8, 9]. Moreover, in 2012, the American Academy of Pediatrics reported that MC was able to significantly reduce the risk of contracting urinary tract infections, some other sexually transmitted infections and carcinoma of the penis [4]. The report recommended that, at the beginning of pregnancy, parents should regularly be informed of the benefits and of the low risk of MC, and that payment for MC by third parties was justified [4, 10]. These results were confirmed by a recent systematic review of the literature, which revealed that performing MC during early infancy was associated with a lower incidence of urinary tract infections, yielded benefits that were up to 200 times greater than the procedural risks involved, and was also cost-saving [11]. The factors contributing to complications clearly include the training and experience of the operator, the characteristics of the instruments used and the sterility of the environment in which the procedure is carried out [12].

Nevertheless, the scientific validity of MC for prophylactic purposes, and also its cost/benefit ratio, continue to be the subject of controversy [13].

In Italy, the CNB (National Bioethics Committee), while acknowledging that prophylactic MC is a critical issue, does not consider this procedure *per se* to be unjustified or unacceptable from the ethical standpoint [14]. Thus, according to the CNB, in the absence of compelling reasons to refrain from performing MC, the procedure may be deemed admissible, provided of course that it is carried out in conformity with the criteria of good medical practice and, in the individual case, supported by a specific scientific judgement.

Ritual circumcision is certainly the procedure most hotly debated from the ethical point of view.

There is no consensus among anthropologists as to the origin of the practice of MC. Ritual male circumcision is certainly a very widespread custom and is practised by many different peoples, from the ancient Eastern Mediterranean to Africa and pre-colonial Australia, though not by populations of the Indo-Germanic language group, nor by those of non-Semitic upper Asia. According to some historians, the procedure was, at

least in some periods, carried out in order to humiliate enemies [15, 16]. However, given the geographic extension of the practice, it is not possible to individuate a single satisfactory explanation.

The historian, anatomist and Egyptologist Sir Grafton Elliot Smith claimed that MC had been practised for more than 15 000 years [17]. Moreover, clear evidence of the existence of this procedure dates back to more than 4300 years ago. Indeed, in the great Egyptian necropolis of Saqqara, not far from Cairo, a decoration on a wall of the tomb of Ankhmahor (an important Egyptian functionary and high priest who lived during the VI Dynasty) depicts male circumcision, performed presumably as a ritual before admission to the priesthood [18]. Although Egyptologists have not fully ascertained what the purpose of circumcision was in ancient Egypt, it is thought that the practice served to certify the passage to adulthood among members of the higher social classes, and that it was performed during a public ceremony [17]. Further testimony to the practice of MC among the ancient Egyptians can also be seen in the so-called Ebers Papyrus, purchased in 1873-1874 at Thebes by the German archaeologist Georg Moritz Ebers [19].

In sum, hygiene, preparation for sexual life, a rite of passage and initiation to adulthood, tribal identity and adherence to a religious belief are the reasons most frequently cited to explain the meaning of ritual circumcision.

References to circumcision can also be found both in the Hebrew Bible (Genesis: 17, 9-14; Leviticus: 12, 3) and in the Christian Bible (N.T.: Acts of the Apostles, 15), which considers the practice unnecessary. By contrast, Coptic Christians perform circumcision as a rite of passage [20]. In South Africa, circumcision is prescribed by some Christian groups, while it is frowned upon by others. The Ethiopian Orthodox Church requires MC, and its prevalence is almost universal among Orthodox men in Ethiopia. For Muslims, circumcision is considered essential. Although it is not explicitly mandated in the Koran, it is attributed to the Prophet Mohammed; for this reason, the practice has taken on the nature of Sunnah, or the tradition of the Prophet. It is also recognised in the Hadith (sayings and deeds of the Prophet).

The age at which ritual circumcision is performed, its modalities and settings, the fate of the excised prepuce, and the figure and function of the circumciser are all extremely variable [21, 22]. As pointed out by Abdul Wahid Anwer, *et al.*, although MC is a religious recommendation, cultural and social norms (such as the actual possibility to organise a sumptuous feast to celebrate the circumcision of a son) are major determinants of when circumcision is performed. Thus, belonging to certain ethnic groups is a risk factor for delayed circumcision [23]. Muslims celebrate MC either within the family or as a community event, and the procedure is usually performed some years after the birth of the child (though always before puberty). In the Jewish community, by contrast, CM is performed on the eighth day after the child's birth (unless adverse clinical conditions necessitate postponement of the procedure until after

recovery) and involves the use of ritual objects (a knife with a particular blade, a protective shield, a container for the prepuce); these prescriptions constitute a precise personal obligation on the parents, or whoever stands in for them, and their fulfilment is regarded as an act of devotion.

From the medical standpoint, it is deemed preferable to perform circumcision in the neonatal period rather than at an older age. Indeed, in the neonatal period, the procedure is not only operationally simpler, but also displays a low rate of complications; this is due to the healing capacity of the newborn and to the fact that suturing is not generally necessary in such subjects [24]. Consequently, beyond religious motivations, performing circumcision in the neonatal period is also safer and less costly.

Despite its great diffusion, ritual circumcision continues to be an extremely controversial practice in view of the various rights and values involved. In particular, recognition of the cultural and/or religious rights of minority communities raises complex issues for liberal democracies and their constitutions. Indeed, from the ethical point of view, legislation is faced with the difficulty of reconciling the need to safeguard minorities with the protection of the rights of the individuals who live within these very minorities. A specific aspect of this dilemma is seen in the relationship between minors and their families who belong to a cultural and religious community that is "different" from that of the majority.

Thus, the perspective that emerges is one within which the debate is not limited to merely legal aspects, however important these may be, nor to the apodictic assertion of an ethical point of view; rather, questions of tolerance need to be examined in their political-prudential dimension.

The safeguard of minors, who are obviously unable to provide valid consent, constitutes a particularly critical aspect [25, 26]. Indeed, the decision to circumcise the minor is usually taken only by parents or guardians, without the consent of the minor.

Citing the principles of good medical practice, the British Medical Association (BMA) asserts that circumcision for purely prophylactic or ritual purposes is not automatically justified by parental consent and urges doctors to inform parents of the issues involved in an invasive medical operation. The Association specifies that doctors must act within the confines of the law and of their own conscience and weigh the benefits and risks (also psychological) of circumcision in each specific case.

On the basis of the laws in force in the United States and of international declarations on human rights, circumcision violates a minor's absolute rights to the protection of his physical integrity, autonomy and freedom to choose his own religion. This means that the doctor is legally obliged to protect children from unnecessary medical interventions [13]. Thus, in the absence of medical justification, parental consent to the circumcision of a newborn would not be legally valid, in that parents may authorise a non-therapeutic procedure only if it is in the best interest of the child [27].

On 28 September 2013, the Swedish Civic Ombud-

sperson for Children and representatives of four leading medical associations in Sweden asserted that circumcising a child without medical justification and without the child's consent is contrary to the child's human rights and to the fundamental principles of medical ethics [28].

Indeed, according to the Convention of New York, minors (aged at least 12 years, or even younger if capable of discerning) have the right to be consulted and to express their opinion on all procedures that concern them. Thus, in the absence of compelling reasons, it seems questionable to exclude minors from a choice that may impact significantly on their physical and mental health and which can easily be postponed until such time as they are able to express an informed opinion regarding a totally personal choice. However, this growing recognition of the will of the minor may clash with the recognition of the (constitutional) right of parents to religious freedom and to bring up their children in accordance with the precepts of the religious faith to which they belong.

If we are to give adequate consideration to the various interests involved, the increased emphasis on the rights of minors must not give rise to simplistic and dangerous commonplaces. Although circumcision impacts on the physical integrity of the minor, it may nevertheless contribute positively to the development of his personality, constituting an overall benefit in the physical, psychological, social and relationship spheres [29]. Indeed, circumcision is an identifying sign of belonging to a religious community; for parents, it constitutes a fundamental element of the structure of the minor's identity and is able to strengthen the rights of the child and his family as an organic unit. Moreover, if properly performed, it does not result in impairment or alteration of the male's sexual and reproductive function.

This consideration has prompted the CNB to view the practice within the operational framework of article 19 of the Italian Constitution, which grants complete freedom of cultural and ritual expression at both the individual and collective levels [14]. In addition to this, and taking into account the elementary nature of the procedure, some members of the CNB have even claimed that dedicated ministers should be allowed to perform ritual circumcision, as long as they are recognised as possessing adequate competence. In this regard, a recent German experience appears to be significant.

In June 2012, the Court of Cologne in Germany ruled that non-therapeutic MC performed on minors constituted an irreversible bodily lesion and violated the individual's right to physical integrity and self-determination, and that the procedure should be delayed until the minor was old enough to decide in a free and informed manner. In addition, the Court stated that doctors who carry out this surgical operation could be prosecuted [30].

However, after a lively public debate concerning the cultural and religious traditions of infant male circumcision, Germany's parliament introduced a modification (§1613d) to the Civil Code that explicitly permits male

infant circumcision, if performed after six months of age and by qualified health personnel [31].

The possibility to have one's child circumcised, should this be deemed necessary for the child's own good, must nevertheless be subordinated to the regulations of medical practice, the administration of efficacious analgesic treatment, the provision of complete information for the parents, and proper consideration for the child's wishes. Moreover, the law explicitly permits circumcision to be performed – during the first six months after the birth of the child – by persons who are not physicians, provided that they possess competence equivalent to that of a physician in performing this specific procedure. This specification takes into account the fact that circumcision for religious reasons is often carried out by “ministers of the faith”, who occupy a certain position within the religious community. As a rule, these individuals possess the necessary skills to perform the operation, as well as being well-versed in the rites that accompany it.

MALE CIRCUMCISION AND PUBLIC HEALTH IN ITALY: PROBLEMS AND OPPORTUNITIES

Unlike the practice of female genital mutilation, which is expressly forbidden by Italian law (Law n. 7 of 09/01/06: “Provisions concerning the prevention and prohibition of practices of female genital mutilation”) [32], MC is commonly admissible.

In Italy, the conviction that the Jewish practice of male circumcision conforms to Italian law seems to find confirmation in some provisions of Law 101/1989 “Norms regulating relations between the State and the Union of Italian Jewish Communities” [33]. In a not very recent case (9 November, 2007) discussed by the Court of Padua, the Court did not contest the lawfulness of ritual male circumcision in itself, in that “ritual circumcision may be viewed as being aimed at achieving a better state of health, a bodily form corresponding to the idea of physical perfection and psychic satisfaction of the individual person, not least with a view to conforming with an ethnic or cultural identity”. In particular, the judge specified that “Although it has been emphasised that male circumcision constitutes a violation of the psychophysical integrity of a subject who, owing to his young age, is generally unable to express his consent effectively (it is the parents who decide during the exercise of their right/duty to bring up their child in accordance with the principles of their culture), it seems difficult to contest the notion that this procedure – given that it is free from the negative physical, psychological and symbolic connotations that characterise female genital mutilation, and probably also owing to the influence of Judaism – has long been amply accepted by Western custom and culture” [34]. The Court, however, also ruled that MC was a practice that necessarily had to be performed by medical personnel, in that “it results in an impairment of the physical integrity which cannot prescind from careful evaluation of the subject who undergoes it, on account of the potential negative consequences that it might have on health, and which must be performed in accordance with good clinical practice

and the subsequent assurance of care”.

Support for the implementation of MC in the hospital setting stems both from the desire to foster the integration of ethnic minorities and from the need to ensure that circumcision is carried out as safely as possible in these communities. At present, however, parents wishing to have their children circumcised for religious and/or cultural reasons are faced with different responses from the various regional healthcare systems.

The Tuscany Region, for example, included MC in the list of essential services offered to all citizens (LEA) back in 2002 (Dgr n. 561/2002); in Friuli Venezia Giulia, the procedure is available on payment of a charge equal to the tariff applied to therapeutic circumcision (Dgr n. 600/2010); in Turin, in the Piedmont Region, ritual MC is available for Muslim children in a day-surgery setting at a reduced charge.

In the Lazio Region, the Umberto I Polyclinic has inaugurated an outpatient clinic where ritual circumcision can be performed on children aged 3 years or more by authorised, specialised personnel. The service is provided on payment and is carried out under a regime of freelance activity; the fee agreed upon with the Rabbinic Office of Rome and the Islamic Cultural Centre in Italy is € 200,00.

In the other regions, however, ritual MC is completely unavailable in public healthcare facilities.

The Union of Italian Jewish Communities, in conformity with the dispositions issued by the bodies of European Judaism, has set up a register of Mohalim (circumcisers), whose standard educational curriculum is certified by recognised international Jewish bodies (OU, UME, Initiation Society, central Rabbinate/Israeli Ministry of Health). The Mohalim must also pledge to observe the protocol of the procedure, which contains a set of rules to safeguard the health of the newborn. Clearly, it is not feasible for all the various religions and ethnic groups which practice circumcision to avail themselves of certified circumcisers; it is therefore desirable that referral centres be instituted in hospitals.

The heterogeneity within the NHS, together with other factors (lack of adequate support by the community to which the individual belongs, scant financial resources of the family, lack of information), may well result in circumcision being carried out in unsafe conditions.

The Italian Authority for Children and Adolescents recently addressed the issue of ritual circumcision in a note of recommendation to the Minister of Health; this invoked intervention to safeguard the health of newborn and children who risk suffering severe, and even lethal, complications as a result of procedures performed outside healthcare facilities, and proposed the introduction of a tariff scheme that would make ritual circumcision accessible to all income groups [35]. Such norms, however, have aroused considerable protest. Specifically, doctors in some Italian Regions have objected to ritual circumcision, invoking their professional independence and, in particular, citing the impossibility, from a deontological and moral standpoint, of subjecting a person to any treatment whatsoever that does not have a medical purpose. Moreover, this rejection has been further

supported by doctors in Turin, who have stressed the possible risks and complications of an invasive and mutilating procedure that is imposed on a minor without any medical justification.

In this sense, it must be stressed the legal position of healthcare professionals performing such a procedure: a delicate matter that should be taken into account especially in times when medico legal claims are always more frequent, both from a criminal and civil point of view. An important aspect that could limit the availability of medical staff providing this service on a nationwide basis.

Therefore, also ritual circumcision has to be preceded by a careful evaluation of newborn and children's conditions, balancing them with an identifiable psychic well-being linked to conforming to an ethnic or cultural identity, and respecting all the rules of good clinical practice.

In recent years, the issue of MC has gained greater attention in Italy, as a result of the increased number of foreign families who carry out the procedure, usually for religious and/or cultural reasons.

According to the data elaborated by the AMSI (Association of Doctors of Foreign Origin in Italy) in collaboration with the Medical Council of Rome (Section for relations with the municipalities and foreign affairs; Section for rehabilitation), 11 000 ritual circumcisions are carried out annually on citizens of foreign origin living in Italy; of these, 5000 are performed in Italy and 6000 in the various countries of origin. Of the 5000 procedures performed in Italy, 35% are carried out clandestinely, at home or in other unprotected environments, and not by doctors [36, 37].

Unfortunately, precise statistical data on the relevance of the phenomenon, processed in Italy, are lacking. Infants of the Jewish community are, in fact, almost always circumcised in their community, while converted adults carry out this procedure privately [38]. The same problems affect the Islamic and Muslim communities.

Based on broader reports, such as those provided by Caritas, the General Secretary of the Islamic Cultural Center in Italy hypothesized that, within the Muslim community in Italy, MC involve a population of about 40 000-45 000 newborn and children [39].

At the same time, Viviani *et al.*, [40] underline that, at least in some cases, ritual circumcisions have been wrongly labelled as “therapeutic” thus benefiting from the services of the national health system.

In order to prevent the potential occurrence of severe lesions and even death, increasing attention has been focused on the question of whether the Italian NHS should perform circumcision on demand. The CNB claims that there are no reasons of an ethical or healthcare nature that should prompt the State to impose on the collectivity the cost of ritual MC practices that are directed not to the advantage of all members of society (regardless of their religious beliefs), but only of those who belong to a specific religious confession [14].

The above-mentioned regional experiments obviously raise questions with regard to the difficulty of adequately justifying the use of public resources to support the exercise of religious freedom and the right to health of

only those who profess some specific religious faiths. Nevertheless, the need to safeguard the right to health (particularly of vulnerable subjects) could justify an approach that permits non-therapeutic circumcision to be offered by the NHS.

The rise in the number of serious, and even fatal, incidents connected with MC procedures, however, prompts careful consideration of the possibility of allowing such operations on minors to be performed in NHS or NHS-affiliated facilities on payment of a fee that disadvantaged families can afford. Indeed, circumcision that is carried out clandestinely in unsuitable environments, by unqualified persons, without proper instruments and without the necessary hygiene, asepsis and assistance, carries a high social cost in terms of the harm that may be done to these particularly vulnerable subjects. As circumcision is a surgical procedure, it must be carried out in a suitable healthcare setting and by properly trained personnel. Indeed, like any surgical operation, this procedure carries a risk of complications, which can be defined as early (such as haemorrhage, infection, damage to the glans and urinary retention) and late (such as phimosis, torsion of the penis and urethrocutaneous fistula) [41].

The rate of complications varies enormously – from 0.06% to 55% – and depends, among other things, on the indications for the procedure, the operator who performs it and the place where it is performed. The lowest complication rates are seen when the procedure is carried out in sterile conditions and by qualified surgeons. Indeed, in order to reduce the risk of complications, it is recommended that the operation be performed by qualified personnel who are trained in this type of intervention [42]. The procedures to be followed in order to perform circumcision safely are described by the World Health Organisation in its “Manual for male circumcision under local anaesthesia” [43]. Serious adverse events are rare and seem to be associated with a range of factors, such as age at the time of circumcision, operator training and experience, the sterility of the environment in which the procedure is carried out, and the indications for the procedure itself. In particular, the qualifications and experience of the personnel are major factors in ensuring a good outcome in both the long and short term, while circumcisions practised for ritual reasons – and consequently outside the clinical context – and for religious or traditional reasons are burdened by higher complication rates.

The possibility that MC could be performed by the NHS has also been entertained by both the Italian Society of Paediatrics [44] and the National Federation of Medical Council (FNOMCeO) [45]. With regard to this latter Council, a study that we conducted on a sample of 10 Provincial Associations of Surgeons (about 10% of the total) brought to light one case in which a regularly qualified doctor was reported to the Council, and subsequently suspended for six months (the maximum sanction) from practising medicine, for having performed MC at the patient's own home and in the total absence of the necessary conditions of health and hygiene. This case shows that, albeit very rarely, even qualified medical practitioners may be prepared

to carry out such procedures clandestinely and with disregard for good clinical and healthcare practice. It also provides further food for thought concerning the need to legislate on this issue.

At the same time, healthcare personnel (particularly obstetricians, gynaecologists and paediatricians) should implement campaigns to inform and educate women who wish to have their child circumcised. This approach may help to raise awareness of the risks of MC, of the importance of implementing proper safety measures and, not least, of the rights of children who are currently unable to decide for themselves, but who may one day decide not to adhere to the religion of their parents. In the light of the case reported above, this type of education should also be targeted to healthcare professionals operating in the field.

CONCLUSIONS

The medical, ethical, cultural and juridical issues surrounding non-therapeutic circumcision are many and complex, and are deeply rooted in Western civilisation, which is unequivocally founded on respect for the fundamental rights of the person and on the safeguard of the psychophysical health of every member of society. This respect clashes with the will to belong to communities in which circumcision is regarded as a primary irrefutable symbol. Thus, the theme of circumcision is in some way paradigmatic of the complexity of today's pluralistic, multi-ethnic and multicultural society, in which various demands, traditions, rights and cultural, religious and ideological references come into conflict or are, at least, difficult to reconcile. At the same time, however, this scenario may constitute a “multicultural laboratory” in which the various protagonists are called upon not only to expound and defend their own ideas, but also, and especially, to listen to the reasons of others, thereby avoiding coercive methods and fostering dialogue among religious leaders. Thus, on the one hand, ritual circumcision, being bereft of therapeutic indications, impacts on the anatomical integrity of the newborn; on the other hand, however, it does not impair the functionality of the organ. Moreover, as it is based on cultural and religious factors that are deeply rooted, to the extent that it is deemed essential in some communities, it may be claimed that it should be provided in conditions of the greatest safety.

Like any other surgical procedure, circumcision must be performed in such a way as to safeguard the child's health. It is therefore essential that it be carried out in conditions of proper hygiene and sterility, in a suitable healthcare setting and by experienced medical personnel. Likewise, procedures of analgesia must be implemented in order to minimise the pain and suffering caused by the operation. After the procedure, adequate post-operative monitoring should be carried out in order to prevent both short- and long-term complications. Obviously, these conditions of safety cannot be guaranteed in the domestic setting, in environments other than proper healthcare facilities, or in the absence of qualified personnel. Indeed, as illustrated by the recent news stories, ritual MC that is performed in the absence of these requisites can have a tragic outcome, and

deaths, mainly due to haemorrhage caused by technical shortcomings or to the lack of prophylaxis, are being reported with increasing frequency.

In the light of the above considerations, we feel that the NHS should make every effort to render ritual circumcision available free of charge. Indeed, the payment of a charge may clash significantly with the symbolic and ritual motivation of the act, thus hindering recourse to its performance under a national health regime. Aware that the solution proposed creates further problems in terms of the allocation of resources, we nevertheless feel that priority must be given to safeguarding the health of minors.

Moreover, we think that this proposal, which is prompted by reasons of a prudential nature, cannot be regarded as an exhaustive solution to a problem that is complex and multiform (even in its operational modalities) and which requires diversified strategies of action. The complexity of the problem is certainly exacerbated by the difficulty of identifying common ground with those communities that are culturally less integrated into our social fabric and which find it hard to accept certain modes of relating to the western world in which they live. Indeed, these issues call into question the foundations of the relationship between the whole and its parts, between the community and its members, between the state and the individual. Thus, they manifest the difficulty of legislation both in reconciling the rights of individuals with those of the collectivity, and in safeguarding the rights of individual persons vis-a-vis the community to which they belong. It is therefore essential to promote constant dialogue, in order to promote a relationship of trust and gradually to foster awareness

of the fact that the sociocultural situation experienced by the minors of these communities differs from that of their parents and ancestors in their countries of origin. Furthermore, the intercultural perspective, as opposed to the antagonism or clash of cultures, should constitute an ethical commitment in all sectors of social life, from education to health care.

Finally, we believe it is necessary to find a compromise between the Italian guidelines about circumcision (no surgical intervention before 4 years of age except in case of urinary retention, infection or inflammation) and the religious dictates indicating that the circumcision has to be done during the first month of life, also in order to prevent medico legal litigation.

Lastly, awareness-raising campaigns should target parents and the communities involved, in order to publicise the potentially lethal risks associated with circumcision outside the proper healthcare setting.

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All the Authors equally contributed to this work.

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