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LOST BOYS: AN ESTIMATE OF U.S. CIRCUMCISION-RELATED INFANT DEATHS

Baby boys can and do succumb as a result of having their foreskin removed. Circumcision-related mortality rates are not known with certainty; this study estimates the scale of this problem. This study finds that approximately 117 neonatal circumcision-related deaths (9.01/100,000) occur annually in the United States, about 1.3% of male neonatal deaths from all causes. Because infant circumcision is elective, all of these deaths are avoidable. This study also identifies reasons why accurate data on these deaths are not available, some of the obstacles to preventing these deaths, and some solutions to overcome them.

Keywords: male, infant, death, mortality, neonatal, circumcision, penis, foreskin, United States

“The life of man is...nasty, brutish, and short.”

—Thomas Hobbes

Circumcision is a surgical procedure performed upon newborn baby boys in the United States once every seven seconds,¹ three thousand times a day, over a million times a year. The practice is so deeply rooted in American childbirth and medical culture that the public is largely unaware of two facts: first, that infant circumcision is not medically necessary in almost all instances, and second, that it carries serious medical risks, including the risk of death. For some parents, circumcising their son will mean losing their baby boy to what they have been told is a harmless procedure.

Medical associations fail to warn parents of the very real risk of death from circumcision. Neither the American Academy of Pediatrics (AAP, 1999), nor the American College of Obstetricians and Gynecologists (ACOG, 2001), nor the American Medical Association (AMA, 1999) mentions death as a possible outcome of the surgery in their policy statements on circumcision. The American Academy of Family Physi-

¹ Based on a workweek of five, 8-hour days.

^a Boy's Health Advisory.

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cians (AAFP, 2002) statement says death is possible, but (according to this study's findings) significantly underreports the risk as 1/500,000.

Parenting and baby books are equally culpable in failing to mention death as a possible, if rare, outcome of circumcision. A survey of ten popular infant-care books found that none warn that circumcision could result in a baby's death.² Most websites and literature on circumcision also minimize or ignore the risk of death, and no contemporary study has attempted to learn the magnitude of this problem. Perhaps this is due to the peculiar place occupied by circumcision in American medicine—an elective, almost incidental, procedure carried out on babies, behind closed doors, and mostly by residents and obstetricians rather than by the baby's own doctor (Stang & Snellman, 1998).

This study reviews the few sources that have reported on deaths occurring as a result of circumcision and attempts to provide a rough estimate for neonatal (first 28 days after birth) circumcision-related mortality in the United States. Since infant circumcision is elective, this study will consider all circumcision sequelae, not just the procedure itself. Its goal is to promote discussion, encourage solutions, and—most importantly—save children's lives.

Background

About 1.3 million boys are circumcised each year in the United States (HCUP, 2007); however, the number of boys who died from those surgeries has not been reported or estimated in any credible way. Some reasons include record-keeping practices, indifference, and—no doubt—concerns about liability.

Death certificates typically do not list circumcision as the *immediate* or *leading* cause of death and rarely list circumcision as an *underlying* cause. Incomplete and inaccurate death certificates for children are a common phenomenon (Cunniff, Carmack, Kirby, & Fiser, 1995). Thus, many circumcision-related deaths are more often reported as surgical mishap, infection, hemorrhage, cardiac arrest, stroke, reaction to anesthesia, or even parental neglect.

In recent years, U.S. infant deaths have been infrequently reported in the media (Rachter, 1982; The State, 1992; Miami Herald, 1993; Lum & Sorelle, 1995; News-Net5, 1998; Proctor, 2002; Cohen, 2005; Verges, 2009). Reports of circumcision-related deaths have sporadically appeared in the medical literature beginning in the early 1900s (Holt, 1913; Reuben, 1916; Sauer, 1943; Scurlock & Pemberton, 1977; Gellis, 1978; Baker, 1979; Hiss, Horowitz, & Kahana, 2000). In Africa, dozens of deaths from circumcision initiation rites are reported every year, but, as in America, are often treated with indifference (Ncayiyana, 2003).

² Survey by author of the ten highest ranked books listed on Amazon.com, November 10, 2008.

Lost Boys

Boys have been lost to circumcision in the United States from the time it was first practiced to the present day, for a variety of reasons, as the following examples illustrate. The first known reported circumcision-related deaths were in New York City, where circumcision was introduced. The first was Julius Katzenstein in 1856 (New York Times) and the second was one-week-old Myer Jacob Levy in 1858 (New York Times). Both boys were circumcised by a Dr. Abrahams, and the same coroner reviewed both deaths. The coroner found that Abrahams had performed the surgeries properly, and that the boys died from blood loss as a result of parental neglect. Neither boy had received a follow-up examination.

Allen Ervin, born 1985, was in a coma for more than six years before he died. He had been on life support after his brain was damaged from oxygen deprivation during his circumcision (The State, 1992).

Demetrius Manker was born in 1993 and died soon thereafter from blood loss. The coroner's examination found a large, gaping wound on the underside of the boy's penis extending almost to the scrotum. The coroner listed cause of death as blood loss due to penile circumcision (Welti, 1993); however, there is no mention of further action being taken.

A West Virginia child, whose name was withheld, was born in 1996 without incidence and circumcised prior to hospital release. A few days later, the parents rushed him to the emergency room because he was having seizures and his penis had turned green in color. He died the next day from septicemia (Ballad, 1997).

Death sometimes occurs following repair of a circumcision complication. Dustin Evans, Jr., was circumcised soon after being born in 1998. The surgeon took so much shaft skin that the scar healed as a tight "collar" around his penis, preventing him from urinating. When he was later given an anesthetic in order to repair the damage, he immediately died of cardiopulmonary arrest (Giannetti, 2000). His father lamented, "You think, 'What could go wrong with a circumcision?' The next thing I know, he's dead."

In a 2004 Vancouver, Canada, incident, one-month-old Ryleigh McWillis was sent home from the hospital immediately following his circumcision. He later bled to death, his disposable diapers absorbing the small amount of blood from his circumcision wound necessary to send him into hypovolemic shock (Newell, 2004).

Because the penis is highly vascularized, blood-loss is a risk even for boys circumcised past the neonatal period. In 2008, 6-week-old Native American Eric Keefe died from massive blood loss. Hospital officials claimed his circumcision was not to blame, but instead faulted the parents because they had administered over-the-counter pain medication that, they also claimed, thinned his blood. The parents were not told about this possible complication (Verges, 2009). Since then the hospital has stopped performing infant circumcisions.³

³ Personal communication with author at the 2009 AAP national conference, Washington, DC.

Nor are ritual circumcisions without risk, either. In 2004, an infant twin born to Jewish parents was circumcised by a *mohel*, a ritual circumciser who was infected with Herpes simplex virus 1. He practiced the orthodox version of circumcision called *met-zitzah b'peh* (in which the circumciser sucks blood from the wound with his mouth), thereby transmitting herpes to the boy via his saliva. The baby boy died a few days later (Cohen, 2005).

Previous Death Estimates

The widely varying results from the handful of researchers that have attempted to estimate circumcision-related deaths can be explained by their choice of survey criteria. A study by Dr. Douglas Gairdner in 1949 included deaths due both to surgery and to ensuing complications. He reviewed case histories of 90,000 circumcisions for boys under five years old from 1942 to 1947 in England and Wales, identifying 95 deaths attributable to circumcision. Of these, he found 16 deaths per 100,000 annually for boys less than one year old, including postoperative, postrelease deaths. Some of these were due to reactions to anesthesia; Gairdner nevertheless classified these as circumcision-related since the boy would not have been administered anesthesia except for circumcision. This was considered a definitive study in the United Kingdom, and led the British government to deem infant circumcision an unnecessary and nonreimbursable medical procedure. When extrapolated to the present-day United States, Gairdner's findings represent an estimated 230 deaths annually. Children's-rights activists in the United States often claim this death toll (Baker, 1979), rather than underreport the risk using lower estimates, in an attempt to portray the gravity of the problem. However, this rate is misleading because it does not allow for improvements in healthcare from post-war, pre-penicillin Britain to the present day United States. Thus, this figure is likely overstated. The question is, How much is it overstated?

In a 1953 letter to the editor of *Obstetrics and Gynecology*, Dr. H. Speert states that of 566,483 circumcisions performed between 1939 and 1951, there was one operative death. Applied to the present U.S. incidence that would equal 2.4 operative deaths per year. Circumcisionists cite this ratio in order to minimize the death risk. But this estimate reports only those who died on the operating table—it ignores the much larger number of postoperative deaths both inside and outside the hospital.

Inexplicably, no deaths at all were reported from any cause in a population of 100,157 circumcised, neonatal boys in a survey of U.S. Army hospital records (Wiswell & Geschke, 1989). However, the national male neonatal death rate from just two causes—hemorrhage and sepsis—is 30.2 per 100,000 (NCHS, 2004), leaving us unsure what to make of this discrepancy.

Hospital discharge records reveal that, during the 1991–2000 decade, on average 35.9 boys died from all causes each year during their stay (average 2.4 days) in the hospital in which both their birth and circumcision occurred (Thompson Reuters, 2004). These were among the average of 1,243,392 boys circumcised annually during the same period, but this number is limited to deaths inside the hospital, some of which are undoubtedly due to circumcision.

Complications from circumcision are as high as 55%, according to Patel's (1966) circumcised-infant cohort study, which reviewed case histories, examined infants in the home, and questioned parents on outcomes, making it the most thorough circumcision-complication study performed to date. Eight percent of boys in the cohort became infected after being circumcised, and they were 700% more likely to have become infected after hospital release than before. Bacterial sepsis and hemorrhage are both frequent fatal complications of circumcision, and circumcised boys are at a higher risk for streptococcus infection (Cleary & Kohl, 1979). Gairdner reported that one in fifty circumcised boys returned to the hospital for treatment of excessive bleeding, some requiring transfusions.

Infection has become even more of a factor recently with the epidemic of methicillin-resistant *Staphylococcus aureus* (MRSA) now under way in the United States. The medical literature is replete with reports of MRSA infections occurring first in hospitals and now in the community (Rabin, 2003; Klevens et al., 2007). Circumcised boys are at a higher risk for this "superbug" than intact (not circumcised) boys (Enzenauer et al., 1985), most likely because of the open circumcision wound. A 2003 outbreak of MRSA in a Long Island, New York, hospital maternity ward resulted in three newborns' being infected: all were boys; all had been circumcised (Rabin). Circumcision is a *double whammy* when it comes to MRSA: the American Medical Association identified both surgery and young age as risk factors (Zeller, 2007). The mortality rate for neonates once subcutaneous tissue becomes infected is more than 70% (Sawin, Schaller, Tapper, Morgan, & Cahill, 1994). The risk from MRSA alone would seem to dictate ceasing the practice of unnecessary surgery such as infant circumcision.

Mortality Estimation

Though the data previously cited are insufficient to establish a definitive death rate on their own, there is enough available information to calculate an estimate. Not all of the reported 35.9 deaths out of 1,243,392 circumcisions can be attributed to related causes. What portion, then, is circumcision-related and how may we extrapolate to the number of deaths after hospital release? What we can safely assume is that it is unlikely that any of these infants would have been subjected to the unnecessary trauma of circumcision if they had been in critical condition, or that they would have been circumcised after their death.

Gender-ratio data can help extrapolate a figure. Males have a 40.4% higher death rate than females from causes that are associated with male circumcision complications, such as infection and hemorrhage,⁴ during the period of one hour after birth to hospital release (day 2.4), the time frame in which circumcisions are typically performed (CDC, 2004). Assuming that the 59.6% portion is unrelated to gender, we can estimate that 40.4% of the 35.9 deaths were circumcision-related. This calculates to 14.5 deaths prior to hospital release.

⁴ Selected from ICD-10 codes P21.9-22.9, 29.0-29.1, 29.8-29.9, 36.0-36.9, 37.5, 39.8-38.9, 50.9, 52.3, 54.3, 54.8-54.9, 55.9, 96.8-96.9

But as is often the case with hemorrhage and infection, some circumcision-related deaths occur days, even weeks, after hospital release. The CDC's online searchable database, *Mortality: Underlying cause of death, 2004* (CDC), lists causes by various age ranges and reveals that the percentage of deaths after release, compared with deaths before, is 772% greater. This ratio is comparable to Patel's (1966) 700% postrelease infection rate.

Multiplying the 772% adjustment factor for age-at-time-of-death by the 14.5 hospital-stay deaths calculated above, the result is approximately 112 circumcision-related deaths annually for the 1991–2000 decade, a 9.01/100,000 death-incidence ratio. Applying this ratio to the 1,299,000 circumcisions performed in 2007, the most recent year for which data are available (HCUP, 2007), the number of deaths is about 117. This is equivalent to one death for every 11,105 cases, which is not in substantial conflict with Patel's observation of zero deaths in 6,753 procedures. It is more than some other estimates (Speert, 1953; Wiswell, 1989), but less than the overstated 230 figure derived from Gairdner (1949). Breaking this statistic down further, about 40% of these deaths (47) would have been from hemorrhage, and the remainder (70) from sepsis, using a hemorrhage-to-sepsis ratio for infant mortality (NCHS, 2004).

In summary: through a thorough review of the literature and the application of common-sense calculations, this study has arrived at a reasoned estimate of circumcision-related neonatal deaths in the United States: approximately 117 per year.

Ulterior Motives

Many factors combine to explain the lack of reliable mortality data or why this problem has not received more attention. To ignore or hide the likely cause of so many infant deaths for so many years requires a significant amount of denial or obfuscation—by: parents, physicians, hospital staff, insurers, medical associations, and legislators. The silence of human-rights, men's-rights, women's-rights, and children's-rights groups concerning these deaths is shocking. It might indicate that they are unaware of the problem, or that they wish to appear politically correct in regard to religious circumcisions, even though more than 96.5% of those performed are not for religious reasons (US Census Bureau, 2008).⁵ The explanation for such lack of concern and discussion is unknown, but one fundamental reason has to be a lack of information disseminated among people who can correct the situation.

Not only will parents of a dead boy be in shock, but also potentially embarrassed, by what seems now to have been a whimsical choice for their infant. Their understandable reaction is to withdraw into protective silence or to defend their choice despite their loss. They might insist, as parents of one deceased child did recently, that they would “make the same choice with their next boy” (Fournier, 2004). Parents are sometimes irrational concerning circumcision. Many quickly sign the consent form without

⁵ If all Jews, Muslims, and Coptic Christians in the United States circumcise.

first learning more about the physical, psychological, and sexual consequences of circumcision. Some sign because they take their physician's mention of the topic as a recommendation, or because they feel coerced by repeated inquires. Others sign because they fear being regarded bad parents, rather than considering what is in the best interests of their son. For instance, nine out of ten parents who chose circumcision did so knowing full well that the procedure was excruciatingly painful for their newborn boy (Ahaghotu, Okafor, Igiehon, & Gray, 2009).

To hospital residents, the birth of a boy is celebrated as an opportunity to practice surgery. A resident's first surgery upon a live human being does not always go as planned—especially when the patient is not a sedated, consenting adult, but a screaming, thrashing baby. The resident's mentor is likely to provide cover for any errors, lest they reflect poorly on him or her and their institution. Busy residents often have a quota of interventions to meet in order to qualify in their specialty, which means that they have a conflict of interest, potentially an unethical stake, in performing the procedure. Thus, most adult American males can be seen as having been child medical-training draftees, now sporting a “scalpel practice” penis, carved on by a twenty-something-year-old undertaking his or her first surgery.

The relative simplicity of circumcision means that a charge that it was done poorly is a glaring indictment of the clinician. The notion that a child died as a result is, of course, even more embarrassing to them and would call forth some sort of preemptive defense. This often takes the form of blaming the parents for inadequate postoperative care, or insisting that it was the child's fault for being too feeble to withstand the procedure, turning the medical phrase “failure to thrive” into a euphemism for these iatrogenic deaths.

Because of the inadequacies of the death-certificate system and the apparent lack of investigation, it is easy to see how the medical system could either unwittingly or intentionally obscure the true cause of these deaths. American courts aid the medical institution by sometimes ruling that the parents signed the circumcision consent form, and that the parents took their chances even if they were not informed of such a possible outcome. Thus, medical practitioners have a tactical choice. They can list on a lengthy consent form every conceivable risk of circumcision, including death, which might undersell the procedure, or, calculating that the danger of failure and detection is low, soft-pedal the risks in hopes that parents will sign anyway.

Few death cases are ever litigated in court because hospitals recognize that their defenses are few and expensive to plead, and that the publicity would prove harmful. Such cases usually result in an offer to the parents of a private, sealed settlement. Sadly, the death of a child is considered less of a liability than an injury case, and therefore compensation for a dead infant is rarely substantial. On the other hand, severe injury cases—loss of all or part of the glans, or, even worse, the entire penis—are intensely litigated and may produce substantial monetary damages in the millions of dollars. The crass logic of the law is that the injured male will have to bear his injury for a lifetime, whereas the dead infant barely sensed his own existence, and so would not even sense the loss of himself. Invariably such settlements include a confidentiality clause, in-

tended, of course, to protect the reputation of both the individual medical practitioner and the institution.

Following a death, the coroner or the medical examiner, who is usually a physician, will rule whether the death was from suspicious causes. In the United States, that coroner (who, if male, is probably circumcised) is not likely to face squarely and on the record the fact that his or her colleague performed an unnecessary and nontherapeutic surgery that resulted in the death of an infant. This malfeasance could itself be cause for an investigation, could have serious repercussions for the circumcising physician and institution, and therefore seems an unlikely move for coroners, especially if they are elected officials.

Primary and secondary causes of death are all too easy to conceal because of the lack of healthcare oversight. There is remarkably little regulation of medical practice by the Federal government, and little coordination among states to regulate medical procedures. Ironically, circumcision devices (e.g., restraints and clamps) are more closely scrutinized than their application.

The American Academy of Pediatrics (AAP) was found to be partially liable in the death of Dustin Evans, Jr., according to the *Iowa Law Review* (Giannetti, 2000). It reached the conclusion that his death was attributable to his circumcision, and that the AAP should either have labeled circumcision as experimental or proved its worth through exhaustive scientific testing. Yet the AAP has continued over the past four decades to issue a string of policy statements regarding circumcision, each one carefully worded so as to increasingly shift liability from its membership to parents, thereby protecting their members' lucrative income stream.

Physicians are less likely to circumcise their sons than the general populace (Topp, 1978), suggesting that they know it is an unnecessary surgery, but don't relay this valuable information to parents. Many physicians say that they prefer not to perform circumcisions, but do them anyway, rationalizing that the boy will be in better hands with them than with a physician they might refer the parents to. This may seem a noble position at first, but there can be no pretending to be a conscientious objector to circumcision while simultaneously performing one.

Circumcision is a \$2 billion healthcare market, which includes costs for the procedure itself, dealing with complications, and payment for repairs (Fauntleroy, 2001). A study of Medicaid records found that a greater number of circumcisions are performed in states where Medicaid pays more for the procedure (Craig & Bollinger, 2006). A busy delivery-room obstetrician will do as many as five circumcisions a week. Physician reimbursement is at about \$167 each⁶ (Van Howe, 2004), which means that they can potentially make an extra \$3,340 per month, or \$40,080 per year. That is more than an entire year's income for 45% of Americans (US Census Bureau, 2005). One

⁶ Adjusted for medical inflation to year 2010, does not include hospital's portion of \$136, or what they obtain from foreskin sales to laboratories and cosmetic companies.

physician brazenly admitted, “I love doing circumcisions—they make my Mercedes payments!”⁷

At the very heart of this problem is a lack of honesty about an entrenched medicalized ritual. Circumcisers are quick to sidestep ethics and put their real patient—the baby boy—at risk. But they are not likely to speak out, simply because calling attention to their unethical actions would likely jeopardize them or their peers, reduce their income, and, possibly, have dangerous legal consequences.

Implications

Risk assessment for an unnecessary surgery must be held to a higher standard than that for a life-saving surgery. We accept that a heart transplant carries with it a substantial risk of death, but without it there is a certainty of death. On the other hand, the risk from circumcision, which has no therapeutic value, needs to be zero for the infant’s sake, all the more so because he is never consulted about whether he wishes to take his chances.

We hear very little in the media about circumcision-related deaths compared with other causes. For instance, compare the 117 annual deaths from circumcision with those from other causes for male infants: suffocation (44), mother’s use of addictive drugs (27), HIV/AIDS (19), homicide (17), automobile accidents (8), drowning (2), and falls (1) (CDC, 2004). Sudden infant-death syndrome (SIDS) killed 1,216 boys under the age of one year in 2004; of those, 115 were under the age of 1 month (CDC), which is the same risk as from circumcision. Approximately 36 teen-aged boys are killed in schoolyard shootings each year (Donohue, Schiraldi, & Ziedenberg, 1998). But there is more publicity for the SIDS deaths and shootings than for the circumcision-related deaths.

Is male circumcision so ingrained in American masculinity that we are hardened to its consequences? Have we inherited the recurring theme in religion and mythology of offering our sons to the gods? Or do we stoically value it as a painful male initiation rite, requiring sacrifice of blood and a body part (Zoske, 1990)—and therefore believed to be worth the occasional death-cost?

If a similar number of children were dying from another optional body modification—say, tattooing or piercing—would the public be outraged at the people and institutions benefiting financially? If not, is it then due to gender bias? Imagine the uproar if a hundred girls were dying from female circumcision each year. Why are so many adults silent about this atrocity? Adults would be furious and highly vocal, to say the least, if someone were to forcibly cut *their* genitals.

Solutions

The problem is this: circumcision is a killer of baby boys. No one, except for some human-rights activists, is trying to save them. It is unlikely that improving circumci-

⁷ Personal communication at the 2003 AAP national conference, New Orleans, Louisiana.

sion techniques would eliminate these deaths. No matter how skilled the physician is, some deaths will always occur.

Improving the process of securing informed consent from parents by listing death as a possible outcome would, at first, seem to be a logical solution, but it would fail to save lives for two reasons. First, even well-informed parents will sometimes insist on circumcision (Binner, Mastrobattista, Day, Swaim, & Monga, 2002). Second, health-care providers cannot be trusted to provide truthful disclosure of the risks involved. The fact that physicians and nurses are already willing to perform well over a million of these unnecessary surgeries a year is proof they are generally untrustworthy.

The overwhelming majority of infant circumcisions are nontherapeutic and therefore unnecessary; the simple solution is eliminating them. To start with, physicians and nurses should be prohibited from initiating a discussion with, or soliciting circumcision from, expectant parents. Circumcision should also be defunded, following the examples set by the sixteen states that have already eliminated Medicaid coverage.

Physicians regularly give parents information favoring circumcision, but rarely provide instructions on how to care for the intact penis. Furnishing parents with this knowledge would alleviate their anxiety concerning a body part unfamiliar to them (Bollinger, 2008). All medical textbooks and parenting guides should include intact-care information and mention death as a possible outcome.

Physicians who perform unnecessary surgeries that result in death must be held accountable for their actions in criminal and civil court. Professional associations that protect their members rather than their patients should be forced to change their policies. Physicians must talk with their peers about ceasing circumcision, or at the very least become conscientious objectors. Legislation to protect boys must be passed, beginning with demanding that Congress rewrite the 1996 Federal law prohibiting female circumcision to make it gender-neutral. A nationwide system that reports all infant deaths with all contributing factors rigorously listed must be established.

Few human emotions compare with the profound grief that results from the loss of a newborn child. Adding guilt to that grief—from the realization that you requested the optional surgery that caused his death—is beyond imagination. Most parents would likely refrain from talking about it publicly. People affected by a circumcision-related death must speak up. Parents must be encouraged to talk about why they chose circumcision, what happened to their son, what they are feeling, what they would advise other parents to do, and whether they would choose circumcision again. Family members and friends must also be involved in the discussion.

Conclusion

It is reasonable to conclude that about 117 circumcision-related deaths occur each year in the United States—approximately 1 out of every 77 male neonatal deaths—and that thousands of boys have died since this practice was first medicalized 160 years ago. These boys died because physicians have been either complicit or duplicitous, and because parents ignorantly said “Yes,” or lacked the courage to say “No.” Every one

of these boys would have had a chance at life had he not been circumcised. Circumcision can no longer be called either a beneficial surgery or a beneficent rite of passage, but by its true designation: an unrecognized sacrifice of innocents.

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