Consent for non-therapeutic male circumcision on religious grounds

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ABSTRACT

INTRODUCTION The aim of this study was to assess whether surgeons are conforming to guidance laid down by professional organisations and the courts in obtaining dual parental consent for non-therapeutic circumcision.

PATIENTS AND METHODS A retrospective case-note review over a 12-month period (April 2005 to April 2006) of circumcisions in boys under the age of 16 years in a tertiary paediatric surgical unit was undertaken.

RESULTS A total of 62 boys aged 1–14 years (median age, 4 years) underwent non-therapeutic circumcision. Written consent from both parents was obtained in only 4 cases (6.4%). In no case was written consent obtained from the patient or their views documented. In 58 cases, the written consent was provided by only one parent; the mother in 34 (55%), the father in 24 (45%). Of these 58 cases, in 25 (43%) both parents attended with the child on the day of surgery.

CONCLUSIONS The data reveal a consistent non-conformity with recommended practice and the common law. It seems unlikely that the doctors involved are deliberate and inveterate law-breakers. The reason for this non-compliance may be ignorance of the rules, or due to the impracticality of their implementation. There is evidence that doctors are ignorant of the legal rules pertaining to their patients, and the results may reflect this ignorance. However, there are also practical difficulties in obtaining dual consent that may be partially responsible for the variance. Inevitably, investment will be required to overcome these difficulties. Cost may tempt service providers to abandon the provision, leaving parents to their own devices.

KEYWORDS

Consent – Religious circumcision

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In 1997, guidance emerged from the UK General Medical Council (GMC) that permission from both parents should be obtained ‘whenever possible’, when obtaining consent for ritual circumcision of boys.¹ This has been repeated and embellished by the British Medical Association (BMA),² advising doctors who were approached by one parent with a request for ritual circumcision to ‘make every effort to contact the other parent in order to seek consent’.

In a case before the Family Division of the High Court,³ a Turkish Muslim father sought an order from the court that his son could be circumcised, against the wishes of the child’s mother. The mother, a non-practicing Christian, was held by the judge not to share the same cultural and religious stance as her estranged husband; her veto was considered a very powerful consideration in the welfare equation, and the father was prohibited from taking any steps to arrange or permit his son to be circumcised. The judge cited the advice from the GMC and BMA, finding that ‘mainstream medical opinion required both paternal and

in particular maternal consent’. His conclusion was upheld in the Court of Appeal. The President of the Family Division held that:⁴ ‘The decision to circumcise a child on a ground other than medical necessity is a very important one; the operation is irreversible, and should only be carried out where the parents together approve of it...’

In the face of such clear professional and legal direction, it seemed surprising that, at least anecdotally, children’s surgeons throughout England and Wales are making little effort to conform to the requirement for dual consent. We thus designed and executed a study to determine whether local practice was consistent with national guidance and to highlight this legal requirement to paediatric surgeons throughout the UK.

Patients and Methods

All boys under the age of 16 years who had undergone non-therapeutic circumcision for religious reasons at a regional

Figure 1 Distribution of age of boys undergoing ritual circumcision.

paediatric surgical centre over the 12-month period April 2005 to April 2006 were identified retrospectively. The case notes for these patients were obtained and analysed. Data collected included the age of the child, complications of surgery, whether both parents attended with the child on the day of surgery, and from whom written consent had been obtained. If written consent was obtained from only one individual with parental responsibility, then data were collected for any documented attempt made to ensure that both parents had been given the opportunity to provide consent. The notes were also reviewed to ascertain the child's involvement in the decision-making process. The consent was taken by either the consultant or a paediatric surgical registrar with suitable experience to perform the operation on the day.

Results

A total of 67 boys aged 1–14 years (mean, 5.1 years) underwent non-therapeutic circumcision during the 12 months to April 2006 (Fig. 1). Sixty-two case notes were obtained. Written consent from both parents was obtained in only 4 cases (6.5%). In no case was written consent obtained from the patient or their views documented. In 58 cases, the written consent was provided by only one parent; the mother in 34 (55%) and the father in 24 (45%). Of these 58 cases, in 25 (43%) both parents attended with the child on the day of surgery.

In no case where single parental consent had been obtained was there documentation to suggest any attempt to involve a second parent in the consent process. It was not possible to determine from the notes of any boy whether there may have been only one individual with parental responsibility. Only two complications were recorded and, in both cases, the parents felt an inadequate amount of tissue had been removed.

Discussion

The data reveal a consistent non-conformity with recommended practice and the common law. It seems unlikely that the doctors involved are deliberate and inveterate law-breakers. The reason for this non-compliance may be ignorance of the rules, or due to the impracticality of their implementation. There is evidence that doctors are ignorant of the legal rules pertaining to their patients, and the results may reflect this ignorance.⁵ However, there are also practical difficulties in obtaining dual consent that may be partially responsible for the variance.

Doctors who perform ritual circumcisions on boys are often presented with the child by only one parent. It is common to encounter a family where the other parent is temporarily abroad, or a non-English speaker. Furthermore, the non-English speaker may be the absent parent. If doctors are to comply with the advice, they must 'make every effort to contact the other parent in order to seek consent'. The conditional nature of the BMA guidance might give the doctor some latitude to consider that 'every effort' would not necessitate refusing to proceed until the absent parent had returned from abroad to provide consent. Alternatively, an interpreter might conduct the disclosure over the telephone; although it will be impossible to verify whether it is to the parent that they are speaking.

It is also commonplace to be presented with a child by both parents, one of whom is a non-English speaker. Traditionally, the English-speaking parent requests the procedure, and translates for their spouse, who invariably agrees to the procedure. It seems likely that the consent process should be deferred if the subsequent attendance of an independent interpreter would enable a second parent to hear the appropriate disclosure, and give valid consent. Both the delay imposed, and the implication that the translating spouse might be preventing their partner's objections

is likely to have a prejudicial effect on the therapeutic relationship. However, in these circumstances, it is foreseeable that consent may be invalid due to the application of undue influence on one parent by another.

Without the attendance of an independent interpreter, to verify both the disclosure and the consent, how can the doctor be confident that valid consent from the non-English speaker has been obtained? (Consistent with other GMC guidance,⁶ to: ‘...make sure, wherever practical, that arrangements are made to meet patients language ... needs’).

The expense of interpretation services would need to be born ultimately by the primary care trust underwriting the provision of the circumcision, although there is evidence of a wider debate concerning the provision of interpreters.⁷

The GMC advise the doctor to ‘obtain the permission of both parents whenever possible’. When two adults attend with a child for ritual circumcision, there is the general assumption that they are the child’s parents. Although this is simply verified by asking if they are, it would be inappropriate to pursue the matter further, since the relationship between doctor, parent and patient is based on trust. But does this satisfy the requirement to make ‘every effort’ to obtain ‘permission from both parents’?

The Court of Appeal gave no such acknowledgement of these practical difficulties, indicating simply that ritual circumcision ‘...should only be carried out where the parents together approve’. The Court places this stark duty on the doctor because of the importance of the decision, and its irreversibility. An obvious solution to this issue is improved education, both for the medical professional and parents. This could take the form of an information leaflets distributed

to parents and general practitioners emphasising the requirement that both parents need to be available to discuss consent.

Conclusions

Doctors who are asked to circumcise male children should follow professional guidance and adhere to the law; here, we have demonstrated an alarming variance to this principle. However, this non-compliance may be due to the considerable practical obstacles that the doctor will encounter when trying to practice lawfully, particularly in families where English is not the first language. Provision of adequate interpretation services may make compliance easier; however, the cost may tempt care providers to withdraw the service altogether, leaving parents who wish for ritual circumcision of their sons to make their own arrangements.

References

1. General Medical Council. *Guidance for doctors who are asked to circumcise male children*. London: GMC, 1997.
2. British Medical Association. *Medical Ethics Today*. London: BMJ Books, 2004; 151.
3. Re J (*Child's religious upbringing and circumcision*) [1999] 2 FLR 678.
4. Re J (*Specific Issue Orders: Child's Religious Upbringing and Circumcision*) CA [2000] 1 FLR.
5. Yallop K, Kevitiyagala D, Wheeler RA. Doctors' interpretation of child law: a gulf between rules and practice. *Arch Dis Child* 2007; **92** (Suppl 1): A34–6.
6. General Medical Council. *Good Medical Practice*. London: GMC, 2006; s23.
7. Jones D. Should the NHS curb spending on translation services? *BMJ* 2007; **334**: 399.