Our study population is also bound to be 'less unwell' than that of Birchley's study, as in his everyone underwent appendectomy. Birchley is incorrect to suggest that the patients in our study presented with 'non-specific abdominal pain' and there was no diagnostic concern of appendicitis. Our cohort included a heterogeneous and unselected population of patients with lower abdominal pain, some of whom were indeed discharged after observation, but some of whom had surgical intervention, including appendectomy. It is entirely possible that, in our hospital, a similar study involving only patients who had appendectomy would yield similar results to those of Birchley's study.

We concluded from our study that those patients in whom there is a low suspicion of acute appendicitis following clinical assessment, in whom both white blood cell count and C-reactive protein level were normal, can be safely allowed home. This advice clearly needs to be interpreted in the context of the study, each individual patient and the experience of the clinician, but will hopefully be of use as one of many clinical and laboratory parameters used in the assessment of patients with abdominal pain in whom the diagnosis is unclear.

Reference

1. Birchley D. Patients with clinical acute appendicitis should have pre-operative full blood count and C-reactive protein assays. *Ann R Coll Surg Engl* 2006; **88**: 27–32.

COMMENT ON

doi 10.1308/003588409X359394

R Robinson, E Makin, R Wheeler. Consent for non-therapeutic male circumcision on non-religious grounds. *Ann R Coll Surg Engl* 2009; **91**: 152–4

COMMENT 1

doi 10.1308/003588409X464586

Dual parental consent

MK MENON

The Ongar Surgery, Ongar, Essex, UK

CORRESPONDENCE TO

MK Menon, The Ongar Surgery, High Street, Ongar, Essex CM5 9AA, UK. E: kenmenon@aol.com

The President of the Family Division held that operation shall only be carried out with the approval of both parents. This places a binding legal obligation on the surgeon to seek dual parental consent without any latitude in the interpretation of this judgement. Additionally, it is assumed that doctors are familiar with the legal environment in which

they have to practice. This is no different from the 'man on the Clapham omnibus' who is deemed to be familiar with the law of the land.

Language difficulties, absence of one parent, etc. do not exonerate the surgeon from failure to obtain dual consent.

Second, the presence of two adults with a child at a consultation may not always imply that the former are the parents of the latter. Also, the question whether they are the genetic parents needs consideration. It is assumed that the judge referred to genetic parents in his judgement. The authors surprisingly view that a breach in professional trust may occur from inquiring about parenthood at a consultation involving a child. On the contrary, it is vital that this be established at the outset. On more than one occasion in the past, the medical profession has been exhorted to 'think the unthinkable'.

Pursuing the need for dual consent requires the surgeon to ensure that:

1. Both adults are the legal parents of the child.
2. The adults understand the matter being discussed and provide consent that is informed and devoid of coercion or misunderstanding.
3. Translation that may be required is independent.
4. The child's view, where practical, is considered.

In the absence of dual consent the surgeon should not proceed with the operation, for which there is no medical reason or urgency.

COMMENT 2

doi 10.1308/003588409X464595

Consent of children for non-therapeutic surgical procedures – general issues

SIMON BOTT

Department of Urology, Frimley Park Hospital, Frimley, Surrey, UK

CORRESPONDENCE TO

Simon Bott, Locum Consultant Urologist, Frimley Park Hospital, Portsmouth Road, Frimley, Surrey GU16 7UJ, UK
E: simonrbott@hotmail.com

I read with interest the article by Robinson et al. which audited the use of two parent consent for childhood circumcision on religious or ritual grounds. This paper raises more general questions about the consent of children for a surgical procedure for non-therapeutic reasons.

The Hippocratic oath states 'I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone'. Performing a circumcision is associated with well-documented complications: postoperative bleeding, wound infection, meatal

stenosis, poor cosmesis and the affect on altered sensation are described in up to 10% of children undergoing circumcision.¹ On top of this there may be an adverse psychological impact that the hospital stay and postoperative pain may have on the boy. By performing non-therapeutic circumcision, surgeons are asked to 'do harm' and breach the Hippocratic oath for a non-medical condition, albeit with the tacit support of the General Medical Council and British Medical Association.

Whilst a child's parent(s) may be of a particular faith there is no guarantee their offspring will be of the same, or indeed have any, faith. Inflicting a circumcision on a boy for religious reasons is inflicting potential harm on someone who is unable to weigh up the risks of surgery and who may not go on to adopt the same religious beliefs.

In our society, where individuals have a right to choose, I do not think non-therapeutic circumcision should be permissible until the individual himself is able to give informed consent. The argument that, by not allowing non-therapeutic circumcision in hospital may drive parents to seek surgery in a non-clinical setting, may be negated if the surgery is more freely available to consenting children after the age of 16 years.

Reference

1. Stenram A, Malmfors G, Okmian L. Circumcision for phimosis: a follow-up study. *Scand J Urol Nephrol* 1986; **20**: 89–92.

AUTHORS' RESPONSE

doi 10.1308/003588409X464603

ROBERT WHEELER

Wessex Regional Centre for Paediatric Surgery, Southampton General Hospital, Southampton, UK

CORRESPONDENCE TO

Robert Wheeler, Consultant Paediatric and Neonatal Surgeon, Wessex Regional Centre for Paediatric Surgery, Southampton General Hospital, Tremona Road, Southampton SO16 6YD, UK
E: robert.wheeler@suht.swest.nhs.uk

Response to Comment 1

Menon's 'man on the Clapham omnibus' is, with due respect, a poor exemplar. He is a creature of legal fiction created (at least) a century ago, providing a standard for the reasonable citizen with which a court can compare defendants' behaviour in alleged negligence. But he was not imbued with knowledge of the law.

However, there is an expectation that doctors should practise at a standard that has been set by the General

Medical Council (GMC); and the GMC sets standards consistent with the law. Dame Butler-Sloss' judgement prescribed the need for dual parental approval for ritual circumcision, but she was silent as to the extent of the surgeon's duty to establish that the dual approval exists, which is a quite different matter.

The GMC's interpretation of her judgement is that we should seek approval from both parents 'wherever possible'. Whilst entirely consistent with her judgement, this offers the latitude required for the practicalities of clinical life as described in our article.

We suggest that those who introduce themselves as the parents of a child should not be further challenged on the point, other than to confirm that at least one of them has parental responsibility.

We do not agree that genetic parenthood is so vital that it must be 'established at the outset'. First, it would potentially endanger the therapeutic relationship, since it might be construed both as rudeness and as an intrusion into the privacy of family life.

Second, it would be disproportionate because there is no legal requirement for a man to have a genetic link with a child for whom he has parental responsibility, provided both he and the mother either accept (or are oblivious to) the reality of the child's parenthood. If a man with parental responsibility for a child later discovers that he is not the biological father, he may take steps to remedy the situation, but few do so, since the vast majority remain in ignorance of their error.

'Legal parent'(age) needs clarification. We would agree that at least one signatory of the consent form must have parental responsibility. The child's mother would almost inevitably have parental responsibility. In reality, there is little that the clinician can do in the out-patient setting to ensure that the man accompanying the child is his father, other than rely on the mother's agreement.

Response to Comment 2

Bott rightly draws attention to the risks associated with circumcision. Ritual circumcision is only justifiable if, in the judgement of the surgeon (and his 'reasonable' peer group), the surgery is in the boy's best interests. To arrive at this conclusion, the balance between risk and benefit must be weighed, as it should be before any other procedure. We can only assume that those surgeons who carry out ritual circumcisions perform this balancing exercise, and have concluded that, for the boy in question, the surgery is in his best interests. If the surgeon is in any doubt of this, then he or she is obliged to defer the procedure until either the situation is clarified in favour of circumcision, or the child is old enough to make the choice for himself.