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The case against neonatal circumcision

Part of the North American way of life is removal of the foreskin within a few hours of birth. Nearly two million boys are born each year in the United States and in some centres 80%–90% are circumcised,¹ using vast amounts of medical and nursing time and costing parents equally vast amounts of money. In Scandinavia, on the other hand, routine circumcision is almost unknown,² and in Britain it is becoming unusual. In the 1930s about one-third of British boys were circumcised,³ but by 1949 the proportion had fallen to one-fifth,⁴ and by 1963 only 10% of schoolboys in Rochdale had been circumcised.⁵ In hospitals in England and Wales in 1975 the rate was about 6%⁶; this represents some 20 000 circumcisions a year. The mortality is negligible.

Practice in Britain may have been affected by Gairdner's important paper,⁴ published in the *BMJ* in 1949. He showed that while 90% of boys have an unretractable foreskin at birth by the age of 3 the proportion has dropped to only 10%. Other studies have confirmed this natural development. In over 9000 schoolboys examined in Denmark⁷ phimosis was found in 8% of 5-year-olds but in only 1% of secondary pupils. Among 152 teenage English boys only one had a non-retractable foreskin, though full retraction was prevented by an adherent prepuce in 22.

Most circumcisions performed on the newborn are therefore unnecessary—in the sense that in time nearly all boys become able to retract their foreskin and wash beneath it. The North American arguments in favour of mass circumcision are that many uncircumcised men do not perform this toilet, that they run a risk of developing carcinoma of the penis, and that their wives may run an increased risk of developing carcinoma of the cervix. These last two arguments could be weighty ones, but some careful studies^{8–9} have failed to show any difference in the incidence of cervical carcinoma in the wives of circumcised and of uncircumcised husbands. Circumcision in infancy does virtually prevent penile carcinoma—there are only six recorded examples of this neoplasm in circumcised Jews.¹⁰ Even in the uncircumcised, however, penile carcinoma is rare. In Sweden, which has a male population of 3·7 million (few of whom are circumcised), there are 15 deaths from carcinoma of the penis in a year.² Some 5600 men die each week in England and Wales but only two of these deaths are due to penile carcinoma—only 0·14% of all deaths from malignant disease in men.¹¹

Surgeons who work in areas where ritual circumcision is not available are sometimes asked to don rabbinical robes on the

eighth day to circumcise a Jewish baby, and they may have been impressed by the absence of distress as the baby sucks on a teat containing some brandy. There is, however, a big difference between these rites and routine circumcision of newborn boys. Too often this is seen as an uninteresting chore to be passed to inadequately trained junior staff, which evidently is not without risk. There are many reports of removal of most of the skin of the penile shaft, injuries to the glans, circumcision of hypospadiacs, and the need to perform a second circumcision on as many as 10% of babies because inadequate removal of mucosa has been followed by secondary phimosis.^{1–12} The present-day hospital nursery, often colonised by antibiotic-resistant organisms, is a dangerous place for a newborn baby with a raw penile wound—as is shown by two recent papers.^{13–14} These record three babies who developed staphylococcal septicaemia (one fatal) and one with spreading septic gangrene of the scrotal skin after circumcision in the first week of life. Haematogenous osteomyelitis and lung abscess have also been reported as complications. Furthermore, all babies who lose their foreskin lose the natural protection of the glans penis, which prevents it being burnt by ammoniacal urine on the wet nappy. Meatal ulceration is a painful condition and meatal stenosis a serious one.

Presumably most Americans are satisfied with their present practice, and some justify it most forcefully.¹⁵ Others, however, do have misgivings,¹⁶ in so far as there really is no rational case for general neonatal circumcision. On the other hand, surgeons and urologists in Britain know that many men conceal a dirty mess beneath the foreskin, that in some the discomforts of phimosis make circumcision necessary, and that this is an embarrassing and uncomfortable procedure in adult life. These problems can be forestalled. Examination of the penis, as well as the testes should be a standard part of school medical inspections. This would allow the few boys with true phimosis to be treated early, and at secondary school would provide an excellent opportunity to back up or amplify parental instruction in personal hygiene.

Many surgeons who are not willing to perform circumcision much before 3 years of age accept that after that age operation is justified for phimosis and recurrent balanitis. The parents' wishes, both for and against the operation, must be taken into account; but operation between 3 and 5 years of age is probably the best compromise since it avoids the discomforts of circumcision later in life. Unfortunately only one-third of the opera-

tions in England and Wales are done before 5 years.⁶ Nevertheless the circumcision rate of about 6% of all males is probably about the correct proportion in a Western country today.

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- ⁵ Kalcev, B, *Medical Officer*, 1964, **112**, 171.
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- ⁸ Aitken-Swan, J, and Baird, D, *British Journal of Cancer*, 1965, **19**, 217.
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- ¹² Leitch, I O W, *Australian Paediatric Journal*, 1970, **6**, 59.
- ¹³ Annunziato, D, and Goldblum, L M, *American Journal of Diseases of Children*, 1978, **132**, 1187.
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- ¹⁵ Dagher, R, Selzer, M L, and Lapidus, J, *Journal of Urology*, 1973, **110**, 79.
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Marriage matters

While marital dysfunction and breakdown are enormous problems, they are difficult to express in figures. About 250 000 people are divorced each year in Britain and upwards of 100 000 approach the marital agencies for help.¹ Add to this the large but unspecified numbers who present their marital distress in more covert ways and the problem becomes one which few in the helping professions can afford to ignore.

Marriage Matters is the ambiguous title of a recent Government document on marital disorder, which should be essential reading for every doctor.¹ It was prepared by a working party on marriage guidance set up at the suggestion of three major, independent, grant-aided organisations: the National Marriage Guidance Council, the Catholic Marriage Advisory Council, and the Institute of Marital Studies. The booklet lists the range of facilities available, tries to assess their adequacy, and suggests how they might be improved.

Several important questions are posed for doctors. Firstly, how far are medical practitioners, either specialists or family doctors, equipped to recognise marital problems, often covertly presented? Secondly, have they the understanding and skill to respond adequately? Thirdly, do they make sufficient use of local, perhaps non-medical resources when referral is necessary, and are they able to handle such referrals sensitively?

Underlying such questions is the fundamental one of the adequacy of doctors' training in fostering the right skills for dealing with human as opposed to medical problems. All might agree in principle that such training is desirable, but how is it best provided, when, and by whom? Today most medical students might recognise functional or psychogenic causes of illness but the recognition of emotional factors is a far cry from adequately responding to such patients. Those concerned in training for such work—be they psychoanalysts, social workers, or counsellors—are convinced that the necessary skills can be acquired only in the field through supervised work. This is true whether the problem is a general difficulty in relationships or a more specifically marital one.

Traditional medical education is poorly suited to meet this

need. Teaching medical students through participation in psychotherapy, as at University College Hospital in London, is the exception. Innovative curricula, such as that at Southampton, bring the student into contact with family medicine from the start, but these promising attempts at providing appropriate opportunities for learning are far too rare.

If he has not had relevant training, what can a doctor do when he recognises signs of marital discord? He may use his intuitive sense of human relationships—though this may have been blunted by years of clinical work. He may give common-sense advice, but this is seldom enough when marriage or individuals have run into serious difficulties. More often, sensing that a problem is beyond his capacity to cope, he will, like the patient, simply deny it. How many relatively useless prescriptions are the price paid for such collusive avoidance of the real emotional issue?

Nowhere are these problems more pressing than for the general practitioner, who in the end has the patient "for better or for worse." Possibly future general practitioners will be better trained for work in marital troubles, but in the meantime those wishing to improve their skills have limited possibilities. The now well-established Balint groups, with their psychotherapist leaders and informal case discussions, help doctors to recognise the emotional and interpersonal processes affecting their consultations. Brook² has reported a different approach, in which the psychotherapist is taken into the surgery to provide help on the spot to the doctor through discussion of difficult cases and, at times, consultation with the patient directly. Such resources, however, are available only to a few doctors. An alternative suggested by the working party is co-operation between general practitioners and marriage guidance counsellors. Marriage guidance resources are little used by general practitioners, though a few practices have tried an attachment of a counsellor. One important cause of the underuse of voluntary marriage guidance workers may be their unprofessional image—which often does poor justice to their present-day training and skills. Both wider recognition of their status and further improvement in training resources might be fostered by a larger Government investment in the marital agencies. If the doctor can overcome his suspicion of the counsellor he might find an unexpected source of professional support. This, however, puts a big responsibility on the marriage guidance councils to ensure that the doctor is not let down.

¹ Home Office, *Marriage Matters. A Consultative Document by the Working Party on Marriage Guidance*. London, HMSO, 1979.

² Brook, A, *Health Trends*, 1978, **10**, 37.

Influenza: naught for our comfort

Few viruses have been studied so intensively as influenza, and its structure and replication are fast being explained in terms of their detailed chemistry. Yet paradoxically we have no satisfactory vaccine, no effective chemotherapy, and apparently little in the way of preventive hygiene to stop an epidemic in its tracks. Furthermore, the disease caused by smallpox virus, of which our knowledge is much less extensive, has been eradicated, and this with the aid of a discovery made nearly 200 years ago.

The explanation lies in the nature of the influenza virus.