# Circumcision: In Whose Care?



Non-clinical Male Circumcision Services in Kensington & Chelsea and Westminster: *An Equality Impact Assessment* 

A Report by the BME Health Forum July 2009

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Acknowledgements: Contents: Executive Summary:	<ul><li>p. 3</li><li>p. 4</li><li>p. 5</li></ul>
Current Study: How this study came about Steering group Community researchers Methodology	<ul><li>p. 8</li><li>p. 8</li><li>p. 8</li><li>p. 9</li><li>p. 9</li></ul>
Introduction: Prevalence of circumcision History of circumcision in Britain Risks and complications Medical debate on the benefits of circumcision Cost benefit analysis of circumcision for non-clinical reasons Current demand for circumcision Models for offering a circumcision service in England Current guidance	<ul><li>p. 12</li><li>p. 12</li><li>p. 12</li><li>p. 13</li><li>p. 13</li><li>p. 14</li><li>p. 14</li><li>p. 15</li><li>p. 18</li></ul>
Discussion: Parents GPs NHS surgeons Private practitioners Rabbi	<ul><li>p. 19</li><li>p. 19</li><li>p. 22</li><li>p. 22</li><li>p. 23</li><li>p. 24</li></ul>
Conclusions:	p. 25
Recommendations: Monitoring and regulating NHS commissioned circumcision services Information	<ul><li>p. 26</li><li>p. 26</li><li>p. 26</li><li>p. 28</li></ul>
Glossary:	p. 29
Bibliography:	p. 30
Appendix 1 Medical debate on the benefits of routine circumcision	p. 33
Appendix 2 Current guidance on circumcisions for non-clinical reasons	p. 34
Appendix 3 Results: Parents GPs NHS surgeons Private practitioners Rabbi	<ul><li>p. 37</li><li>p. 37</li><li>p. 37</li><li>p. 45</li><li>p. 47</li><li>p. 48</li><li>p. 50</li></ul>

# **Executive Summary**

This is a study about circumcision services in Kensington & Chelsea & Westminster (KCW). It aims to capture and analyse the experiences and views of the community and the relevant health professionals in order to recommend how existing arrangements may be improved.

This study also forms an equality impact assessment designed to assess how the current approach to the provision of circumcision services for non-clinical reasons is affecting the communities who practice male circumcision.

In this study, 63 interviews were conducted with parents who are residents in KCW and whose sons were recently circumcised for non-clinical reasons. In addition, 10 GPs, 2 NHS surgeons, 3 private practitioners (all of whom were local GPs), 1 service manager and 1 rabbi were interviewed.

The most significant findings of the study were:

- 1. Complications after circumcision are far more prevalent in older children than in newborns. Our study, which explicitly looked for cases of complications found that all instances of complications occurred in children aged 3 months or older (15/44) while none occurred in children aged 1 week-2 months old (0/22).
- 2. Complications are far more likely to occur when the practitioner is medically unqualified. In our study, all cases of circumcision performed by a non-medical practitioner were followed by complications (4/4). However, it should be noted that in all these cases the child was over 3 months old and that none of these circumcisions had been performed by Jewish mohels.
- 3. Boys ages 1-11 years old are frequently circumcised in the community under local anaesthetic. While there is some debate among the NHS practitioners interviewed about the ethics of circumcising boys aged 4 months to 1 year of age under local anaesthetic (rather than general anaesthetic), they all agreed that boys aged 1 year old or older should always be circumcised under general anaesthetic because of the difficulties medically and ethically in restraining a child this age in order to perform the procedure.
- 4. Circumcisions as they are currently performed in the community or in hospitals examined under this survey do not fully conform to the BMA guidance outlined in the document The Law & Ethics of Male circumcision –guidance for doctors. Medical Ethics Committee, British Medical Association.<sup>1</sup> The relevant issues of guidance are: a) appropriate analgesia and b) informed consent by both parents, including informing the parents about the risks associated with the

http://www.bma.org.uk/ethics/consent\_and\_capacity/malecircumcision2006.jsp

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<sup>&</sup>lt;sup>1</sup> British Medical Association, The law and ethics of male circumcision - guidance for doctors, 12 November 2007,

- procedure and the fact that any associated benefits of the procedure are still a matter of debate within the medical community.
- 5. The overwhelming majority of parents would prefer to have their sons circumcised in an NHS service rather than a private one (53/62). Furthermore, more parents preferred an NHS service because they though it would be caring and of high quality rather than because it would be free. Generally, for most parents, the cost of the procedure was not a factor of very high importance when choosing a provider. On the other hand, where the local NHS have commissioned circumcision services which charge the parents considerably more than they would be charged in the community they have had some difficulty in operating at full capacity.

# Recommendations

Recommendations are made with regard to three areas:

# **Monitoring and Regulating**

Given that the circumcision of boys for non-clinical reasons is legal and widely practiced in many communities, the state has a duty to ensure that they are performed competently and safely regardless of the fact that they are not widely regarded to be medically beneficial.

- The Care Quality Commission should regulate circumcisions for nonclinical reasons
- The local NHS has a responsibility as part of its Public Health role to monitor and regulate the local arrangements for circumcisions for nonclinical reasons, possibly in cooperation with the voluntary and community sectors

# NHS commissioning of circumcision services

One of the most effective ways to reduce complications and the suffering of children would be to introduce circumcision services commissioned by the NHS. Two services need to be commissioned:

- A service for children to be circumcised under general anaesthetic. The
  full costs of such a service for children would be considerable for the
  NHS (£500-£700) but it would be possible to charge some costs to the
  parents (up to £300). Such a service is necessary because children
  who are circumcised in the community undergo considerable suffering
  when the procedure is performed under local anaesthetic and are
  particularly vulnerable to complications
- An outpatient service for newborn babies aged up to 10 weeks or an inpatient service for newborns on the first or second day after they are born. The circumcisions would take place under local anaesthetic. Full or nearly full costs (£100-150) can be charged to the parents. Ideally, for those on benefits a cheaper service could be offered, funded by external organisations. Such a practice would reduce complications significantly, including 'repeat' circumcisions that are performed by

surgeons within the NHS and therefore could reduce costs to the NHS as well as suffering in the community

Both services should follow BMA's guidance for best practice with regard to analgesia, consent from both parents, and the explanation of medical risks and benefits.

### Information

Information about circumcision services needs to be publicised in a number of languages and locations particularly maternity hospitals and local community groups. Any such leaflet should contain information about:

- How the procedure is performed
- Risks and benefits
- The much lower risk of complications if the circumcision is performed while the baby is very young and if the practitioner performing the procedure is medically qualified
- A list of medical practitioners who practise circumcision safely.
- After-care
- What to do in an emergency

# **Current Study**

# How this study came about

In 2006, NHS Westminster issued a letter to GPs clarifying that circumcision for non-clinical reasons was not funded. This letter led to two health professionals voicing concerns that vulnerable families who were unable to find a trained professional to perform a circumcision for religious or cultural reasons or who were unable to pay the going rate for such a procedure may end up having their children circumcised by unqualified people in unsuitable environments. The result from such a situation would be children suffering unnecessarily and increased costs to NHS trusts which would have to deal with the consequences of any incompetent procedures. The Director of Public Health in NHS Westminster brought these concerns to the attention of the BME Health Forum, which decided to investigate this issue. Preliminary consultations with community members showed that this was a matter of concern to them and led to the BME Health Forum commissioning this study.

In Kensington & Chelsea, while no similar directive has been issued to GPs, the policy of the PCT follows that of the NHS in general, which is that circumcisions for non-clinical reasons should not be funded.

The aim of this project is to research the impact of the local NHS's current approach to the provision of circumcision services through an analysis of the experience and views of the communities and the relevant health professionals, and to provide recommendations about how these arrangements may be improved.

As such this report forms an equality impact assessment of the circumcision arrangements in KCW and will enable the local NHS to meet their legal requirements in this respect. The recommendations are intended to assist the local NHS take the necessary steps to reduce the potential negative impact of the current policy. However, it should be noted that the report does not consider the experience of all equalities strands, since the conclusion of initial assessment was that the current policy impacted most significantly on those groups which practice circumcision for religious or cultural reasons. As such, it is the experience of these groups that is the focus of this report.

# Steering group

The members of the steering group are:

Lesley Bown, Head of Equality and Human Rights, NHS Kensington & Chelsea

Brian Colman, Head of Equality, Diversity and Human Rights, NHS Westminster

Vivien Davidhazy, BME Health Forum Administrator, Migrants Resource Centre

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Lev Pedro, Organisational Development Manager, Kensington & Chelsea Social Council

Ziaur Rahman, Community Development Manager, Queens Park Bangladeshi Association

Amjad Taha, BME Health Forum Manager Nafsika Thalassis, BME Health Forum Project Manager

### **Community researchers**

The BME Health Forum community researchers are a group of volunteers recruited in 2005 and 2007 to carry out interviews with community organisations, health professionals and KCW residents. They have contributed to a number of BME HF projects including 'Minding the gaps Are BME groups partners or substitutes in health provision?' and 'Primary Concern Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea and Westminster'. The researchers were recruited from BME community groups in KCW. For this project they were given particular training on the issues relating to circumcision for non-clinical reasons. During the training, the volunteers piloted the questionnaire for the parents of boys who were circumcised and identified questions which were unsuitable. They were therefore instrumental in producing the final version of this questionnaire.

# Methodology

The project was managed by Nafsika Thalassis who worked under the supervision of the BME Health Forum Manager, Amjad Taha and the Project Steering group. The steering group met every month to discuss the progress of the project and to give advice on how the project should proceed.

The research part of the project was based on semi-structured qualitative interviews. The questionnaires were put together by Nafsika Thalassis and were then amended according to the advice of the steering group and the community researchers. Four different questionnaires were put together for the following groups of interviewees:

- Parents of children whose sons had been recently circumcised
- GPs in Kensington & Chelsea and Westminster
- NHS Surgeons who, in the past, carried out circumcision for nonclinical reasons within the NHS
- Private Practitioners who currently carry out circumcisions

Additional telephone interviews were carried out with some service managers of circumcision services in other parts of the country and a rabbi.

Parents of children whose sons had been recently circumcised In total, 63 interviews were conducted, concerning 66 children.

The parents interviewed in this study were almost exclusively Muslim. This reflects partly the fact that there is a very large Muslim community in KCW but

<sup>2</sup> BME Health Forum, 'Minding the Gaps, Are BME groups partners or substitutes in health provision?' June 2006, <a href="http://www.westminster-pct.nhs.uk/pdfs/MindingTheGaps.pdf">http://www.westminster-pct.nhs.uk/pdfs/MindingTheGaps.pdf</a>

<sup>&</sup>lt;sup>3</sup> BME Health Forum, 'Primary Concern, Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea and Westminster', June 2008, http://www.westminster-pct.nhs.uk/pdfs/bme\_Primary\_Concern.pdf

also that the organisations through which the interviews were conducted have a large Muslim client base. Furthermore, the project did not intend to interview Jewish parents in KCW as our assessment of the situation was that provision of circumcision services within the Jewish community is very well established and organised and is not an issue of need for the Jewish community or concern to the local NHS. As a result, the experience of Jewish parents and parents of other traditions who have their children circumcised was not covered in this project. However we did interview a rabbi who attends circumcisions in the Jewish community to look at how the system is regulated. We also tried to interview a mohel (Jewish circumciser) but were unable to do so. In addition, we interviewed health professionals who occasionally circumcise non-Muslim children.

Furthermore, our sample was not representative because we looked specifically for parents whose sons had suffered some kind of complication after the circumcision and for cases of children who were circumcised as toddlers and children rather than new-born babies. In total, 15 children in our study had suffered some kind of complication and 33 were children who were circumcised at an age older than 5 months (oldest was 11 years old).

The rationale behind choosing this sample was that in a small scale study such as this, a representative sample would not be able to inform us about the issue of post-operative complications and the factors that lead to them (for example, type of practitioner, age of child). To establish the true prevalence of complications, a much larger epidemiological study would be required which is beyond the capacity of the BME Health Forum.

It should also be kept in mind that a condition which is defined as a complication by a parent is not necessarily one that would be defined as a complication by a medical professional. For example, in our sample, complications include 5 cases where the procedure had to be repeated -but we know that sometimes the cosmetic result of a circumcision is a matter of opinion. Other complications, would probably not be seen as particularly serious from the point of view of the health professional e.g. the ring taking 9 days to fall instead of the usual 5, the baby experiencing what to the parent seems like excessive discomfort or the parent suspecting an infection which is not confirmed. We took the view that if a parent said there was a complication we would take that as valid without attempting to investigate whether the complication was medically verifiable. The two patterns that emerged from the study were that the risk of complications hugely increase if the procedure has been performed by a non-medical practitioner (4/4 compared to 11/62) and if the child is 3 months old or older (15/44 compared to 0/22). These numbers are so striking as to suggest that even if parents have in certain instances exaggerated the complications, the overall patterns are still valid.

The intention of this research was to study circumcisions which have taken place recently and it was with that criterion that cases were selected. The majority of circumcisions (47/66) used in this study were performed after 2006. A further 10/66 took place in 2004-2005, and another 6 took place in 2000-2003. We have no data in a further 3 cases. We also have no exact data

about when the procedures performed to correct prior circumcisions took place.

The sample was found through links with local community and religious organisations. Sample recruitment and interviews were coordinated by Charmaine Mukherjee and individual interviews were undertaken by community researchers. Parents received a small payment for attending the interview.

# **GPs in Kensington & Chelsea and Westminster**

All GPs in Kensington & Chelsea and Westminster were contacted via email. Ten responded (only 9 responses included information). One further interview was carried out face to face by the project manager.

# NHS surgeons who in the past carried out circumcision for non-clinical reasons within the NHS

Two NHS surgeons were contacted. One of the surgeons has continued to perform circumcisions within his private practice. The interviews were carried out by the project manager.

# **Private practitioners**

Three private practitioners were interviewed. All three were local NHS GPs who performed circumcisions as part of a private practice. None had replied in the emailed survey used to assess GPs' views on circumcision (above). Some practitioners received a payment for attending the interview.

# **Service managers**

The service managers of circumcision services set up by the NHS were contacted by members of the project steering group.

### Rabbi

One rabbi was contacted for a telephone interview with the project manager.

# Introduction

### Prevalence of circumcision

Male circumcision is nearly universal (over 98%) among Jewish and Muslim men. It is also mainstream among many other communities, including communities who are Christian, secular or practise traditional religions. Male circumcision is routine amongst non-Jewish and non-Muslim populations in Angola, the Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Madagascar, the Philippines and Nigeria. The majority of non-Jewish and non-Muslim males are circumcised in Australia, the Republic of Korea, the United States and the United Republic of Tanzania. Furthermore, over a quarter of non-Jewish and non-Muslim men are circumcised in Canada, Indonesia and South Africa.<sup>4</sup>

Babies of Jewish faith are generally circumcised on the 8<sup>th</sup> day after birth provided there is no contraindication such as jaundice. However, the age at which circumcision is performed on boys of other religions varies between and within countries. In the United States, most circumcisions take place on the first or second day after birth before the mother and baby leave the hospital.<sup>5</sup> In Pakistan, while most babies born in hospitals are circumcised soon after birth, babies born at home are circumcised 3-7 years old, or occasionally after adolescence.<sup>6</sup> In Turkey, there are a variety of practices and while some circumcisions take place in infancy, many circumcisions take place in childhood. Sometimes large groups of children are circumcised together.<sup>7</sup>

# History of circumcision in Britain

In the UK, male circumcision was popular in the 19<sup>th</sup> century amongst those of high socio-economic status because it was thought to prevent the spread of syphilis and to discourage masturbation.<sup>8</sup> In boys attending the best public schools prevalence was reported be as high as 84% while in boys attending primary schools in Cambridge prevalence was only 30% and the prevalence of circumcision in boys born in Newcastle-upon Tyne was only 12%.<sup>9</sup>

In 1949, a highly influential article by Douglas Gairdner concluded that there was no medical justification for routine neonatal circumcision and highlighted a number of deaths of children which had occurred as a result of the procedure. <sup>10</sup> In 1950, the National Health Service removed routine infant

<sup>&</sup>lt;sup>4</sup> World Health Organization and Joint United Nations Programme on HIV/AIDS, 'Male circumcision: Global trends and determinants of prevalence, safety and acceptability', 2007. <a href="http://www.malecircumcision.org/media/documents/MC\_Global\_Trends\_Determinants.pdf">http://www.malecircumcision.org/media/documents/MC\_Global\_Trends\_Determinants.pdf</a>
<sup>5</sup> For example, <a href="http://www.uptodate.com/patients/content/topic.do?topicKey=~33PE4iTilXjAf;">http://www.uptodate.com/patients/content/topic.do?topicKey=~33PE4iTilXjAf;</a>
<a href="http://familydoctor.org/online/famdocen/home/men/reproductive/042.html">http://familydoctor.org/online/famdocen/home/men/reproductive/042.html</a>;
<a href="http://www.urologychannel.com/circumcision/benefits.shtml">http://www.urologychannel.com/circumcision/benefits.shtml</a>; <a href="http://www.webmd.com/sexual-conditions/quide/circumcision">http://www.webmd.com/sexual-conditions/quide/circumcision</a>.

S.A. Rizvi et al. Religious circumcision: a Muslim view. BJU Int, 1999, 83(Suppl. 1):13–16.
 E. Ozdemir, Significantly increased complication risks with mass circumcisions. Br J Urol, 1997, 80(1):136–139; M. Mossman, 'Sultan of Circumcision still reigns in Turkey', The Globe and Mail (Toronto), Monday, June 1, 2009, p. A11.

<sup>&</sup>lt;sup>8</sup> WHO, 'Male circumcision', p.11.

<sup>&</sup>lt;sup>9</sup> D. Gairdner, 'The fate of the Foreskin', BMJ, 1949, Vol 2, Number 4642: pp. 1433-1437. http://www.nocirc.org/articles/gairdner.php

<sup>&</sup>lt;sup>10</sup> D. Gairdner, 'The fate of the Foreskin'.

circumcision from its list of covered services. Since then, the prevalence of circumcision in Britain has declined sharply.<sup>11</sup>

# **Risks and complications**

Definitions of what constitutes a complication vary widely as do estimates of the likelihood of complications. The most extreme complications reported are amputation of the penis and death from bleeding or from general anaesthetic. The death rate from circumcisions in the United States is estimated to be 1 in 500,000 cases while the rate of complications was estimated in one study to be 1 in every 476 circumcisions. <sup>12</sup> On the other hand, in developing countries, the rate of complications may be higher. <sup>13</sup>

In the UK, the Bradford circumcision service has reported complications with the ring (3.6%) and bleeding (3%).<sup>14</sup> In the Bristol service, the complication rate is 9.4%.<sup>15</sup> In the Tower Hamlets service a survey of 20 users found that 5 reported complications.<sup>16</sup> One of the surgeons interviewed reported that that in his private practice the complication rate is below 1%.

### Medical debate on the benefits of routine circumcision

The current view of the national paediatric associations in the industrialised world is that there are no medical benefits that justify routine circumcision. The While circumcision is thought to reduce the incidence of urinary tract infections (UTI) and reduce the incidence of penile cancer, because these conditions are rare it is difficult to justify routine circumcision on this basis. Some studies, including three large randomised trials conducted in Kenya, South Africa and Uganda have found that circumcision offers some protection against STIs, particularly HIV and HPV. According to the World Health Organisation (WHO) there is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Furthermore, WHO is leading UN Agencies (UNAIDS,

<sup>&</sup>lt;sup>11</sup> http://www.cirp.org/library/history/

<sup>&</sup>lt;sup>12</sup> American Academy of Family Physicians, 'Circumcision: Position Paper on Natal Circumcision', 2007.

http://www.aafp.org/online/en/home/clinical/clinicalrecs/circumcision.html; D.A. Christakis,et al, 'A trade-off analysis of routine newborn circumcision', *Pediatrics*, 2000, 105, pp. 246-249. 

Magoha GA, 'Circumcision in various Nigerian and Kenyan hospitals', *East African Medical Journal*, October 1999, Volume 76, Number 10: pp. 583-586. 

http://www.cirp.org/library/general/magoha1/

Palit et al, 2007, A unique service in UK delivering Plastibell circumcision: review of 9 year results, Pediatric Surgery International, Volume 23, Number 1 / January, 2007, pp. 45-48. http://www.springerlink.com/content/4131833x33366075/

<sup>&</sup>lt;sup>15</sup> Information provided by the Practice Manager, Eastville Health Centre

http://www.wyps-nhs.com/help.php?a=3&b=16; S. Abbott & S. Shahriar 2007, 'An NHS religious and cultural male circumcision service: service users' views', Community

<sup>&</sup>lt;sup>17</sup> Canadian Paediatric Society (CPS), 'Neonatal circumcision revisited', Fetus and Newborn Committee, Approved by the CPS Board of Directors in 1996; American Academy of Pediatrics, Task Force on Circumcision, Circumcision Policy Statement, *Pediatrics*, March 1, 1999, Volume 103, Number 3, pp. 686-693.

<sup>&</sup>lt;sup>18</sup> CPS, Neonatal circumcision revisited.

<sup>&</sup>lt;sup>19</sup> Tobian et al, Male Circumcision for the Prevention of HSV-2 and HPV Infections and Syphilis, *The New England Journal of Medicine*, March 26 2009, Volume 360, pp. 1298-1309, Number 13

<sup>&</sup>lt;sup>20</sup> http://www.who.int/hiv/topics/malecircumcision/en/

UNICEF and UNFPA) to set norms and standards, develop policy and programme guidance for safe male circumcision services and support countries with heterosexual epidemics to develop male circumcision policies and strategies within the context of a comprehensive HIV prevention strategy. (See Appendix 1)

# Cost benefit analysis of circumcision for non-clinical reasons

There is considerable debate about both the benefits and the risks associated with circumcision for non-clinical reasons. The health benefits associated with circumcision are largely dependent on the environment a boy will find himself in as an adult and on the sexual behaviour he will display. Similarly the risks are largely dependent on the age in which he will be circumcised and the conditions in which the procedure will take place. Ultimately, any cost-benefit analysis largely depends on what the risk of complications and the risks of contracting these STIs are assumed to be, and because these vary considerably it is a difficult calculation to make.

# **Current demand for circumcision**

Approximately 30% of the world's male population aged 15 and over are circumcised.<sup>21</sup> It is estimated that 30,000 circumcisions take place every year in the UK.<sup>22</sup> However, we are not aware of how many circumcisions are performed for non-clinical reasons in KCW.

In Kensington & Chelsea it has been estimated that approximately 45 Jewish children and 320 Muslim children are born annually. This suggests that the local demand would be approximately 182 circumcisions per year. While it is likely that most Jewish families would prefer to use Jewish circumcision services, which have an excellent reputation, it is also the case that some non-Muslim African and North-American families would be interested in using an NHS supported or regulated service so demand may be higher.

<sup>22</sup> P Messent, An investigation of male circumcision in Barking, Dagenham and Havering, Public Health Research Report No 107, January 1999, http://www.bhha.org.uk/circ107.pdf

<sup>&</sup>lt;sup>21</sup> WHO, Male circumcision, pp.7-8.

# Models for offering a circumcision service in England

# Birmingham

A free NHS service is provided for babies up to 3 months of age who are registered with GPs under the Heart of Birmingham Teaching PCT. Circumcision is carried out using Plastibell and local anaesthetic in a GP surgery. The cost to the PCT is £85. A private service using the same methods is offered to children up to 1 year old by the same providers and costs £85 for children aged 3-6 months old and £90 for children aged 6-12 months old.<sup>23</sup>

### **Bolton**

The Bolton Council of Mosques (BCoM) in partnership with the Bolton Primary Care Trust (PCT) has run a circumcision clinic for over 10 years which operates on a fortnightly basis at the Pikes Lane Health Centre. The cost to the parents is £55.24

### **Bradford**

A nurse-delivered circumcision service led by consultant urologists was set up in 1996 when Imams in Bradford approached the Equality & Diversity Director at the hospital. The service is for infants between 6 and 14 weeks old and is performed under local anaesthesia using the Plastibell technique. The service is private and costs the parents £100, which covers costs. The fee is paid to the hospital and there is no involvement by the local PCT. Between July 1996 and June 2005, 1,129 circumcisions were performed. The common complications were problems with the ring (3.6%) and bleeding (3%). Overall, there was 96% satisfaction rate among the service users.<sup>25</sup>

### **Bristol**

Bristol Primary Care Trust Public Health Department, is working with other organisations and members of the community, to establish a non-NHS funded, quality assured, not for profit safe circumcision service as a two year pilot. The service is for baby boys aged 1 – 6 months and is provided at Eastville Health Centre. The circumcision is performed under local anaesthetic. The cost to the parent is £180 and includes full clinical support and aftercare. In researching some existing circumcision services, it became evident that there were 'hidden' costs being absorbed by the NHS. The cost of £180 was arrived at following a comprehensive cost analysis and includes all staffing, equipment, administration, advertising, stationery, postage, audit and overheads.

The PCT funded the original set up costs, including training of relevant staff and provided contingency funding to support the service before it was able to run at full capacity. While the service is running at just below full capacity at the moment (7 procedures per session) it has been difficult to achieve this because many patients regard the service as too expensive and believe there

<sup>&</sup>lt;sup>23</sup> http://www.charlesroadsurgery.co.uk/info.aspx?p=4&pr=M85679

http://www.thebcom.org/ourwork/health-forum/219-bcom-bolton-pct-circumcisionservice.html
<sup>25</sup> Palit et al, 2007.

should be a free service. As a result, considerable efforts have been put into raising awareness about male circumcision and the possible risks and in explaining the benefits of the new service. Nevertheless, the patients are very pleased with every other aspect of the service and the complication rate is very low (16/170, all minor).<sup>26</sup>

A service for boys older than six months is provided by a consultant paediatric urologist at Bristol Children's Hospital. The circumcision is performed under general anaesthetic. The cost to the patient is £700 and includes full clinical support and aftercare. Children are referred to this service through their GP and the waiting list is up to 3 months. Circumcisions of up to 6 children take place in a single session on Saturday mornings.<sup>27</sup>

### London/Tower Hamlets

Tower Hamlets PCT's Religious & Cultural Male Circumcision Service is a service for baby boys aged between 6 weeks to 5 months, registered with a GP in Tower Hamlets. The cost to the patient is £100. To access the service a GP/Health Visitor/Midwife must complete a 'parent referral request letter' on the parents' behalf. Waiting time is up to 6 weeks. All parents are contacted on the third day after their son's operation by telephone and every baby is asked back the week after the operation for a half an hour check-up appointment with the nurse or doctor. A survey of 20 users found that 5 users reported complications, 3 of which were easily resolved with further advice and two of which had to be taken to A&E. Generally the users chose the NHS service because they expected it to be safe and of high quality.<sup>28</sup>

# London/St George's

A service for children aged over 1 year of age. The procedure is carried out under general anaesthetic and costs £500. Patients are referred by their GPs.

# London/ Wandsworth

A free NHS service for boys living in Wandsworth who are under 8 weeks old. Self referral. The service takes place at the Furzedown Primary Care Centre.

### Oldham

Oldham PCT has commissioned a service for boys aged up to 6 months old living in Oldham. Self–Referral. The procedure is carried out by two GPs in Glodwick Primary Care Centre who were trained by the consultant urologists leading the Bradford service. The cost is covered by the parents who pay £50 per procedure and by the PCT which pays £95 per procedure.<sup>29</sup>

<sup>&</sup>lt;sup>26</sup> Information provided by the Practice Manager, Eastville Health Centre

<sup>&</sup>lt;sup>27</sup> Bristol PCT, 'Male Circumcision, A guide to choosing safe services'. http://www.bristolpct.nhs.uk/theTrust/equality/Religion/Pt%20Info%20Leaflet%20011007.pdf; <sup>28</sup> S. Abbott & S. Shahriar, 2007.

<sup>&</sup>lt;sup>29</sup> Professional Executive Committee, Oldham Primary Care Trust, 'Minutes of the Professional Executive Committee', meeting held on Thursday, 12<sup>th</sup> May 2005 at 12:30 pm; N. King 'Annual Report On The Gender Equality Scheme', April 2008, Oldham Primary care Trust; Oldham Primary Care Trust, Service level agreement for the provision of a routine/ritual circumcision service in Oldham, Financial Year 2007-2008, http://www.oldham.nhs.uk/publica /pctannl/annrep0506.pdf

# Sandwell

A free service has been established for providing male circumcisions solely for religious reasons to infants aged under 2 years old registered with a Walsall GP. The procedure takes place under local anaesthetic. Referral by GP.<sup>30</sup>

### Sheffield

A free service in Sheffield Children's Hospital for boys aged over 6 months. Referral from GP. The procedure takes place under general anaesthetic in hospital.31

A More4 news item has claimed that PCTs in Leeds, Birmingham South and Hackney also offer circumcision services but it has not been possible to find out any more information on those services.<sup>32</sup>

http://www.muslimnews.co.uk/home.html
 http://www.sheffieldchildrens.nhs.uk/patients/resources/002\_circumcision\_pm.pdf
 http://www.londoncircumcision.org.uk/circumcision-on-the-NHS.htm

# Current quidance on circumcisions for non-clinical reasons

Currently, there are no particular regulations or clinical governance that apply to practitioners performing circumcisions for non-clinical reasons. An inquiry to the Health Care Commission led to the following response:

Currently the regulation of male circumcision for therapeutic reasons falls within the definition of a "listed service" under section 2(7)(a) of the Care Standards Act 2000, because it is classed as medical treatment under anaesthesia or sedation. However this definition may not include circumcision for religious or cultural reasons as by definition this type of circumcision is undertaken with no intended medical benefit.

Following extensive internal and external legal review of the situation, a policy decision was made by the Executive Team of the Healthcare Commission. This took into account the Department of Health view that the legislation was not intended to capture religious circumcision.

The Executive Team have decided that as religious circumcision has not been regulated to date, and that as the existing legislation is due to be replaced in the near future, the Commission will continue to regulate male circumcision undertaken for therapeutic reasons. However we will not regulate male circumcision undertaken for religious or cultural reasons.

In cases where the procedure is undertaken by a medical practitioner and where there are concerns about the safety or quality of the procedure, a referral must be made to the General Medical Council.<sup>33</sup>

Currently, therefore, the only recourse available to patients if anything goes wrong with a circumcision is to appeal to the General Medical Council if the practitioner is a doctor or to try and bring about criminal proceedings if the practitioner is not medically qualified. Such methods are only likely to succeed in extreme cases and there are no known cases of such prosecutions with regard to circumcision in the UK.

Nevertheless, the British Medical Association (BMA) and the British Association of Paediatric Urologists (BAPU) have produced best practice recommendations about how circumcisions for non-clinical benefit should be performed. (see Appendix 2 for this guidance).

<sup>&</sup>lt;sup>33</sup> Email response to the BME Health Forum dated 27 February 2009.

# **Discussion** (See Appendix 3 for the Results)

# **Parents**

# Age:

It is well known that different ethnic groups circumcise their children at different ages. According to this study the group that seemed most reluctant to circumcise their children as young babies was the Egyptian community (11/11 were circumcised above 6 months old). In contrast, the Somali community seem to want to have the circumcision done as early as possible with several parents wishing that their sons had been circumcised at a younger age (5/17) even though the majority were circumcised before the age of 5 months (11/17). Three of the parents who said they wished they had done the procedure earlier had had their sons circumcised when they were 5 months old or younger. While a number of Bangladeshi boys were circumcised at quite a late age, the fact that in 4/6 cases the parents said that they wished they had had it done earlier suggests that the delay may be more a matter of fear and inability to find the right provider rather than a matter of principle.

# Why circumcise?

Our sample overwhelmingly identified themselves as Muslim (60/63) and the vast majority of the sample (52/63 including 1 Christian) identified religion as a reason for having their son/s circumcised. Nevertheless, only 23/63 parents identified religion as the sole reason for circumcising their son. Furthermore, 11 parents identified health, culture or a combination of the two as a reason for having their son circumcised and did not mention religion. Nevertheless, when specifically asked if religion was a factor in their decision making, 7/11 said it was, and identified themselves as Muslim. One said yes and identified themselves as Christian. One said that religion played some part as the interviewee's mother who was Rastafarian decided to get the boy circumcised. Another said that religion did not play a role because even though the boy's father is Muslim, she is Christian and had decided to do it for health reasons. Another said that religion was not important but that in Eritrea, circumcision is important and is done for hygienic reasons.

### Where did the circumcision take place?

In the 45 cases where location was given, 14 cases took place at home, 27 took place at a GP surgery, and 4 took place in a hospital. There does not seem to be any link between the location of the circumcision and the rate of complications.

# **Non-medical practitioners**

There were only 4 instances where a child was circumcised by a non-medical practitioner. In each case some complication occurred. In one of these cases the complication was relatively mild requiring only painkillers for an extensive period of time but in the other 3 cases, extensive treatment was required and in two cases the procedure had to be repeated. The evidence from this research is that circumcisions performed by unregulated non-medical practitioners are not safe.

### Cost

The average cost of a circumcision appears to be £100-150 (44/65). However, the cost of circumcising an older child is higher even when the procedure is still done under local anaesthetic. In our sample, 14/33 parents who circumcised a child over 5 months old paid over £150. In 14/15 cases where the cost was over £150 the child was over 5 months old. In 9/15 cases the child was over 2 years old.

### Anaesthetic

Local anaesthetic was used in at least 60/66 cases. The vast majority of parents were happy with the use of local anaesthetic (51/66) and only 2/66 said they were unhappy. In addition, 30 parents commented either that their son was not in pain during the procedure or that he did not cry. Twelve of these cases were parents of children older than 1 year old. Furthermore, 3 parents (all were parents of children younger than 5 months old) added they preferred local to general anaesthetic because they thought that general anaesthetic was too risky.

This suggests that in the local community local anaesthetic is seen as an appropriate method to circumcise children regardless of age. In the case of young babies especially, local anaesthetic is preferred to general anaesthetic, which is perceived as being too risky.

# **Choice of practitioner**

The majority of parents 38/59 felt that they had no choice in selecting a practitioner. The overwhelming majority said that given the choice they would prefer an NHS practitioner over a private one (53/62). From the 9 parents who gave their reasons about why they would prefer an NHS service, only 3 said they would prefer it because it would be free, the others saying they would prefer it because the NHS is safer and more caring. 6 parents expressed concern that having this procedure under the NHS would take too long and require too much bureaucracy.

Furthermore, for the majority of parents (35/60), the practitioner being a doctor/surgeon/NHS employee and/or the procedure taking place in a medical setting were the most significant factors when selecting a provider. The most significant of these, was the practitioner being a doctor (27/60). For the rest, the practitioner being experienced was the most important factor (15/60) followed by the practitioner's religion (7/60). Only 9/60 parents did not place any importance on the practitioner being medically qualified or the procedure taking place in a medical setting (5 of these said the most important factor was experience, 3 said the practitioner's religion, and 1 said high cost).

Cost was a factor in the top 3 priorities for 22/60 parents. For 27 parents, cost was not regarded as a factor at all.

Other factors which were given some significance were: the practitioner being experienced (39/60), the practitioner having been recommended by someone who had used the service (24/60), the procedure being done under local anaesthetic (17/60, 6 of whom were parents of children aged 1-9 years old), knowing that that the practitioner would provide good after-care if anything

went wrong (15/60) and the procedure taking place within a few weeks of referral (13/60).

The evidence suggests that an NHS circumcision service would be very popular even if it was not free, provided the waiting list for the procedure was not too lengthy and referral was not too complicated. In our sample, 41/63 parents said that they would be happy with the procedure being conducted by a nurse practitioner. One person who was not happy with the practitioner being a nurse added that the practitioner should be a male doctor and another said that boys would be shy of a female nurse. So to maximise the popularity of the service the practitioner would be a doctor, regarded as experienced, Muslim and male.

# **Complications**

This study aimed to interview as many parents of children who had suffered complications as possible. Therefore, the sample of 15/66 children who suffered some form of complication is not representative of circumcisions in the community. In five of these children, the procedure needed to be repeated. A further two reported problems with the ring, 2 reported bleeding, and 3 reported being given medication (probably antibiotics) by the doctor. The others were cases of swelling, suspected infection, pain and discomfort. All of the children who suffered complications were 3 months or older which supports the conclusion that circumcisions of older children are much more likely to cause complications than those of younger children (15/44 children aged 3 months or older suffered complications compared to 0/22 children aged 1 week –2 months).

# **Best practice**

The majority of parents who answered the question said that they were happy with the service they received (50/61) and felt that the environment where the circumcision had taken place was suitable (56/63). The majority were given adequate instructions on how to care for their son after the procedure (50/57) and were given additional pain relief (47/62). However, in the majority of cases, consent was sought from one parent only (33/58) while the medical risks of the procedure were not explained (39/60) and no discussion took place regarding whether there were genuine medical benefits to the procedure (49/55). Thirteen parents made the additional comment that they already know that the procedure is beneficial while 1 mentioned that circumcision protects against transmission of HIV. A couple of parents suggested that such a discussion was not needed, 1 commenting that such a discussion can be found in Islamic scripture.

This suggests that it may be challenging for practitioners to discuss with parents the fact that medical benefits to circumcision are a matter for debate or to inform them of the relevant risks. There is therefore a need for practitioners to be trained in order to be able to do so.

### **GPs**

Different GPs experience different levels of demand from patients with regard to information about circumcision. This probably relates to the area of the practice and the ethnicity and religion of the particular GP. It is also likely that many parents do not regard circumcision to be an NHS issue.

For some GPs, the current situation is problematic because they are unable to refer patients to the local hospitals as they did in the past. Although some GPs currently refer to local private practitioners, one mentioned that s/he was unable to refer older boys. It is possible that this is a more widespread problem and the other GPs are simply not aware of it.

While some GPs have no experience of complications as a result of circumcisions, others have suggested that the complication rate could be as high as 5-10%. The severity of such complications is hard to determine.

GPs' views differ widely on whether the NHS should have a role in regulating circumcision services or provide a free service.

Two GPs said that there should be no change in current provisions, because any funds required would not be well spent since circumcision is not a medical priority, and because circumcision is not a procedure which should be performed without the consent of the person undergoing it and therefore should be delayed until the child was old enough to make the decision himself.

Three GPs said that while the NHS should not provide circumcisions for free, it should take a role in regulating private practice (e.g. a maximum infection standard) in order to minimise complications and suffering. One GP also suggested that community work could be undertaken with the Bengali community to encourage circumcisions to take place at a younger age.

Four GPs said that the NHS should provide a circumcision service. The reasons provided were that there is a need in the community and that it was important to ensure high standards and best practice. One GP thought that the NHS should circumcise routinely in a pilot project in order to reduce the incidence of HIV and cervical cancer.

### **NHS** surgeons

Both surgeons interviewed believe that circumcisions are best carried out in babies under 2-3 months old under local anaesthetic and that older children should be circumcised under general anaesthetic only. They also felt that circumcisions should not be taking place at home. They both thought that the NHS should provide two services, one for babies and one for older children, although one surgeon thought that the practicalities of having a service for babies may be very difficult. They thought that there were enough qualified surgeons who could carry out circumcisions to meet the local demand but that trained nurses could carry out the procedure provided he or she would have the back up from a surgeon or doctor for the cases where there was excessive bleeding or any other complication.

Both surgeons felt that there were significant problems with circumcisions performed in the community both on medical and ethical grounds. Medically, since the funding for circumcisions for non-clinical reasons has ceased at Chelsea and Westminster Hospital, the number of repeat procedures for circumcisions performed in the community has nearly doubled (however the numbers involved are very small, the increase being from 6 per year to 11 per year). The surgeon who still circumcises boys privately said that on average 1 circumcision per month in his practice was a repeat procedure for a circumcision done in the community. He felt certain that complication rates in the community were considerably higher than those performed at his practice where the complication rate is less than 1%. On medical and ethical grounds, both surgeons felt that performing circumcisions on older children under local rather than general anaesthetic caused them unnecessary fear and suffering. They were also concerned that the administration of local anaesthetic by injection was a difficult procedure to do effectively while the child is awake and needs to be physically restrained.

In terms of best practice, neither the old service at Chelsea & Westminster nor the private service at Cromwell Hospital conforms fully to the BMA guidance on best practice. In Chelsea & Westminster, a full discussion about the risks and the debate about the medical benefits took place only with parents who wanted their sons circumcised for social reasons rather than religious reasons with the aim of dissuading them. Parents who had their sons circumcised for religious reasons were told about the risks but the doctor's aim in this case was to avoid frightening them since he was sure they would go through it regardless. Consent from both parents was not insisted on.

In the private practice at the Cromwel, the risks are always discussed with the parents but the fact that equally good levels of hygiene can be maintained without circumcision is only mentioned if the parents bring up the issue. Consent from both parents is preferred but not insisted upon. If only one parent is present (usually the mother) the doctor asks if the father consents to the procedure.

# **Private practitioners**

All three GPs said that it was better to circumcise children while they were young babies, under local anaesthetic (10 days-3 months). All doctors had specialised surgical training and said they had very low complication rates. They all thought the NHS should provide a service for babies which would reduce morbidity and stop children missing school unnecessarily. One doctor thought that providing a mop up service for older children was also important since many parents missed their chance to have the procedure done when their son was very young.

One practitioner said that he uses no anaesthetic when he circumcises boys younger than 6 weeks. This practitioner is therefore failing the BMA guidance on providing analgesia. From the parents we interviewed, two parents reported that their child was circumcised by this doctor without an anaesthetic (one at 3 months of age, the other at 6 weeks) and while one made no comment about this, the other parent said that they were not happy that no anaesthetic had been used. On the other hand, 2 parents of children who

were circumcised by this doctor at an age younger than 6 weeks said they were happy that local anaesthetic had been used which suggests that this doctor does occasionally use anaesthetic with young babies.

Furthermore, only two doctors said that they explained the risks involved in the procedure and tried to obtain consent from both parents whenever possible. None discussed the issue of whether the procedure was medically beneficial unless specifically asked by the parents. These practitioners are therefore failing the BMA guidance on informed consent.

### Rabbi

In the Liberal Judaism tradition, practitioners of circumcision have to be members of an organisation called The Association of Reform and Liberal Mohelim (ARLM). This association provides medical and religious training to doctors who want to practise circumcisions. All members of the association are doctors and use local anaesthetic in their procedures. Practitioners of ARLM are happy to circumcise non-Jewish children and have a tradition of doing so. The practitioners of the orthodox Jewish community are organised in a different association entitled The Initiation Society.

# **Conclusions**

In KCW, there are a significant number of circumcisions taking place in unregulated settings. While it is not possible for this study to estimate the local rate of complications, it obviously far exceeds the rates documented in the United States (in this study one researcher was able to locate 15 parents whose sons suffered complications within a few weeks of research). Best practice guidance with regard to analgesia and informed consent are not followed. In addition, the experiences of the older children who are circumcised under local anaesthetic are undoubtedly unpleasant if not traumatic.

At the same time, the findings of this study suggest that a service provided under NHS auspices would be popular and would also be able to ensure best practice.

NHS commissioned circumcision services need not be free. Parents expect to pay £100-150 for the circumcision of a baby and more for the circumcision of a child. Therefore, such services can be commissioned at a small cost to the tax payer. Careful consideration needs to be given to the appropriate level of charges to optimise take up and impact on the level of complications, given that the Muslim community in KCW which would be the main beneficiary of such a service is financially disadvantaged in comparison to the general population.

# **Recommendations:**

Monitoring and regulating

# **Option A**

The Care Quality Commission (formally Health Care Commission) should regulate circumcision services. Given that male circumcisions for non-clinical reasons is legal and widely practiced, the state has a duty to ensure that they are performed competently and safely regardless of the fact that they are not regarded to be medically beneficial. The Equality Bill which is due to come into force in 2010 may make such a step a legal necessity. Regulation by the Care Quality Commission would make it possible to enforce the BMA recommendations with regard to analgesia, anaesthesia, consent and informed choice and ensure proper clinical governance of training, methods used and complication rates across the community.

# **Option B**

Given the evidence that lack of regulation contributes to levels of complication, the local NHS has a responsibility as part of its Public health role to monitor & regulate the local arrangements. One possible method for regulation would be the creation of a professional organisation along the lines of the Jewish organisations "The Association of Reform and Liberal Mohelim" and "The Initiation Society". The aim of such an organisation would be to ensure its members are qualified to perform circumcisions, keep statistics with regard to complications and abide by the BMA regulations on consent and best practice. Such an organisation could become self-funding from funds it would obtain for membership and for training. However, the creation of such an organisation would initially require support.

# NHS commissioning of circumcision services

One of the most effective ways to reduce complications and the suffering of children would be to introduce circumcision services commissioned by the NHS. In our research we have found that parents would much prefer to have the children circumcised by the NHS provided the waiting list is not very long (this is important because once a child is over a certain age the risk of complications increases). Furthermore, we found that the cost of the procedure was not an issue of overwhelming importance for most parents when choosing a provider, and that their preference of an NHS service has more to do with expectations that such a service would be caring and of high quality rather than it would be free. Such services could be largely funded by the parents and external organisations and therefore incur only a small cost to the taxpayer.

Two services are required: one for children under general anaesthetic (the minimum age of the child depends on a risk assessment over the safety of general anaesthetic, possibly 1 year old) and one for babies up to 10 weeks old. Both services should follow BMA's guidance for best practice guidance with regard to analgesia, consent from both parents, the explanation of medical risks and benefits and the keeping of medical records for monitoring the service.

1. A service is urgently required for children as they are far more vulnerable than babies to complications. Our study, which included 66 children, 15 of which had suffered complications (not a representative sample) showed that all cases involving complications occurred in children aged over 3 months old. (15/44 children aged 3 months-11 years old suffered complications compared to 0/22 children aged 1 week-2 months). Furthermore, it is in the circumcision of older children where the practice in the community is most divergent from that recommended by clinicians. We found that 29/31 children aged 7 months-11 years were circumcised under local anaesthetic, a practice which 4 out of 5 clinicians we interviewed regarded as unacceptable (the fifth thought it was ok to use local anaesthetic up to the age of 1).

If the NHS offer a service for children using general anaesthetic the cost of the procedure will be considerable (£500-£700) and it is unrealistic to expect parents to pay such a high fee when the cost of the procedure in the community under local anaesthetic is around £200. It is recommended that the parents are charged up to a maximum of £300. While there is not sufficient evidence that such a service would be financially beneficial to the NHS there is no doubt that it would reduce the suffering of children. Ideally, this would be a service, which in time would become less and less used as parents learnt that it was better to have their sons circumcised when they are babies.

Similar services are offered by Bristol Children's Hospital where the cost to the parents is £700, by St George's Hospital in London where the cost to the parents is £500 and by Sheffield Children's Hospital where the procedure is free.

2. An outpatient service for newborn babies aged up to 10 weeks or an inpatient service for newborns on their first or second day after birth. The circumcisions would take place under local anaesthetic. Full or nearly full costs could be charged to the parents (£100-150) and therefore no cost to the tax payer need to be incurred. Ideally, for those on benefits a cheaper service could be offered, funded by external organisations.

While the evidence is that circumcisions at this age group are performed competently within the community, such a service would be able to implement the BMA's recommendations which are not currently fully implemented in any service. Furthermore, if such a service was well publicised, it would attract the vast majority of parents who are currently using private practitioners and would help encourage those who currently have their sons circumcised at a later age to have the procedure done early. (In our study, 12/44 parents of children circumcised at 3 months or older said they wished they had had their children circumcised at a younger age. The two reasons given for having postponed circumcision were inability to find a suitable provider and fear of the procedure). Such a practice would reduce complications

significantly, including 'repeat' circumcisions that are performed by surgeons within the NHS and therefore could reduce costs to the NHS as well as suffering in the community.

Similar services are offered by The Heart of Birmingham Teaching PCT; Furzedown Primary Care Centre, Wandsworth; Manor Hospital, Sandwell (free to the parents) Bradford PCT (costs only); Oldham PCT (£50); Tower Hamlets's PCT (£100) and Eastville Health Centre, Bristol (£180).

### Information

Information about circumcision services needs to be publicised in a number of languages and locations particularly maternity hospitals and local community groups. Any such leaflet should contain the information required for informed consent as set out by the BMA:

- What the procedure involves
- Risks and Complications
- An explanation of what the medical benefits of circumcision may be and the debate surrounding this matter

Furthermore, it should also contain information that will help the parent make an informed decision about where and when they should have their son circumcised:

- An explanation that circumcision appears to be far less likely to cause complications if performed while the boy is very young and if the practitioner performing the procedure is medically qualified. For example, our study showed that all cases of complications (n=15) occurred in children aged 3 months old or older. In the 4 cases of children who were circumcised by a non-medical practitioner, all suffered from some complication
- A list of medical practitioners who practise circumcision safely. A similar list has been produced by Bristol PCT<sup>34</sup>

Finally it should also contain information likely to be of use to parents who have already had their sons circumcised:

- Advice on after-care
- What to do in an emergency

<sup>34</sup> Bristol PCT, Male Circumcision, A guide to choosing safe services, , <a href="http://www.bristolpct.nhs.uk/theTrust/equality/Religion/Pt%20Info%20Leaflet%20011007.pdf">http://www.bristolpct.nhs.uk/theTrust/equality/Religion/Pt%20Info%20Leaflet%20011007.pdf</a>;

Circumcision: In Whose Care?

28

# **Glossary**

### **BME**

Black and Minority Ethnic

### Contraindication

A symptom or condition which indicated against the advisability of a particular remedy or treatment.

# **Equality impact assessment**

An equality impact assessment is a tool for identifying the potential impact of an organisation's policies, services and functions on the population it serves and its staff. It can help an organisation provide and deliver excellent services to residents by making sure that these reflect the needs of the community. By carrying out an equality impact assessment a council may also ensure that the services that it provides fulfil the requirements of anti-discrimination and equalities legislation.

### HIV

Human Immunodifficiency Virus

# **HPV**

Human Papillomavirus - can cause cervical cancer

### **KCW**

The boroughs of Kensington & Chelsea and Westminster

### **Neonate**

An infant aged 28 days or less.

# **Non-Therapeutic Circumcision**

Circumcision for non-clinical reasons

# Plastibell

A circumcision device consisting of a clear plastic ring with a deep groove running circumferentially which is placed on the head of the penis. In 3 to 7 days the device falls off and the boy is circumcised.

# **Ritual Circumcision**

Circumcision for non-clinical reasons

### STI

Sexually Transmitted Infection

### UN

**United Nations** 

### **WHO**

World Health Organisation

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Circumcision: In Whose Care?

30

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http://familydoctor.org/online/famdocen/home/men/reproductive/042.html http://www.caringforkids.cps.ca/pregnancy&babies/Circumcision.htm http://www.charlesroadsurgery.co.uk/info.aspx?p=4&pr=M85679 http://www.cirp.org/library/history/http://www.courtchallenge.com/refs/history0.html

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http://www.muslimnews.co.uk/home.html

http://www.sheffieldchildrens.nhs.uk/patients/resources/002\_circumcision\_pm.pdf

http://www.thebcom.org/ourwork/health-forum/219-bcom-bolton-pct-

circumcision-service.html

http://www.uptodate.com/patients/content/topic.do?topicKey=~33PE4iTilXjAf

http://www.urologychannel.com/circumcision/benefits.shtml

http://www.webmd.com/sexual-conditions/guide/circumcision

http://www.who.int/hiv/topics/malecircumcision/en/

http://www.wyps-nhs.com/help.php?a=3&b=16

### Appendix 1

The current view of the national paediatric associations in the industrialised world is that there are no medical benefits that justify routine circumcision. For example, the Canadian Paediatric Society' policy since 1975 (last revised in 1996) has been that circumcision of newborns should not be routinely performed.<sup>35</sup> Between 1984 and 2004 all provinces in Canada stopped insuring circumcision and it is now a practice that is paid by the patients unless performed immediately after birth before mother and baby leave the hospital.<sup>36</sup>

In the United States, the American Academy of Pediatrics issued the following statement:

Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision. In the case of circumcision, in which there are potential benefits and risks, yet the procedure is not essential to the child's current well-being, parents should determine what is in the best interest of the child. To make an informed choice, parents of all male infants should be given accurate unbiased information and be provided the opportunity to discuss this decision. It is legitimate for parents to take into account cultural, religious, and ethnic traditions, in addition to the medical factors, when making this decision. Analgesia is safe and effective in reducing the procedural pain associated with circumcision; therefore if a decision *for* circumcision is made, procedural analgesia should be provided.<sup>37</sup>

Most American private insurance policies cover neonatal circumcisions although state sponsored Medicaid in some states do not.

While circumcision is thought to reduce the incidence of urinary tract infections (UTI) because such infections in boys are rare this is not regarded as justifying the possibility of complications arising from the procedure. Similarly, while there is some evidence that circumcision may reduce the incidence of penile cancer, this is a disease so rare that routine circumcision cannot be recommended on this basis.<sup>38</sup>

With regard to sexually transmitted infections including the Human Papilloma Virus (HPV) which causes cervical cancer in women the evidence is complex. Some studies (but not all) including three large randomised trials conducted in Kenya, South Africa and Uganda have found that circumcision offers some protection against the transmission of HIV, HPV, herpes, chlamydia, gonorrhoea and syphilis. Evidence with regard to HIV (protecting the male partner in heterosexual intercourse only), according to the World Health Organisation (WHO) there is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately  $60\%^{40}$ . Furthermore, WHO is leading UN Agencies (UNAIDS, UNICEF and UNFPA) to set norms and standards, develop policy and programme guidance for safe male circumcision services and support countries to develop male circumcision policies and strategies within the context of a comprehensive HIV prevention strategy.

<sup>&</sup>lt;sup>35</sup> Canadian Paediatric Society (CPS), 'Neonatal circumcision revisited', Fetus and Newborn Committee, Approved by the CPS Board of Directors in 1996. For a leaflet from the Society regarding the advantages and disadvantages of circumcision, see: <a href="http://www.caringforkids.cps.ca/pregnancy&babies/Circumcision.htm">http://www.caringforkids.cps.ca/pregnancy&babies/Circumcision.htm</a>

<sup>&</sup>lt;sup>36</sup> http://www.courtchallenge.com/refs/history0.html; Personal communication by employees of Midaynta Community Services, Toronto.

<sup>&</sup>lt;sup>37</sup> American Academy of Pediatrics, Task Force on Circumcision, Circumcision Policy Statement, *Pediatrics*, March 1, 1999, Volume 103, Number 3, pp. 686-693.

<sup>&</sup>lt;sup>38</sup> Neonatal circumcision revisited.

<sup>&</sup>lt;sup>39</sup> Tobian et al, Male Circumcision for the Prevention of HSV-2 and HPV Infections and Syphilis, *The New England Journal of Medicine*, March 26 2009, Volume 360, pp. 1298-1309, Number 13.

<sup>&</sup>lt;sup>40</sup> Male circumcision for HIV prevention, WHO http://www.who.int/hiv/topics/malecircumcision/en/

### Appendix 2

The following extracts are from the report entitled: The Law & Ethics of Male circumcision –guidance for doctors. Medical Ethics Committee, British Medical Association.<sup>41</sup>

Male circumcision is generally assumed to be lawful provided that: it is performed competently; it is believed to be in the child's best interests; and there is valid consent.

Consent for any procedure is valid only if the person or people giving consent understand the nature and implications of the procedure. To promote such an understanding of circumcision, parents and children should be provided with up-to-date written information about the risks.

All children who are capable of expressing a view should be involved in decisions about whether they should be circumcised, and their wishes taken into account.

The BMA and GMC have long recommended that consent should be sought from both parents. Although parents who have parental responsibility are usually allowed to take decisions for their children alone, non-therapeutic circumcision has been described by the courts as an "important and irreversible" decision that should not be taken against the wishes of a parent.

In all cases, doctors should ask parents to confirm their consent in writing by signing a consent form.

In the past, circumcision of boys has been considered to be either medically or socially beneficial or, at least, neutral. The general perception has been that no significant harm was caused to the child and therefore with appropriate consent it could be carried out. The medical benefits previously claimed, however, have not been convincingly proven, and it is now widely accepted, including by the BMA, that this surgical procedure has medical and psychological risks. It is essential that doctors perform male circumcision only where this is demonstrably in the best interests of the child. The responsibility to demonstrate that non-therapeutic circumcision is in a particular child's best interests falls to his parents.

It is important that doctors consider the child's social and cultural circumstances. Where a child is living in a culture in which circumcision is required for all males, the increased acceptance into a family or society that circumcision can confer is considered to be a strong social or cultural benefit. Exclusion may cause harm by, for example, complicating the individual's search for identity and sense of belonging. Clearly, assessment of such intangible risks and benefits is complex. On a more practical level, some people also argue that it is necessary to consider the effects of a decision not to circumcise. If there is a risk that a child will be circumcised in unhygienic or otherwise unsafe conditions, doctors may consider it better that they carry out the procedure, or refer to another practitioner, rather than allow the child to be put at risk.

The BMA is generally very supportive of allowing parents to make choices on behalf of their children, and believes that neither society nor doctors should interfere unjustifiably in the relationship between parents and their children. It is clear from the list of factors that are relevant to a child's best interests, however, that parental preference alone is not sufficient justification for performing a surgical procedure on a child.

There is significant disagreement about whether circumcision is overall a beneficial, neutral or harmful procedure. At present, the medical literature on the health, including sexual health, implications of circumcision is contradictory, and often

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<sup>&</sup>lt;sup>41</sup> British Medical Association, The law and ethics of male circumcision - guidance for doctors.

subject to claims of bias in research. Doctors performing circumcisions must ensure that those giving consent are aware of the issues, including the risks associated with any surgical procedure: pain, bleeding, surgical mishap and complications of anaesthesia. All appropriate steps must be taken to minimise these risks. It may be appropriate to screen patients for conditions that would substantially increase the risks of circumcision, for example haemophilia.

Doctors should ensure that any parents seeking circumcision for their son in the belief that it confers health benefits are fully informed of the lack of consensus amongst the profession over such benefits, and how great any potential benefits and harms are. The BMA considers that the evidence concerning health benefit from non-therapeutic circumcision is insufficient for this alone to be a justification for doing it.

The General Medical Council does not prohibit doctors from performing nontherapeutic circumcision, although it would take action if a doctor was performing such operations incompetently. The Council explicitly advises that doctors must "have the necessary skills and experience both to perform the operation and use appropriate measures, including anaesthesia, to minimise pain and discomfort".

The following extracts are from the report entitled 'Management of Foreskin Conditions' by the British Association of Paediatric Urologists on behalf of the British Association of Paediatric Surgeons and The Association of Paediatric Anaesthetists.<sup>42</sup>

### Anaesthesia

There is an increased risk from general anaesthesia in the neonatal period. According to the Royal College of Anaesthetists handbook, any general anaesthetic should be administered by an appropriately trained anaesthetist with ongoing relevant paediatric experience.

### Analgesia

It is essential that adequate analgesia be provided when undertaking male circumcision. Dorsal nerve block and ring block are equally effective. Adequate time needs to elapse after the block before surgery is started. Eutectic mixture of local anaesthetics (EMLA),contraindicated on open wounds and mucous membranes, should be allowed 1 hour to take effect. This can be tested by picking up the foreskin in forceps before commencing the procedure. Non pharmacological methods (non nutritive suckling, rocking, massaging, cuddling) or systemic analgesia with paracetamol are inadequate in isolation for analgesia.

### The operator

- **a)** The person performing the procedure should be experienced and competent to do so. Written consent should be obtained from both parents.
- **b)** The operator should be able to identify co morbidity and deal with it appropriately.
- **c)** The operator should have a full understanding of the risks and complications of the procedure and their management.
- **d)** The operator should be familiar with various modes of analgesia for the procedure.
- e) The operator should keep thorough records and regularly audit his/her practice.

### Standards of care

**a)** The operation should be undertaken in an environment capable of fulfilling guidelines for surgical procedures in children.

**b)** Adequate analgesia is essential. This involves systemic (oral) paracetamol and an adequate local anaesthetic. Sufficient time for the local infiltration to provide analgesia is crucial and this should be tested prior to conducting the circumcision.

<sup>&</sup>lt;sup>42</sup>British Association of Paediatric Urologists on behalf of the British Association of Paediatric Surgeons and The Association of Paediatric Anaesthetists 'Management of Foreskin Conditions' http://www.apagbi.org.uk/docs/circumcision2007.pdf

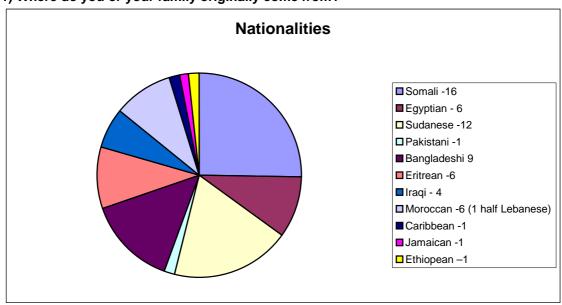
- c) There should be close links with the community, GP and hospital services for ongoing care and ease of referral if complications arise.
  d) Regular audit of practice at individual level, trust level and in the community is
- essential.

#### Appendix 3

#### **Results: Parents**

In total, 63 interviews were conducted, concerning 66 children.

#### 1) Where do you or your family originally come from?



#### 2) Age

This study specifically looked for cases of children who were circumcised as toddlers and children rather new-born babies. We used 33 cases of babies who were circumcised at the age of five months or younger and 33 cases of children who were older than 5 months (oldest was 11 years old).

These are the overall results according to age and nationality:

	0-5 months	6 months -3 yrs old	4-11 yrs old
Bangladeshi	4	1	5
Egyptian	0	5	1
Eritrean	3	2	1
Moroccan	4	2	0
Somali	11	4	2
Sudanese	6	6	1
Other	5	2	1

In the case of the young babies, 20/33 parents said that they were happy with the age the circumcision had taken place. Their ethnicities were Bangladeshi=4 Eritrean=1, Ethiopian=1 Sudanese =3, Iraqi=3, Jamaican =1, Moroccan=2, Somali =5. A further 3/33 cases (all Somali) said they would have preferred it if the circumcision had been carried out even younger. The rest did not comment.

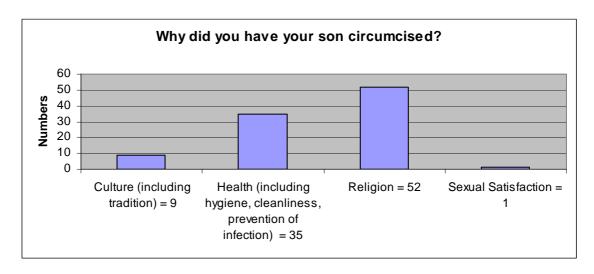
In the case of the children aged 6 month-11 years old, 6 parents said that they were happy with the age the circumcision had taken place. Three of these children were Egyptian, 1 was Bangladeshi, 1 was Eritrean and 1 was Sudanese.

Another 9 cases said that they wished they had had the procedure done sooner. There were 4 from Bangladesh, 2 Somali, 1 Egyptian, 1 Caribbean and 1 Moroccan. Seven of these parents gave an explanation as to why they had not carried out the procedure sooner.

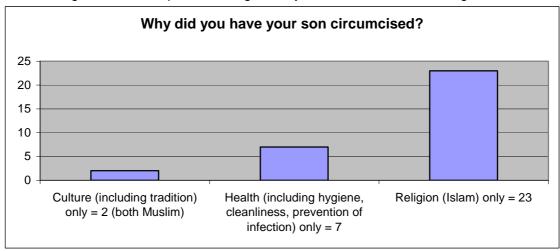
Fear of the procedure = 4 Lack of availability of provider =1 Not knowing the system=2

#### 3) Why did you decide to have your son circumcised?

This was an open question, and parents were able to give as many reasons as they wanted.



The following results are for parents who gave only one reason for circumcising their sons.



In the 11 cases of people who did not cite religion as a reason for getting their sons circumcised, when asked if religion was a factor, 7 said it was, and identified themselves as Muslim. One said yes, and identified themselves as Christian. One said that religion played some part as his mother who was Rastafarian decided to get the boy circumcised. Another said that religion did not play a role because even though the boy's father is Muslim because she is Christian and had decided to do it for health reasons. Another said that religion was not important but that in Eritrea, circumcision is important and is done for hygienic reasons.

#### 4) When and where did the circumcision take place?

The intention of this research was to study circumcisions which have taken place recently and it was with that criterion that cases were selected. The majority of circumcisions (47/66) used in this study were performed after 2006. A further 10/66 took place in 2004-2005, and another 6 took place in 2000-2003. We have no data in a further 3 cases. We also have no exact data about when the procedures done to correct a circumcision which went wrong took place.

The data on where the circumcision took place and who performed it is very incomplete. In the 45 cases where location was given, 14 cases took place at home, 27 took place at a GP surgery, and 4 took place in a hospital.

There were 4 instances where the person who performed the operation was a non-medical practitioner.

Egyptian family, procedure performed at home, painful for the child, £80, 1 yr old child, ring method, no anaesthetic, complications, had to be repeated in Egypt, still cannot pass urine properly, referred to St Mary's.

Sudanese family, procedure performed at home, £80, 2 yr old child, local anaesthetic, ring method, complication- deformed, had to be performed again by GP.

Bangladeshi family, procedure performed at home, £150, 4 yr old child, ring method, local anaesthetic, pain for 10 days, then gave Calpol and the child was ok.

Bangladeshi family, procedure performed at home by a mullah, £150, child was 18 months old, ring method, no anaesthetic, complications-bleeding, itching and pain, had to be taken to GP for further treatment, sorted out in 3 weeks.

In the 5 instances where a repeat procedure was required, 2 repeat procedures occurred in a hospital, 2 took place in Egypt (1 of which now has a referral to St Mary's for ongoing problems) and 1 took place in a GP's surgery.

In 57/66 cases the Plastibell method was used. Cutting was used in the remaining 9 cases.

#### 5) Cost

Information known about 65 cases (including 1 repeat)

Free=1 (Another 3 cases stated that the service was free but that they paid £100).

Below £100 =5

£100-150 =44

Over £150=15

No information=6 (including 4 repeats)

In 14/15 cases where the cost was over £150 the child was over 5 months old. In 9/15 cases the child was over 2 years old.

#### 6) Anaesthetic

In almost every case, local anaesthetic was used. General anaesthetic was used in 2 cases. There were 3 cases where it was reported that no anaesthetic was used, but in two of those cases, this is likely to be a communication error (the parent probably meant that no general anaesthetic was used) because the circumcisions were reported to have taken place in a GP's surgery.

The vast majority of parents (51/63) said they were happy with the anaesthetic used. Only 3 parents said they were unhappy and 9 parents gave no reply.

Parents who were happy provided these additional comments:

The child was not in pain and did not cry (n=30, 14 children younger than 5 months old, 12 children over 1 yr old).

The anaesthetic caused no side effects (n=2, all younger than 5 months).

Prefer local anaesthetic to general anaesthetic because general anaesthetic is too risky (n=3, all younger than 5 months). One parent said she refused to have the procedure done under general anaesthetic.

These are the 3 cases where the parent was unhappy with the choice of anaesthetic: Local anaesthetic was used by a non-medical professional. The procedure was painful and had to be repeated in Egypt. The child (1 yr old) has since been referred to St Mary's for problems with urination.

No anaesthetic was used. The child (6 weeks old) was circumcised in a GP surgery. There were no complications.

Local anaesthetic applied by a doctor. The procedure took place at home. The child (6 months old) cried the entire time. The child was referred to a hospital in K&C and the operation was repeated.

#### 7) Choice of practitioner

#### Did you feel you had choice in choosing a provider?

Yes = 21 No =38

No answer =4

### If you had the choice between an NHS provider and a private provider which would you choose?

NHS =53 Private =9 No answer =1

#### Additional Comments:

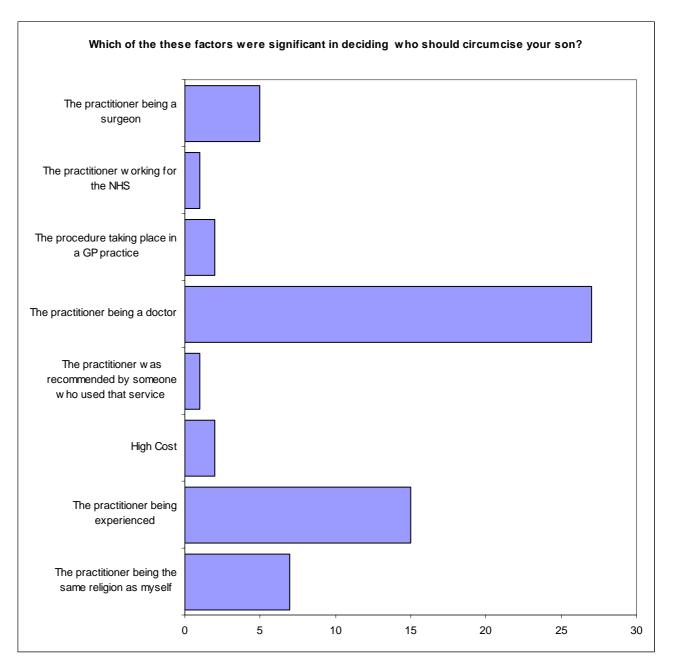
5 parents said that they would prefer NHS because they considered it to be safer and 1 said that the NHS was better because it was more caring. 3 parents said they would prefer using the NHS because then the procedure would be free. 6 parents expressed concern that the NHS would take too long or that private treatment would be faster and 1 said that a private provider would be better because treatment in NHS would involve too much paperwork.

#### How did you decide who should carry out the procedure?

Previous personal experience = 1
Recommendation =50
Because they were local = 4
Wanted a professional (not a traditional practitioner) =4
Chose the cheapest option = 2
No choice =4

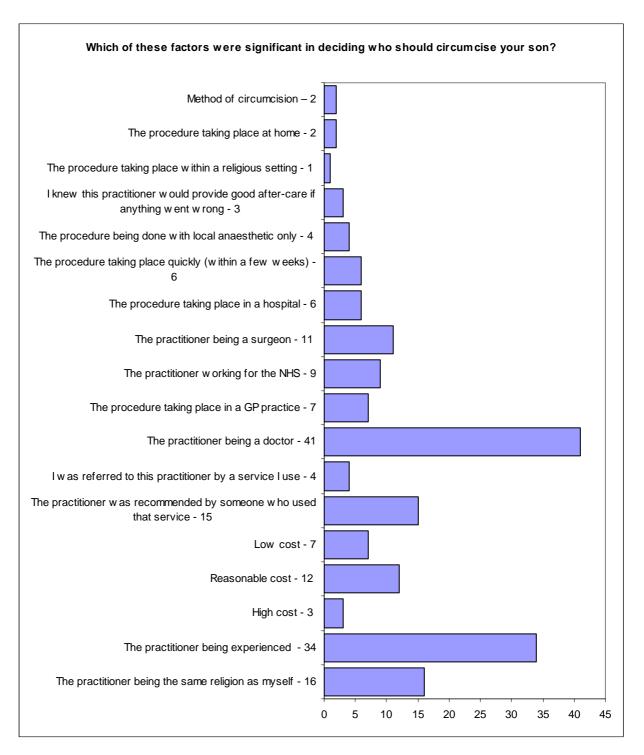
#### How did you find out about this particular provider?

Recommendation = 61(2 said the recommendation came from a midwife. Internet = 1

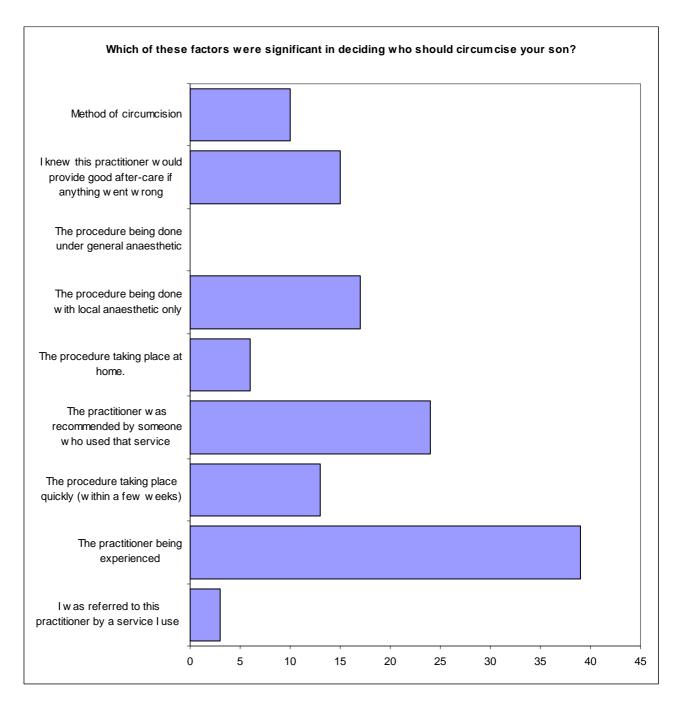


Which of the factors were the most significant in helping you make the decision about who should circumcise your son? Tick as many as apply and order in terms of importance.

The graph above shows the factors which were indicated by parents to be the *most important*.



The graph above shows which factors were amongst the top 3 most significant.



This graph shows some of the factors which were indicated to be significant (independently of how significant they were). For example, the practitioner being experienced (39/60), the practitioner having been recommended by someone who used the service (24/60), the procedure being done under local anaesthetic (17/60, 6 of whom were parents of children aged 1-9 years old), knowing that that the practitioner would provide good after-care if anything went wrong (15/60) and the procedure taking place within a few weeks of referral (13/60).

Only 9/63 did not express the need for some kind of medical requirement either in terms of the practitioner or the setting. Two of these gave importance to the use of local anaesthetic.

No parent regarded the use of general anaesthetic as an advantage. 27/63 did not regard cost as a factor.

The majority 36/63 did not give any importance to the practitioner being of the same religion or the procedure taking place in a religious setting.

#### 8) Were you happy with the service?

Happy = 50 (Including 2 who were happy but felt the procedure had been too costly.)

Not happy = 6

Ok = 5

No comment = 2

#### 9) Did you feel that the environment were the circumcision took place was suitable?

Yes = 58 (Additional comments: "Very clean" from 5 parents.)

No =5 (Additional comments: "Done at home without adequate equipment" from 1 parent, "No anaesthetic" from 1 parent)

#### 10) Were you given any pain-relief for your son? (Pain killers, herbal remedies etc)

Yes =47 (Additional info: Painkillers from 35 parents; Cream/ gel from 3 parents)

No = 15

Don't remember = 1

#### 11) Were you given information about how to care for your son after his circumcision?

Yes = 52 but 2 said the advice was inadequate.

No = 5

No Answer =6

## 12) Did anyone explain to you the medical risks involved in the practice of circumcision? If yes how were these explained? (a leaflet, a form, a chat with the practitioner). Can you remember what risks you were told about?

Yes = 21(Infection mentioned by 9 parents, Bleeding mentioned by 12 parents, Swelling mentioned by 3 parents, Difficulty in passing urine mentioned by 1 parent, Told to go to the hospital if the ring doesn't come off mentioned by 1 parent, General advice mentioned by 2 parents, Consent form mentioned by 1 parent.)

No = 39

No comment - 3

#### 13) Was written consent sought from both parents?

Both parents= 25

1 parent =33 (Just father = 6, Just mother = 1)

No answer = 5

# 14) Did anyone explain the medical debate around the health benefits of circumcision? If yes how were these explained? (a leaflet, a form, a chat with the practitioner). Can you remember what information you were given?

Yes = 6

 $N_0 = 49$ 

No answer = 8

(Additional Comments: Community discussion = 1, We know it's beneficial = 13, It's traditional = 2, Debate is in Islam scripture =1 Debate not needed = 2, Helps to protect children from diseases such as HIV = 1)

## 15) Did anyone see your son after he was circumcised to check he had healed properly? If yes, who?

Yes = 24 (GP/doctor – 12, By a family member – 3, in one case a trained nurse)

No = 38

No Answer = 1

#### 16) Were there any complications? If yes what were these?

Yes = 15 (Additional points specified: Looked deformed = 1, Change in penis size = 1, Itching = 2, Bad smell = 1, Bleeding = 2, Child could not urinate properly = 2, Infection and pain = 4, Took a bit longer for the ring to fall off = 1, Cut didn't heal, skin hanging down = 1, Bleeding = 2, Swelling = 1)

No = 50

No Answer = 1

All of these children who suffered complications were 3 months or older (15/44 children aged 3 months or older suffered complications compared to 0/22 children aged 1 week –2 months).

## 17) What treatment did they require? Who provided this treatment? Were there any long-term consequences?

Medication/Antibiotics = 3

Salt bath advised = 2

The procedure was repeated = 4 (2 of which done in Egypt the second time, 1 preferred Jewish doctor.)

Referred to hospital = 2

GP gave treatment = 3 (1 stated that it took 2-3 weeks to sort out)

18) Would you have been happy to have had your son circumcised by a specialist nurse with relevant training? If not, why not?

Yes = 41

Additional info:

Nurse is fine because it's simple procedure = 2

Yes if nurse is experienced = 1

Nurse is fine if it's NHS and low cost = 1

Yes if there can be a follow up with GP if there's a problem = 1

No = 20

Additional info:

Would prefer doctor or GP = 14

Prefer male doctor = 2 (1 said because small boys are shy of female nurses)

Prefer Muslim doctor = 1

Prefer doctor because of experience = 3

No answer/ Not sure = 2

#### **Results: GPs**

Total number of responses =11 (only 10 responses included information).

Responses from surgeries in the following areas:

Westminster: Harrow Road, Lisson Grove, Maida Hill, Marylebone, Pimlico

Kensington & Chelsea: Holland Park, Kensal Town, Latimer Road, South Kensington,

Westbourne Park.

#### Do many patients ask you for help or information about circumcision?

No = 2

Yes = 2

2 per year

1or 2 per month

2-3 per year

5-6 per year

Many patients used to ask for referrals but now demand is dropping because I have to say no and the patients are learning that.

Yes, many patients ask where they can be referred to for NHS circumcision. And then they ask if we can recommend anyone who does it not on NHS -as it does not cover circumcision.

#### (If yes) What help or advice do you provide?

Used to refer to St Mary's or Chelsea & Westminster =4

Refer to Portland Hospital =1

Signpost to private practitioner in the area =4

Doesn't have anyone to refer older boys to =1

Patients come to me because they worry their sons have phimosis, in which case I refer them even if I don't think it's necessarily a problem. Some patients pretend there is a medical problem even when there isn't one in order to get the circumcision done and then I have to say no. I don't know where they go.

#### Which communities do these patients belong?

Muslim =6

Bengali =3

American =2

Arab =2

Jewish = 2

Somali =2

Eritrean =1

Moroccan =1

Sudanese =1

## Have any of your patients raised any concerns about the lack of provision of NHS circumcision services? If so, what were these concerns?

Yes = 5

No =5

Payment =1

Safety =2

# In your experience how prevalent are complications in circumcisions performed by private practitioners? How serious are the complications? (if possible, please give us your estimates about the prevalence of haemorrhages, infections or disfigurements and how significant you think these are.)

Complications are rare =2

I have never seen any complications =4

I'm not concerned about babies but I am concerned about older boys –reports that they're being circumcised without adequate anaesthetic –don't know if that's true.=1

Don't know =1

5-10% complication rate, mostly infections. Disfigurement is more rare about 1% =1 Sometimes the ring doesn't come off. =1

Every year I see about 4-5 case of children who have had botched circumcisions. Problems include disfigurements, infections and haemorrhage. =1

## In your experience, is there a difference in the complication rate of circumcisions performed by private practitioners and those performed by the NHS?

No =1

Yes =1

Don't know =5

#### What training do you think is necessary to carry out circumcisions?

Don't know =5

Accredited training from Royal College of Surgeons =3

I am not in a position to judge but self evidently it does not need full medical training as Mohels have been doing it for centuries without that=1

#### In your opinion should the NHS change the way it deals with this issue? If so, why?

Yes = 4

No = 3

Don't know =3

- 1) No. The Jewish community has made arrangements among themselves for centuries without putting any costs on non believers. The larger Muslim community is equally capable of doing the same. It is not a medical procedure. My own personal view, which I do not enforce in my practice see above, is that it is an assault on the child and no less deserving of censure than ritual female circumcision and wholly contrary to my Western ethics on the rights of the individual. IMHO it should be delayed like Confirmation until the child is old enough to decide reliably for themselves.
- 2) Yes. Although clinically circumcision is not necessary, culturally many people want it for their sons and will obtain it elsewhere if it is not provided.

Circumcision: In Whose Care?

46

- 3) No. There are more equitable things that should be improved in the NHS before this minority issue
- 4) I think some work should be done with the Bengali community about why circumcisions are left until boys are older and to ensure that if they are having this procedure privately that the providers meet high standards. I don't think it should be done on the NHS but do think PCTs should monitor safety in the private sector especially when looking at the provision for less wealthy communities and should work with the Bengali community to ensure boys are not put at risk of significant injury.
- 5) From the point of view of preventing HIV and cervical cancer we should circumcise routinely as a pilot study but I believe this has been done before with positive outcomes, obviously it will be expensive.
- 6) Yes, as significantly large number of patients will require the procedure, do not want complications, want to encourage choice, and good practice.
- 7) NHS should provide religious circumcision, because it is widely needed, and to maintain standardised health care.
- 8) Not sure about NHS changing but think there should be minimum training expected of all those doing the procedure.
- 9) It's hard to say. We practise evidence based medicine and there is no evidence that circumcisions are medically beneficial. On the contrary, there is a reasonably high complication rate, and there other issues about sexual experience and about the rights of the children. It's understandable that the PCTs don't want to use taxpayer's money for it. On the other hand, this is a procedure that concerns minors and we should be doing everything we can to minimise complications. The NHS should regulate the private practitioners that carry out this work, make sure they comply to certain standards, for example, have a maximum infection rate etc. The problem is that private practice in contrast to the NHS is almost completely unregulated with no clinical governance.

#### **Results: NHS surgeons**

We spoke to two surgeons who work for the NHS. Both used to carry out circumcisions for non-clinical reasons within the NHS. Since that service was stopped one of the surgeons has stopped carrying out circumcisions for non-clinical reasons while the other offers the service privately at Bupa Cromwell hospital.

#### The old service at Chelsea & Westminster Hospital

Boys over the age of 9 months old were circumcised under general anaesthetic. Consent from both parents was not insisted upon. The parents were asked if they wanted to carry out the circumcision for social or for religious reasons and the two groups were treated differently. If the parents wanted to carry out the circumcision for religious reasons, this was perceived as non-negotiable and therefore little discussion about the medical risks and no discussion about the absence of medical benefit to the procedure took place. Alternatively, if the parents wanted to carry out the procedure for social reasons, an effort was made to dissuade them by pointing out that there were no proven medical benefits to the procedure and that the procedure carried medical risks. A one page information sheet was given out to parents requesting circumcision for social reasons which highlighted that the benefits were minimal if any and pointed out the risks including a 10% risk of infection, 1 in 70 risk of significant bleeding, that a large proportion of boys would be unable to wear normal clothes for about a week and that some patients are not satisfied with the cosmetic result. The risk from general anaesthetic was described as 'minimal'. In the rare cases where a child said he did not want to be circumcised the procedure was not carried out.

The withdrawal of NHS provision did cause a rise in the number of repeat procedures that had to be done in the hospital but because the overall numbers are small they are difficult to interpret. The increase was from 6 per year to 11 per year.

#### The service at Bupa Cromwell Hospital

Boys up to two months old are circumcised under local anaesthetic (cream and injection) and boys over two years old are circumcised with general anaesthetic. The service for neonates cost £300-400 while the service for older children is £1200. Some discussion is had with the parents about why they want to have their sons circumcised and if the issue of hygiene is mentioned it is explained that equally good hygiene can be maintained without circumcision. The risks associated with the procedure are discussed and a leaflet which discusses aftercare is given to the parents. Statistics with regard to complications are kept and the risk of complications including bleeding and infection is less than 1%. Approximately one circumcision per month is a repeat from those done in the community where something has gone wrong, e.g. not enough skin has been cut. Consent from both parents is preferred but not insisted upon. Usually, if only one parent is present, it is usually the mother and the doctor asks if the father consents to the procedure.

#### Best practice

The surgeons believe that best practice for carrying out circumcision was to do it under local anaesthetic in very young babies (younger than 2-3 months old) because at that age they are least likely to suffer complications or feel afraid. There is some debate about whether in the cases when the circumcision is done under general anaesthetic, it is best to wait until the child is no longer in nappies which makes caring for the wound easier or whether to do it as early as possible so the child does not remember the procedure. One surgeon said the best for the procedure would be any time over 9 months old while the other surgeon said it's best to wait until 2 or 2 1/2 so that the child is out of nappies. Both surgeons felt strongly that carrying out circumcisions on older children under local anaesthetic is wrong and should possibly be made illegal because of the unnecessary fear and suffering it causes children. They were also concerned that the application of local anaesthetic by injection is a difficult procedure to do effectively, when a child is awake and needs to be held in position.

The surgeons also felt strongly that circumcisions should not be taking place at home.

It was also said that one of the most important issues about the practice of circumcision was having someone highly qualified to provide back up to the practitioner in case of complications. It was also important that someone was available to the patients for follow up.

#### NHS

It was accepted that there is a need for the NHS to deal with the problem. The options suggested were either a service for young babies under local anaesthetic or a service for older children under general anaesthetic. However, one of the surgeons thought that a service for infants would be difficult to run practically. With the older children services it was suggested that it is possible to minimise costs down to about £400-£500 by having lots of children done at the same time during a lunch time (and therefore not interfere with the treatment of NHS patients) or for the NHS to subsidise the procedures.

#### Training and personnel

The surgeons said that there were enough qualified surgeons who could carry out circumcisions to meet the local demand because circumcision is often a training procedure for prospective surgeons. To carry out a circumcision a practitioner should ideally be a fully trained doctor with specialised surgical training. It would be possible for a nurse with specialised training to carry it out but he or she would need back up from a surgeon or doctor for the cases where there was excessive bleeding or any other complication.

#### **Results: Private practitioners**

Three GPs who carry out circumcisions as part of private practice were interviewed. Two of the doctors said they only carried out circumcisions for non-clinical reasons and the third said that the majority of the circumcisions he carried out were for non-clinical reasons. One said that about 95% of his patients were Muslim and 5% were Jewish. Another said that as well as Muslim patients he also had patients who were North American, Australian, African and West Indian.

#### Age & anaesthetic

All three doctors said that it was better to circumcise children while they were young babies. One said that as young as possible after the first 10 days was optimum, another said that the 2<sup>nd</sup> week after birth was optimum and the third said that anytime within the first three months was best. He added that after 10-12 months of age much greater restraint was required if one was to operate under local anaesthetic and that therefore general anaesthetic was best at that age but that older children also took longer to heal particularly after they have started crawling.

One doctor said that he circumcised children under 3 months old using local anaesthetic but that if they were younger than 6 weeks he used no anaesthetic at all, because he had read that in very young children, anaesthetic can cause arrhythmias. Another said that he circumcised children under 4 months but that this was an arbitrary limit and that he did occasionally go up to six months. The third GP said that he circumcised children up to 1 year old with local anaesthetic.

Nevertheless, according to the data from the parents, in 2003, one of the GPs circumcised two boys aged 3 and 7 years old and in 2005, another of the GPs performed a repeat procedure on a 2yr old. The doctors however were only asked about their current practice.

#### **Training**

All 3 doctors said they had specialised training. One said he has 30 years surgical experience. Another doctor said that he had background training in paediatric surgery and training in minor operations and that he learnt the Plastibell procedure after 3 months of working alongside surgeons who performed the procedure as part of their work for the organisation Muslim Welfare House. He also said that he worked together with a surgeon in Slough who could provide support if anything went wrong and that he referred to him cases which needed to be redone. The third said that he had experience of paediatric surgery in a previous job and had observed circumcisions in secondary care.

When asked about what training was required to carry out circumcisions, two said that practitioners should be doctors with surgical experience but they agreed that a nurse with specialised training and supervision could also carry out the procedure. The third doctor said that the most important point was that the practitioner should be aware of his or her own limitations, know what to do with regard to infection control and informed consent and have the backing of a colleague who is an expert in paediatric surgery in case anything goes wrong.

One doctor said that he thought there were enough qualified practitioners within the NHS to meet the local demand for the service, one said there were not and one said he did not know.

#### Complications

All 3 doctors reported very low complication rates. One said he had had no cases of bleeding or infection, but one case where the parents though there should be less skin left and so went to a paediatric surgeon to repeat the procedure. Another said he had no infections, one case were the parents wanted the procedure repeated and one case where they were dissatisfied with the result. The third doctor said that he had had no cases where a child came to harm or had permanent damage. He thought 1-2% of all cases required a second procedure, and infection was really uncommon.

In the patients' interviews there are two recorded cases of minor complications with these particular doctors; one case where the ring took 9 days to fall off instead of the usual 5 and one case where the ring was too tight and the boy could not urinate properly. According to the parents, the GP refused to help them and the boy had to be taken to hospital.

#### Best practice

Two doctors said that they explained the risks involved in the procedure and that they tried to obtain consent from both parents but that this was not always possible. One added that usually it was the mother that gave consent for the procedure. The third doctor said that he sought consent from one parent and did not discuss the risks of the procedure.

Two doctors said they asked the parents why they wanted to have their son circumcised but none discussed the issue of whether the procedure was medically beneficial unless specifically asked by the parents.

None of the doctors had experience of a child who expressed the wish not to be circumcised.

In terms of aftercare the doctors said that patients had contact details in case anything went wrong and were given advice on how to look after their son.

#### NHS

All 3 doctors said that the NHS should provide some kind of circumcision service and/or regulation because there was an unmet need and that since the parents would have their sons circumcised anyway it was important that this was done safely. One suggested that a service for babies was most important because that was the right time to perform circumcisions but another doctor said that a service for older children was also important because parents often left it too late and it was right to offer a mop up service. It was argued that a service for young babies would reduce morbidity and decrease other problems such as children missing school. One of the doctors suggested that the service did not have to be free as parents liked to pay a small amount because this was part of the celebration of the event.

#### Results: Rabbi from the Liberal Judaism community

This rabbi does not perform circumcisions personally but occasionally attends circumcisions in the community. The circumcisions take place either in the baby's home or at the doctor's surgery. The circumcisions are carried out on the 8<sup>th</sup> day after birth unless there are any contraindications such as jaundice in which case the circumcision is postponed until the child is well. The rabbi believes that complications are rare.

In the Liberal Judaism tradition, practitioners of circumcision have to be members of an organisation called The Association of Reform and Liberal Mohelim (ARLM). This association provides medical and religious training to doctors who want to practise circumcisions. All members of the association are doctors and use local anaesthetic in their procedures. Practitioners of ARLM are happy to circumcise non-Jewish children and have a tradition of doing so.

The practitioners of the orthodox Jewish community are organised in a different association entitled The Initiation Society.

The rabbi believes that there is a shortage of circumcision practitioners in the community and the NHS should make more funds available so that parents who wish to have their sons circumcised can do so.

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