Circumcision: The Uniquely American Medical Enigma

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The continuing practice of routine neonatal nonreligious circumcision represents an enigma, particularly in the United States. About 80 percent of the world's population do not practice circumcision, nor have they ever done so. Among the non-circumcising nations are Holland, Belgium, France, Germany, Switzerland, Austria, Scandinavia, the U.S.S.R., China, and Japan. People employing circumcision do so either for "health" reasons or as a religious ritual practiced by Muslims, Jews, most black Africans, non-white Australians, and others.

The origin of the ritual practice is unknown. There is evidence of its performance in Israel in Neolithic times (with flint knives) at least 6000 years ago. Jews accept the Old Testament origin as a covenant between God and Abraham, although it is generally agreed that the practice of circumcision in Egypt predated the Abrahamic Covenant by centuries. Ritual Circumcision is not germane to this discussion except insofar as the surgical ritual impinges upon accepted medical practice.

So called "health" circumcision originated in the nineteenth century, when most diseases were of unknown etiology. Within the miasma of myth and ignorance, a theory emerged that masturbation caused many and varied ills. It seemed logical to some physicians to perform genital surgery on both sexes to stop masturbation; the major technique applied to males was circumcision. This was especially true in the English-speaking countries because it accorded with the mid-Victorian attitude toward sex as sinful and debilitating.

The most prolific enumerator of the health benefits of circumcision was Dr. P. C. Remondino. In 1891 this physician claimed that the surgery prevented or cured about a hundred ailments, including alcoholism, epilepsy, asthma, enuresis, hernia, gout, rectal prolapse, rheumatism, kidney disease, and so forth. Such ludicrous claims are still disseminated and possibly believed. The book was reprinted in 1974, without change, and the Circulating Branch Catalogue of the New York Public Library (1983) listed the Remondino book, showing a publication date of 1974. One physician, writing in Medical Aspects of Human Sexuality (1974), called the book "pertinent and carefully thought out."

Remondino was not the only one expounding such views. In 1911, Dr. Joseph Preuss, in a monumental tome, Biblical-Talmudic Medicine, claimed that Jewish ritual circumcision endowed health benefits; his sole source was Remondino. Some espoused more extreme views; in 1910 an article in J.A.M.A. described a new circumcision clamp. The author/inventor claimed that with this device, the operation was so simple that men and women could now circumcise themselves.

In the 75-year period (1875 to 1950) there was virtually no opposition to routine circumcision in the United States. Instead there were many articles in medical journal and textbooks extolling the practice; the issue was ignored in the popular press. Yet in the more than a century of acceptance of routine circumcision in the English-speaking countries, from 1870 to the present, no other country adopted newborn circumcision.

The first serious questioning of the practice did not occur until late 1949 (in England with the publication of Gairdner's "The Fate of the Foreskin," which began to affect the practice of circumcision by the British. In 1963, an editorial in J.A.M.A. called the attitude of the medical profession paradoxical and confused, and admitted that the facts about circumcision were still unknown. This was followed by several critiques of circumcision such as those by Morgan (1965 and 1967) and Preston (1970). In 1968 Øster confirmed Gairdner's findings as did Reichelderfer and Fraga, who presented a comprehensive study of circumcision. Yet some physicians continued to support circumcision for surprising reasons. For example, Dr. Robert P. Boland, writing in The New England Journal of Medicine in 1969, compared circumcision with tonsillectomy, calling both procedures "ritualistic," and "widely performed on a non-scientific basis." He opposed routine tonsillectomy but concluded vis-a-vis circumcision: "Little serious objection can actually be raised against circumcision since its adverse effects seem miniscule."
Table 1. Estimated Newborn Nonreligious Circumcision Rates in English-Speaking Countries.

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Britain</td>
<td>1</td>
</tr>
<tr>
<td>New Zealand</td>
<td>10 (Personal Visit)</td>
</tr>
<tr>
<td>Australia</td>
<td>upper 30</td>
</tr>
<tr>
<td>Canada</td>
<td>upper 30</td>
</tr>
<tr>
<td>United States</td>
<td>80</td>
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</table>

In the 1970's, a change seemed in the offing. In 1971 and 1975, the American Academy of Pediatrics Task Force on Circumcision declared: "...there are no valid medical indications for circumcision in the neonatal period." In 1978, the position of the American Academy of Pediatrics was endorsed by The American College of Obstetricians and Gynecologists. In 1983 both groups jointly reaffirmed their positions. The "firm" firm declarations should have caused a marked drop in the United States circumcision rate. They did not.

To explore the circumcision rate in the United States, it is essential to compare the American experience with the other English-speaking countries. Anticircumcision articles appeared in the medical press in all of these countries. Gairdner and Øster were published in journals in England; Morgan (1967) was published in Australia. In 1971, the Australia Paediatric Association recommended: "Male infants should not as a routine be circumcised." In 1975, the Canadian Paediatric Society stated, ". . .there is no medical indication for circumcision in the neonatal period.

Although there is no precise data on circumcision from any country, approximated rates for the English-speaking countries reveal that in Great Britain, the practice has virtually been abandoned; New Zealand follows closely behind. (In a 1982 visit, a number of physicians were apologetic for the "inordinately high" rate of 10 percent. Several physicians stated categorically that they refused to perform routine circumcisions.) The rates in Canada and Australia appear to be declining at about 10 percentage points per decade. The United States stands alone as the only country in the world in which the majority of newborn males are circumcised, purportedly for health reasons.

Before addressing the phenomenon of circumcision in the United States let us examine the Canadian and Australian data. In Canada (Table 2), there are considerable rate differences among the provinces but the overall rate is clearly declining, and in Quebec the practice has been virtually been discontinued. In Australia (Table 3), unlike Canada, the rates by states are relatively uniform, but clearly declining. In 1978, the Australia government recommended that payments for circumcision be reduced or eliminated. In a visit to Australia in 1982, I was told that a national campaign was planned to reduce unnecessary surgery; circumcision was high on the list.

Table 2. Hospital Inpatient Male Newborn Circumcision in Canada by Province (data from British Columbia and Newfoundland not reported)* 1970 to 1978 by Rank Order of Percentage change.

<table>
<thead>
<tr>
<th>YEARS</th>
<th>CHANGE (% Rounded)</th>
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<tbody>
<tr>
<td></td>
<td>1970</td>
</tr>
<tr>
<td>Total</td>
<td>64,015</td>
</tr>
<tr>
<td>Quebec</td>
<td>12,995</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>2,477</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>1,543</td>
</tr>
<tr>
<td>Alberta</td>
<td>10,857</td>
</tr>
<tr>
<td>Manitoba</td>
<td>5,006</td>
</tr>
<tr>
<td>Ontario</td>
<td>24,476</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>3,276</td>
</tr>
</tbody>
</table>

Table 3 Estimated Neonatal Circumcision Rate in Australia by State, 1973-74 to 1979-80(%)*
YEARS PERCENTAGE DECREASE

Total 49 39 10
New South Wales 52 42 10
Victoria 39 28 11
Queensland 62 51 11
South Australia 47 41 6
Western Australia 51 38 13
Tasmania 68 43 25


[CIRP note: The Australian College of Paediatrics reported in 1996 that the all-Australia incidence of circumcision has further declined to 10 percent.]

Although nationwide data on circumcision for Canada and Australia are admittedly imperfect, precise data for the United States are virtually non-existent. The H.E.W. Hospital Records Study excludes neonates. The Cycle III Health Examination Survey, conducted from 1963 to 1965 among youths aged 12 to 17, reflected the practice of circumcision in the early 1950's. The total circumcision rate was 765 (whites, 80 percent; blacks, 45 percent); regional differences were also noted.

In 1980 Wallerstein provided a crude compendium of circumcision rates reported in the literature. This was updated in 1981 by King and Roebuck. Since these compendia, other reports from individual hospitals have been noted in the literature (Table 4). Of the five hospitals reporting, the lowest rate was 80.7 percent; the other rates ranged from 90 to 98 percent. These data are static, that is, reported within a fixed period, making it impossible to discern a trend. Several hospitals reported longitudinal changes. One New York City maternity center stated that "in the past" the rate was 90 percent; in 1980 it was 60 percent. Other reports are more precise, indicating changes from 1978 to 1980, and 1975 to 1979 (Table 4, last two hospitals). The year-to-year changes were negligible; clearly there was no precipitous decline. This stability of rate was confirmed by the Commission on Professional and Hospital Activities, which publishes annual data based on projections from atypically large hospitals. They show a 1970 rate of 88 percent and a 1980 rate of 86 percent. The mean rates from 1970 to 1975 and from 1976 to 1980 are identical (86 percent).

Table 4. Circumcision Rates, Selected Hospitals

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>YEARS</th>
<th>RATE(%)</th>
</tr>
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<tbody>
<tr>
<td>New Britain General Hospital, Connecticut</td>
<td>1976-1977</td>
<td>80.7</td>
</tr>
<tr>
<td>Southern Illinois Hospital</td>
<td>1979</td>
<td>95</td>
</tr>
<tr>
<td>Johns Hopkins Hospital</td>
<td>1980</td>
<td>97.6</td>
</tr>
<tr>
<td>St. Agnes Hospital, Baltimore</td>
<td>1981</td>
<td>96-98</td>
</tr>
<tr>
<td>Hershey, Pennsylvania, Hospital</td>
<td>1983</td>
<td>90-96</td>
</tr>
<tr>
<td>George Washington University Medical Center</td>
<td>1979</td>
<td>79</td>
</tr>
<tr>
<td>Largest Hospital in Salt Lake County, Utah</td>
<td>1975</td>
<td>92</td>
</tr>
<tr>
<td>1976</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>1977</td>
<td>92</td>
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<tr>
<td>1978</td>
<td>92</td>
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<tr>
<td>1979</td>
<td>93</td>
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</table>

In 1982 Slatkowski and King approached the question of circumcision rates specifically with respect to the pronouncements of the American Academy of Pediatrics on the practice of circumcision in Illinois. They obtained data from 18 Chicago-area hospitals; the rates ranged from 27 to 92 percent (mean 78 percent). Five of the hospitals reported rates from 80 to 88 percent; five from 90 to 92 percent; the rates ranged from 74 to 97 percent, with a single exception: one hospital reported a rate of 4.5 percent. Upon further query, that hospital reported a circumcision rate decline beginning after 1974-75.

These United States data reveal no significant national decline in the circumcision rate desperate the pronouncements of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. However there are instances of sharp declines in several hospitals. Dr. Joan Hodgman, director of the Newborn Division of the Los Angeles County University of Southern California Medical Center, reported in 1983 that their circumcision rate is zero. Similarly, J.H.T. Chang, pediatric surgeon at the
Why have most United States physicians persisted in the practice? One reason is that the medical and popular literature abounds in serious errors of scientific judgment, equivocation, and obfuscation. Space limitations permit a brief examination of four issues: pain, venereal disease, cancer, and hygiene.

**PAIN**

Pain of circumcision is not a debatable question; it is a fact. However, a perusal of writings in the popular press (1982 and 1983) reveals confusion.

Proctor and Gamble, one of the nation's largest advertisers, promotes Pampers to parents by offering the *Expectant Parents Information Kit* (1982), which contains the following statement: "You may be surprised to learn that circumcision will not be painful to your baby because, at this early stage of development, the penis does not yet have functioning nerve endings."\(^{15}\)

A contrary view was found in *American Baby* (May 1983), in which parents were told that "Newborns who undergo circumcision experience a great deal of stress and pain . . ." Parents were advised that it was now possible to employ local anesthetics to alleviate such pain.\(^{34}\)

*Mother's Manual* (1982) argues against local anesthesia because " . . . it swells the area to the extent of making an unsatisfactory circumcision too likely."\(^{2}\) *Genesis*, published by the American Society for Psychoprophylaxis in Obstetrics, carried an article in 1982 in which two writers who attended a Jewish ritual circumcision described the surgery as bloodless, painless and stressless. They suggested that non-Jewish parents explore the possibility of employing ritual circumcisors.\(^{11}\)

Parents who read such an array of literature are bound to be bewildered.

**VENEREAL DISEASE**

Prior to the turn of the century, little was known about venereal disease, either causes or cures. Understandably, the false claim could be made with impunity that circumcision prevented sexually transmitted diseases.\(^{64}\) These claims persisted beyond the middle of the twentieth century: Urologist A. Ravich titled his 1973 book *Preventing V.D. and Cancer by Circumcision*.\(^{18}\)

Within the past decade there has been virtually no statement that circumcision prevents syphilis or gonorrhea; the present day "whipping boy" is genital herpes. Even a cursory exploration of a link between circumcision and herpes reveals that such claims are without foundation; the presence or absence of the foreskin neither aids nor deters the transmission of herpes. A definitive statement regarding this claim was made in 1979 by Y.M. Felman, director of the New York City Bureau of Venereal Disease Control: " . . . I don't believe that circumcision is of any value in preventing genital herpes, as this disease is quite common in circumcised males and their female sex partners."\(^{16}\)

Yet in 1981, Warner and Strashin wrote: "Herpes genitalis appears to be the only sexually transmitted disease associated with circumcision status."\(^{67}\) Strashin defended his statement the following year.\(^{68}\) If circumcision prevents herpes or deters its transmission, how can we explain the phenomenal rise in the incidence of this disease to epidemic proportions, particularly among the most sexually active males, ages 15 to 25, of whom perhaps 75 percent are circumcised? Nevertheless, the 1975 American Academy of Pediatrics Task Force reported: "Adequate studies to determine the relationship between circumcision and the incidence of venereal disease have not been performed." This statement is obvious outdated.

**PENILE CANCER**

Few diseases strike greater fear than cancer, and no site is more potentially alarming to males than the penis. It is not surprising, therefore that when newborn circumcision is presented as an absolute prophylaxis against penile carcinoma, it is a potent argument for circumcision. Wolbarst wrote in 1932: " . . . cancer of the penis does not occur in Jews circumcised in infancy. There is no case on record."\(^{23}\) Subsequent research indicate that there are such cases on record.\(^{4}\)

The understatement of the incidence of penile cancer in Jews should be contrasted with the overstatement in regard to the uncircumcised people of India and China. In 1973, deKernion and colleagues wrote: " . . . the disease accounts for 12 percent of all malignancies among the Hindus of India."\(^{12}\) In 1977 Kaplan claimed, "In China, penile carcinoma accounts for 18 percent of all carcinomata."\(^{38}\) In a visit to the Peoples Republic of China (1976) and India (1982) the incidence of penile cancer was discussed with health officials. They stated that no nationwide health data was available; more specifically, no National Cancer Registries were maintained (much as they would like to do so). They remarked that no reputable scientist in their country would provide such data.
Such a task is retraction of the foreskin to clean the glans of smegma, and the United States that prophylactic reason given most frequently was “hygiene.”

It could be argued that in Japan, Norway, Sweden, high standards of hygiene are maintained. The variable in penile cancer prophylaxis may be hygiene, not retention of foreskin. This is essentially the position taken by the 1975 American Academy of Pediatrics Task Force, which denied a relationship between circumcision and prostatic cancer and stated that “non-circumcision is not of primary etiological significance” in cervical cancer.2 In regard to penile cancer, they wrote: “There is evidence that carcinoma of the penis can be prevented by neonatal circumcision. There also is evidence that optimal hygiene confers as much or nearly as much protection” (emphasis added)22 In 1981, 6 years later, Grossman and Posner took a more forthright position. Writing in Obstetrics and Gynecology, they stated: “No one today seriously promotes circumcision as a prophylactic against cancer in any form. No significant correlation between cancer and circumcision has ever been proved.”22

The claim that circumcision is related to penile cancer is based upon the “fact” that smegma is a carcinogen. Smegma in infancy consists solely of desquamated epithelial cells, and in adulthood additionally of the secretions of the Tyson’s glands. Many attempts have been made to prove a simple cause and effect between smegma and cancer; all failed but one. In 1947 Plaut and Kohn-Speyer "demonstrated" that smegma was a carcinogen. Of the animals examined, 27 percent of those treated with smegma developed cancer whereas 15 percent of the animals treated with cerumen developed cancer.44 Is it now possible to claim that cerumen is also a carcinogen with only one half of the carcinogenicity of smegma? This study is deficient in conceptualization, methodology, execution, gathering of data, and analysis.44 Understandably, the study has largely been ignored; however, as recently as 1981 it was accepted in one medical journal article without question.43

Penile cancer scare techniques are still with us. In 1980, Kochen and McCurdy stated that “. . . uncircumcised men are uniquely at risk . . . .” They “demonstrated” that the predicted lifetime risk among uncircumcised men was one in 600.31 They did not address why 599 out of 600 at risk “males will not contract penile cancer in their lifetime. More importantly, Kochen and McCurdy based their calculations on the 1968 Stern and Lachenbruch study of one cancer detection center in Los Angeles.32 Their 1968 data are obviously skewed in age, ethnicity, religion, social class, and so forth, and are admittedly non-random. Such inadequate local data should not be extrapolated to a national statistic.

The threat of penile cancer hangs over the discussion of circumcision like some mystical demon. It deserves to be exorcised, not circumcised.

**PENILE HYGIENE**

In several studies, mothers were asked why they agreed to their son's circumcision. The answer given most frequently was “hygiene.”52 (In a 1981 United Nations study of female genital surgery in Africa, one reason given for such surgery was “hygiene.”19) Why is male genital hygiene viewed with such alarm in the United States that prophylactic surgical intervention is necessary?

For over a century, and to this day, mothers have been warned that proper penile hygiene involves full retraction of the foreskin to clean the glans of smegma, and this procedure should start almost at day one. Such a task is virtually impossible, because in almost all infants the foreskin is attached firmly to the glans.

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### Table 5. Penile Cancer: Comparison of Approximate Incidence and Death Rates per 100,000 Males for Selected Countries*

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>YEAR</th>
<th>INCIDENCE</th>
<th>DEATH RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>1972</td>
<td>0.8/100,000</td>
<td>0.3</td>
</tr>
<tr>
<td>Japan</td>
<td>1980</td>
<td>NA</td>
<td>0.2</td>
</tr>
<tr>
<td>Norway</td>
<td>1967</td>
<td>1.1</td>
<td>NA</td>
</tr>
<tr>
<td>Sweden</td>
<td>1968</td>
<td>1.1</td>
<td>NA</td>
</tr>
</tbody>
</table>

The problem with this hygienic technique is that it is totally in error. Care of the foreskin is not exceedingly difficult; it is exceedingly simple: leave it alone. The foreskin in infancy should not be retracted. In 1977 Kaplan wrote, "... freeing 'adhesions is tantamount to cruel and unusual punishment and is unfounded physiologically or medically." Development of the foreskin and the inadvisability of forced retraction was noted by Gairdner (1949), Øster (1968), Reichelderfer and Fraga (1968), and others.

Many, if not most, American physicians are ignorant of proper care of the foreskin. This was demonstrated by Osborn and colleagues in 1981, who queried Utah pediatricians and found that 67 percent estimated that the foreskin should retract easily by one year. This is contrary to all findings of studies of the foreskin. Only 3 percent said the newborn foreskin should never be retracted. In interviewing a small sample of mothers of uncircumcised boys, Osborn and colleagues also found that retraction of the foreskin caused such anxiety that 40 percent of these mothers stated that they would have their next male infant circumcised.

The problem is not limited to Utah. In a study of physicians in the Chicago area, Patel and colleagues reported in 1982 that "only 49 percent of the physicians [in the total sample] were aware of the AAP's [American Academy of Pediatrics position]." Among the pediatricians and obstetricians in the sample, 62 percent were aware of this position. The major reason given for recommending circumcision was "hygiene" (90 percent). In a 1982 study by Stein and colleagues conducted in San Diego, they noted, "Only 36 percent of the responding physicians were aware that the newborn's foreskin is characteristically not found retractable." When asked "if a nonretractable foreskin is an indication for circumcision," 47 percent of all respondents answered incorrectly. Such incorrect responses were more likely to be given by those in family practice (50 percent), obstetrics (55 percent), and general practice (67 percent) than by those in pediatrics (13 percent). At the Spring 1983 meeting of the American Academy of Pediatrics in Philadelphia, an exhibit on circumcision was conducted. The most frequently asked question related to proper care of the foreskin.

If physicians are ill-informed about care of the foreskin, how can parents be well informed? There are thousands of books, pamphlets, and articles available to parents relating to child care. Almost none devotes attention to proper care of the foreskin. Discharging a circumcised child without informing the parents of proper wound care constituted negligence. Discharging an uncircumcised child without informing the parents of proper care of the foreskin is equally negligent.

Osborn and colleagues reported that the only written information they could find on the subject was this statement in a 1978 book: "... retract the foreskin gently and return the foreskin to its normal position to prevent constriction and swelling." To begin to correct this lack of information, in 1982 Wallerstein wrote a pamphlet entitled "When Your Baby Boy is Not Circumcised." Boyce also addressed the subject in an article entitled "Care of the Foreskin (1983)." The American Academy of Pediatrics has issued a pamphlet entitled "Care of the Uncircumcised Penis" (1984).

The issue of hygiene is obfuscated by the American Academy of Pediatrics Task Force Report in two ways. As noted earlier, the Report stated that to prevent penile cancer, "optimum hygiene was necessary. The reader, lay public or physician may ask: What constitutes "optimum hygiene? Can parents guarantee such optimum care? If not, isn't it better to play it safe and circumcise? The Report also cautions that retention of the foreskin requires "lifelong" hygiene. This statement is not incorrect; it is incomplete. All body parts require lifelong hygiene, body bathing, hair shampooing, oral hygiene, labial hygiene, and so forth. The discontinuance of any aspect of hygiene may well have deleterious effects. Why single out the foreskin?

The crux of the circumcision/hygiene rationale had its origin in the fear of the "effects" of masturbation; this may persist in attenuated form. Today, however, it is basically a lack of knowledge: (1) the foreskin and glans in infancy are essentially fused, and should not be retracted forcibly, and smegma is not a carcinogen.

Another claimed hygienic benefit is that thousands of United States servicemen, particularly in the South Pacific required circumcision. Would it not be better to circumcise in infancy and thereby avoid the more troublesome operation in adulthood? However, Japanese soldiers were fighting in the identical environment, and the Japanese did not practice newborn circumcision. When Japanese health officials were visited by Wallerstein (1982), they stated that to the best of their knowledge, Japanese military surgeons did not find it necessary to circumcise after World War II. More to the point, in the event of thermonuclear war, the role of the foreskin will pale to insignificance.

Thus, much of the current circumcision misinformation, both lay and professional, is false and misleading. In 1971 and 1975, the American Academy of Pediatrics appeared to take definitive positions; actually they did not.
The American Academy of Pediatrics Committee on the Fetus and Newborn noted in 1971 that "there are no valid medical indications for circumcision in the neonatal period."2 In 1975, the American Academy of Pediatrics Ad Hoc Task Force on Circumcision reported that there was no basis for changing this statement and concluded, "There is no absolute medical indication for routine circumcision of the newborn."2

However, as previously noted, the use of the words "optimum" and "lifelong" with regard to to penile hygiene and the stated uncertainty of a possible link between circumcision and venereal disease represented equivocation. An additional equivocation is found in the 1975 Report: "A diagnosis of phimosis cannot be made with assurance in the newborn period because the cleavage plane between the glans and the deep preputial layer of the penis is not developed at birth. There is a real need for research which will improve diagnostic accuracy in this area."2

In 1983, this statement was challenged by Thompson, who chaired the ad hoc Committee. He wrote: "One major reason used to justify neonatal circumcision - correction or prevention of phimosis has been shown to be untenable by serial studies from birth to adulthood."2 Furthermore, overwhelming epidemiologic evidence from countries that never adopted circumcision or abandoned the practice obviates the need for further study.

Thompson also provided the setting for the equivocation and the absence of a more definitive position: "The ad hoc committee was sharply divided in its opinions, and the resulting statement was a compromise that stated that there was no absolute medical indication for routine circumcision of the newborn.' The words absolute and routine were meant to convey a different impression from the conclusion of the AAP Committee on the Fetus and Newborn, but this has no always been the interpretation of readers."2

If the American Academy of Pediatrics Committee was sharply divided and the report subject to misinterpretation, how can physicians and parents take an unequivocal position on circumcision? They cannot. And if the position of the American Academy of Pediatrics is equivocal, the position of the American College of Obstetricians and Gynecologists is even more so. When the American Academy of Pediatrics committees reported, the statements were published.56 The endorsements of the American College of Obstetricians and Gynecologists were not published in their journal.64 Moreover, in 1978 Grimes raised an unanswered question: "... the American Board of Obstetrics and Gynecology, Inc., warns that 'physicians who assume responsibility for the health of male patients for operative or other care will not be regarded as specialists in obstetrics-gynecology . . .'. It is well known that obstetricians perform a large percentage of circumcisions.

The acceptance of circumcision was noted by Herrera is 1983, who reported on a nationwide survey of 400 pediatricians and obstetricians; 50 percent believed circumcision indicated in the newborn, 33 percent opposed, and 17 percent were undecided.26 As to advice to parents, there was acquiescence; 15 percent encouraged it, 19 percent discouraged it, and 66 percent remained neutral. "This is one reason why nearly every male neonate is circumcised," Herrera wrote.26

Ambivalence on the part of physicians about circumcision was illustrated in one study by a Canadian hospital in 1983 where there were two patients with a serious complication of circumcision, denuding of the penile shaft that required plastic surgery. A formal proposal to suspend neonatal circumcisions was made but rejected because of anticipated adverse community reaction. However, the circumcision rate in that hospital dropped from about 40 to 20 percent as a result of the mishaps.61

Judging from the record, American medical professionals are not truly opposed to circumcision; they perform about 1.25 million annually. Some continue to insist that there are health benefits. Some physicians place the responsibility on the parents. In 1983 Maisels and colleagues wrote, "If circumcision practices are ever to be changed, such changes will likely result from organized advocacy of lay groups . . . rather than from the efforts of the medical profession."34 However when physicians demonstrated that routine tonsillectomy and adenoidectomy were unwise, the rate dropped. No amount of parental pressure would cause an ethical physician to perform such an operation if it were unnecessary.

Some charge venality, possibly true for some physicians, but not for all, and impossible to document. Some of the highest circumcision rates are to be found in military hospitals, where the doctors are salaried. Contrast this with the abandonment of routine tonsillectomy; some physicians had reduced revenues, but no one clamored for the reinstatement of the procedure to refill the coffers. Venality may not be dismissed entirely; in private practice, circumcision results in a fee, and there is loss of time convincing parents not to have their sons circumcised.

Then there is the Jewish question. Some non-Jewish physicians may be hesitant to question routine "health" circumcision in the mistaken belief that this stance may offend Jews. However, according to Jewish theologians, the Jewish ritual has nothing to do with health.59 Obversely, occasional private comments suggest that Jews are responsible for nonreligious circumcision. This is a canard.

The "enigma" lies in the United States medical profession's apparent inability to come to grips with the
simple fact that there are no demonstrable health benefits of circumcision, and there are risks. (Space limitations preclude delineation.) It should also be noted that the foreskin is useful erogenous, and protective tissue. Smegma, both clitoral and penile, is beneficial, not detrimental. Meatitis is not uncommon in circumcised males; rare in the uncircumcised. Moreover, the penis is the only organ subjected to routine prophylactic surgery.

One explanation for holding to outmoded views was provided by a medical professor who told his students, "It takes less than five minutes to print an article in a medical journal and 50 years to erase it." In 1979 Colletti approximated this estimate. He noted that efforts to reverse current circumcision practice "will need at least a generation of widespread education, coaxing, and encouragement to succeed." Warn and Strashin are even more pessimistic, based upon an erroneous premise: "As for the likelihood of a successful hygiene education program we can only point to our own profession's impotence in combating smoking and obesity." This approach overlooks the fact that hundreds of millions of dollars are expended annually to promote smoking and food intake. No such effort on behalf of circumcision exists.

As scientific evidence mounted to dispute each of Remondino's exaggerated claims, physicians clutched at straws to retain at least one "health" benefit. Now that such claims have been refuted, circumcision today has become cultural surgery, not very different from ear- and nose-piercing and tattooing. The extreme to which such cultural surgery is carried may be found in the 1983 warning given by the British Social Service Secretary to Harley Street surgeons who charged up to $1500 for a clitoridectomy performed on young girls from Africa, where such surgery is traditional. More serious examples were found in France in 1982.

The medical profession was successful in eliminating routine tonsillectomy and adenoidectomy. This is precisely what is needed for routine circumcision. It is necessary to overcome ignorance and the emotional superstructure surrounding the penis, not very different from ancient (and present phallic) worship. It is necessary to accept scientific facts; it is necessary to discard myths about circumcision: the foreskin causes premature ejaculation, it keeps the penis from growing, some disaster will befall the uncircumcised child, the uncovered glans is more esthetically pleasing (that is the foreskin is ugly). The special myth that the boy's penis must be identical to his father's ignores the historic truth that no objection was raised, and no problem arose when circumcising millions of boys whose fathers were uncircumcised.

To resolve the problem, the positions of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists should become definitive statements that circumcision is unnecessary surgery, not to be undertaken except in rare medical circumstances. Endorsements of this position should be obtained from all relevant medical groups. This information should be disseminated to the entire medical profession, to all hospitals, nurses and nursing associations, childbirth educators, and most certainly to parents via the popular press. Meetings of professional and lay persons should be called on local, state and national levels to discuss circumcision. With such an approach, routine newborn nonreligious circumcision will soon pass from the scene to join blood-letting and cupping in medical history.

As Prucha observed in 1980, "The history of these few millimeters of skin is utterly fascinating."

REFERENCES

18. Genesis, Chapter 17.
Circumcision. The uniquely American medical enigma. Urol Clin North Am 1985; 12: 123-132. Williams N, Kapila L. Technical report: urinary tract infections in febrile infants and young children. The Urinary Tract Subcommittee of the American Academy of Pediatrics Committee on Quality Improvement. Pediatrics 1999; 103: e54. Rushton HG. The complete amputation of the prepuce organ (as performed in North American style infant circumcision) initially began in an effort to curtail masturbation and 'promiscuous' behavior among boys and men. The prepuce ('foreskin') was well known to be the key organ at play in whole sexual health, and the theory was that if the prepuce was removed, men's pleasure and sexual drive would also be hampered as well. The reason this genital surgery started to be performed on infants without anesthesia is twofold: (1) It was commonly believed that babies 'do not feel pain' and