Diversity in Health and Social Care 2005;2:37–40

Research papers

Promoting safer male circumcisions for British Muslims

Abdul Rashid Gatrad OBE PhD FRCP FRCPCH
Consultant Paediatrician

Amir Khan FRCS
Consultant Surgeon

Manor Hospital, Walsall, UK

Shuja Shafi MBBS FRCPath
Consultant Microbiologist, North West London Hospitals Trust, Harrow, UK

Aziz Sheikh MBBS MSc MD MRCP DFFP
Professor of Primary Care Research and Development, Division of Community Health Sciences: GP Section, University of Edinburgh, UK

ABSTRACT

Male infant circumcision is the most common surgical procedure in the world. Although in some cases performed for clinical reasons, it is today in Britain most commonly performed for religious reasons in Jewish and Muslim infants. This procedure is, however, currently not available on the NHS in most parts of Britain, resulting in difficulties for parents in accessing suitably trained practitioners and consequently increasing the risk of potentially avoidable complications associated with the procedure. This paper considers the faith background to male circumcision in Muslim communities and discusses approaches to reducing the risks associated with it.

Keywords: circumcision, male, Muslims, religious, safety

Introduction

Male circumcision, which entails removal of the penile foreskin, is the most common surgical procedure in the world (Maxwell, 1996; Gallaher, 2000). Circumcision is performed either for clinical reasons such as a pathological phimosis, preventative reasons such as reducing risk of developing HIV/AIDS, or to comply with religious practice. Within a faith context, circumcision is considered beneficial not only because of the resulting improved genital hygiene, but also for offering additional benefits relating to sense of identity.

We have previously discussed the ethics and legality of male infant circumcision, exploring these issues with particular reference to the European Human Rights Act (Articles 3, 8 and 9), and concluded that parents are within their rights to request that their male children be circumcised (Gatrad *et al*, 2002). Our experiences suggest that the lack of NHS availability for religious circumcisions, however, often makes it difficult for parents to have the procedure safely performed.

Against this backdrop, this article explains the faith background to circumcision and then presents a discussion of key steps that need to be taken to improve the safety profile of this procedure in Britain.

Faith background

The Book of Genesis (17:10–13) recalls that a key condition of God's Covenant with Abraham in making 'him a great nation' was that 'every male amongst

you in every generation shall be circumcised on the eighth day'. The majority of Jews continue to respect this covenant and so have their male infants circumcised on the eighth day of life.

Although initially observed by the followers of Christ, it was largely under the influence of St Paul's interpretation, which saw Christ as representing a New Covenant thereby rendering Old Testament practices null and void, that the Church departed from this old Judaic practice. As Paul notes:

> For freedom, Christ has set us free; stand fast therefore, and do not submit again to a yoke of slavery. Now I, Paul, say to you that if you receive circumcision, Christ will be of no advantage to you. I testify again to every man who receives circumcision that he is bound to keep the whole law. You are severed from Christ, you who would be justified by the law; you have fallen away from grace. For through the Spirit, by faith, we can wait for the hope of righteousness. For in Christ Jesus neither circumcision nor uncircumcision is of any avail, but faith working through love. (Galatians 5:1–6)

As for Islam, circumcision is seen by Muslims as a continuation of the Abrahamic tradition. Muhammad, the Prophet of Islam, reinforced the message of male circumcision almost 600 years after Jesus. Although there is no clear mention of this practice in the Holy Qur'an, it is noted in the 'Ahadith' (the sayings and actions of Prophet Muhammad) as necessary for male infants. Circumcision is seen as a symbol of spiritual purity and religious identity in which many Muslim (and Jewish) parents take great pride. It has furthermore always been the belief of Muslims that the foreskin is unclean and may harbour disease.

Male infant circumcisions performed in the community

The 2001 census revealed that Britain is now home to approximately 1.6 million Muslims of whom almost 50% are British born (National Statistics Online, 2005). Evidence suggests that the vast majority of these male British Muslim infants continue to be circumcised and it is likely that this pattern will continue for the foreseeable future (Bhopal *et al*, 1998).

Although there are some areas in the UK where Muslims are circumcised by Jewish Mohels (trained Rabbis), more typically, general practitioners (GPs) perform the procedure at an average cost of £50–£100 (Circumcision Agency, 2005). British Muslims generally circumcise their infants within a few days of birth (in keeping with the Prophetic dictum recommending circumcision on the seventh day of life). Delays are, however, not uncommon; these either represent cultural variations in preferred timing or, more commonly, difficulties in accessing an appropriately qualified doctor.

The General Medical Council advises clinicians that (see Box 1 for best practice guidelines from the General Medical Council):

> ... if you decide to circumcise a male child you must have the necessary skills and experience, both to perform the operation and use appropriate measures, including anaesthesia, to minimise pain and discomfort (General Medical Council, 1997).

Although many of these circumcisions appear to be competently performed, there are grounds for concern that, in some cases, infants continue to be put at

Box 1 Best practice guidance from the General Medical Council, 1997

If you decide to circumcise a male child you must:

- have the necessary skills and experience both to perform the operation and to use appropriate measures, including anaesthesia, to minimise pain and discomfort
- keep up to date in the development of practice of male circumcisions including when the procedure is, and is not, necessary for medical reasons
- explain objectively to those with parental responsibility for the child any benefit or risks of the procedure, taking into account the age of the child
- explain to those with parental responsibility that they may invite their religious advisors to be present at the circumcision to give advice on how the procedure should be performed to meet the requirement of the faith
- listen to those with parental responsibility and give careful consideration to their views. You are not obliged to act on a request to circumcise a child, but you should explain if you are opposed to circumcision other than for a therapeutic reason. You should also tell those with parental responsibility that they have a right to see another doctor
- obtain the permission of both parents whenever possible, but in all cases obtain valid consent, in writing, from a person with parental responsibility before performing the procedure
- provide appropriate after care.

risk of complications by a failure to undertake a satisfactory pre-operative assessment, poor technique and/or inadequate follow-up (McManus, 2001).

This has led to a number of complaints received by defence unions of potentially avoidable problems such as a failure to obtain informed consent, inadequate analgesia, excessive haemorrhage and sepsis (Lipley, 1997). Similarly, a recent study has found that over a period of 20 months, 31 circumcision-related complications (of which 19 represented bleeding problems, five of whom needed transfusion) were recorded presenting to one hospital in the north of England (Corbett and Humphrey, 2003; see Box 2 for possible complications of circumcisions). Furthermore, parental reports reveal that British community practitioners use a range of analgesics, either singly or in combination; these include: paracetamol, vallergan, chloral hydrate and pethidine (Gatrad, 2002). On occasions, the post-operative application of a local anaesthetic gel may also be used and we are also aware that some do use a 'ring block' with a local anaesthetic. There are, however, practitioners who do not use any anaesthetic for babies less than eight weeks (Cohen and Zoltie, 1991) in the (mistaken) belief that 'babies do not feel much pain' and/or that the 'procedure only takes a few minutes'. Research has, however, confirmed that there is a well developed pain pathway in the neonate and that circumcisions can cause severe pain (Stevens *et al*, 2000).

Male infant circumcisions performed in hospital

Performing these procedures within hospitals appears to be far safer. Reassuringly, in a series of 500 000 consecutive circumcisions performed in a hospital in the USA, no deaths were reported (King, 1982). Furthermore, a separate north of England study has, for example, found that the complication rate for circumcisions performed in hospital is less than 1%, and this finding has been echoed in other large case series which have found complication rates of about 0.2% (Wiswell and Geschke, 1989). Also of note are results from Bradford where advanced nurse practitioners officially carry out this procedure with low complication rates (Shah *et al*, 1999).

In our centre in Walsall, circumcisions have been performed for the past three years on Muslim boys (age range 2–24 months) by one of the authors (AK), a consultant surgeon, working for the NHS and on NHS premises without charge to the patient. A detailed pre-operative assessment is made and written informed consent is obtained. The procedure, which takes approximately 20 minutes, is carried out in a sterile environment with an anaesthetic ring block followed by the 'Plastibell method' and a local application of 2% lignocaine (Instagel) post-operatively. A paediatric trained nurse is in attendance. Instagel and paracetamol are given to the parents to take home, with clear instructions on bringing the child back to the paediatric surgical ward in case of any complications. In over 300 procedures carried out, we have a known complication rate of less than 1%, none of which were life threatening.

Box 2 Possible complications of circumcisions

- Dressing too tight
- Unable to pass urine
- Excess bleeding
- Dressing falling off too early, etc.
- Meatal ulceration – as a result of stagnant urine in a nappy
- Infections
- Amputation of penis – as a result of a very tight knot slipping onto the shaft after the Plastibell method

Making circumcisions safer

Considering the difficulties many parents face in finding a suitable practitioner, the safety concerns around the performance of some of these procedures in the community, and the comparative reassuring data which show that the procedure is very safe when performed in a hospital setting, we believe that much wider NHS availability is the key step to improving safety. It is, furthermore, important that the procedure be performed by practitioners who are adequately trained (see Box 3 for contraindications to circumcisions), who keep a log of all procedures performed that can be subject to analysis if the need should so arise, and who commit to regular audit and periodically undergo reassessment. Registers of appropriately trained clinicians can then be published

Box 3 Contraindications to circumcisions

- Hypospadias/epispadias (foreskin needed for reconstruction)
- Buried penis
- Presence of jaundice (increased risk of bleeding)
- Premature babies (increased risk of bleeding)

and made available to national and local religious organisations that are frequently approached to provide information on the availability of circumcisions in their area.

Conclusions

At the Muslim Council of Britain, we regularly receive queries from anxious parents wanting to circumcise their newborn males. From these interactions and the limited published evidence, we can conclude that there is a considerable demand for this procedure from British Muslim parents, many of whom would like to have it performed on the NHS. This demand comes both from a recognition that, as tax payers, they feel that they have a right to services that better meet their needs (a position that is likely to gain strength as we move to a health service which is predicated on a 'choice' agenda), and also because they have either had or know of a previous bad experience with community circumcisions.

There is, however, currently something of a 'post-code lottery' in operation as circumcisions are currently available on the NHS in only some regions. Greater availability on the NHS is now needed where minimum standards of care can be set, monitored and, where found to be lacking, enforced. This is likely to need registration of practitioners wishing to carry out this procedure, and training provisions.

While the debate on issues of ethical, therapeutic, legal and parental choice for circumcision continues, we believe that there is a need for this procedure to be made safer. Although in many hands it is already safe, steps need to be taken to ensure that minimum standards of competence can be achieved in relation to all male circumcisions performed in Britain. The Muslim Council of Britain (MCB) is willing and will support initiatives to this end, and we invite healthcare professionals to work with us in helping us realise this vision.

REFERENCES

Bhopal R, Madhok R and Hameed A (1998). Religious circumcision on the NHS: opinions of Pakistani people in Middlesbrough, England. *Journal of Epidemiology and Community Health* 52:758–9.

Circumcision Agency www.circumcision-agency.com/circumcision_agency_prices.html (accessed 1 February 2005).

Cohen J and Zoltie N (1991). Should religious circumcisions be performed on the NHS? *British Medical Journal* 302: 788.

Corbett HJ and Humphrey GME (2003). Early complications of circumcisions performed in the community. *British Journal of General Practice* 53:887–8.

General Medical Council (1997). *Guidance for doctors who are asked to carry out male circumcisions*. London: General Medical Council.

Gatrad AR (2002). Variations in anaesthetic and analgesic practice during male circumcisions of Muslim boys in the community (unpublished).

Gatrad AR, Sheikh A and Jacks H (2002). Religious circumcisions and the Human Rights Act. *Archives of Disease in Childhood* 76:76–8.

Gallaher DL (2000). *Circumcision: a history of the most controversial surgery*. New York: Basic Books, pp. 126–7.

King LR (1982). Neonatal circumcision in the US in 1982. *Journal of Urology* 128:1135–6.

Lipley N (1997). Guidance needed on circumcision method. *GP magazine, UK*. 3 October:18.

Maxwell M (1996). Male circumcision. *Liverpool Public Health Observatory* 8:3.

McManus J (2001). Circumcision dangers spelt out. http://news.bbc.co.uk/1/hi/health/1670590.stm (accessed 1 February 2005).

National Statistics Online www.statistics.gov.uk/default.asp (accessed 1 February 2005).

Shah T, Raistrick J, Taylor I *et al* (1999). A circumcision service for religious reasons. *BJU International* 83:807–9.

Stevens B, Gibbins S and Franck LS (2000). Acute pain in children. In: Yaster M (ed.) *The Paediatric Clinics of North America*. London: Saunders 47:633–50.

Wiswell TE and Geschke DW (1989). Risks from circumcision during the first month of life compared with those from uncircumcised boys. *Paediatrics* 83:1011–15.

CONFLICTS OF INTEREST

Shuja Shafi chairs the Health and Medical Committee of the MCB and Aziz Sheikh chairs its Research and Documentation Committee; Rashid Gatrad is an advisor to the Research and Documentation Committee of the MCB.

ADDRESS FOR CORRESPONDENCE

Dr AR Gatrad, Manor Hospital, Moat Road, Walsall, UK. Tel: +44 (0)1922 656568; fax: +44 (0)1922 656742; email: sec.gatrad@walsallhospitals.nhs.uk

Received 3 August 2004
Accepted 12 December 2004