General Practitioner, Dr C

A Medical Clinic

Unregistered Doctor, Dr E

A Report by the

Health and Disability Commissioner

(Case 09HDC00810)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mr and Mrs B decided to have their four-year-old son, Master B, circumcised for religious reasons. After seeing an advertisement, Mr and Mrs B made an appointment for 7 January 2009 with Dr C at a medical clinic. At this appointment, Dr C undertook a preoperative assessment of Master B and discussed the procedure with Mr and Mrs B. At the end of the appointment, Mr and Mrs B signed a consent form and arranged to bring Master B in on 23 January 2009 to be circumcised.

At the appointment on 23 January, Master B was given a local anaesthetic. However, he was distressed throughout the procedure and would not lie still. Attempts were made to hold Master B still, but he continued to move erratically and Dr C was unable to insert the stitches to stem the bleeding from the frenular artery. Master B was transferred by ambulance to hospital, where the bleeding was deemed too profuse to be stopped with local pressure alone. He subsequently underwent haemostasis and a revision of the circumcision under general anaesthetic, and was discharged on the morning of 24 January 2009.

The family noted the presence of another man in the room during the circumcision procedure at the Medical Clinic. They had no knowledge of his identity at the time; however, it later transpired that the man was Dr E, an overseas registered doctor who is not registered in New Zealand. The family alleged that it was Dr E who performed the circumcision on Master B, not Dr C.

Complaint and investigation

On 29 January 2009 the Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs B about the services provided by Dr C and a Medical Clinic. The following issues were identified for investigation:

- *The appropriateness of the care provided by Dr C to Master B on 23 January 2009.*
- *The adequacy of the information provided by Dr C to Master B's parents.*
- *The appropriateness of the care provided by the Medical Clinic to Master B on 23 January 2009.*
- *The appropriateness of the care provided by Dr E to Master B on 23 January 2009.*

An investigation was commenced on 10 February 2009.

The parties directly involved in the investigation were:

Master B	Consumer
Mr B	Complainant/Consumer's father
Mrs B	Complainant/Consumer's mother
Dr C	Provider
The Medical Clinic	Provider
Ms D	Practice manager at the Medical Clinic
Dr E	Unregistered doctor
Dr F	Paediatric registrar
Dr G	Paediatric surgical fellow

Information was reviewed from:

Dr C
Mr and Mrs B
Dr E
The DHB
Dr F
Dr G
The Medical Clinic

Others mentioned in this report:

Dr H, Medical practitioner
Dr I, Medical practitioner

Independent expert advice was obtained from general practitioner Dr Gerald Young (see **Appendix 1**).

Information gathered during investigation

Initial consultation
Mr and Mrs B decided to have their four-year-old son, Master B, circumcised for religious reasons. The family contacted Dr C at a Medical Clinic after learning in an advertisement about the circumcision services he provided. Mr and Mrs B were advised by the clinic that, before the circumcision could be performed, Dr C would need to examine Master B to ensure there were no abnormalities, and to provide the parents with more information.

On 7 January 2009, Mr and Mrs B took Master B to the clinic to see Dr C. Dr C examined Master B, and noted that Master B's foreskin was "very much adherent" (which meant there was difficulty in lifting it back). Mr and Mrs B do not recall Dr C commenting on this. They remember him advising that it would be a straightforward procedure as Master B's penis was fully developed for his age and there were no abnormalities.

Dr C advised HDC that he did point out Master B's adherent foreskin to Mr and Mrs B, and he recalls showing Mr B how the foreskin could not be raised. He also advised that he told the family that this could complicate the procedure and cause discomfort to Master B postoperatively. Dr C also believes he advised Mr and Mrs B of the risks of bleeding and infection, which he "[does] for every patient", but told them not to worry, as Master B would be given antibiotics. Mr and Mrs B do not recall these risks being discussed with them.

Mr and Mrs B recall raising the issue of general anaesthetic with Dr C, asking whether Master B could be put to sleep as they did not want him to feel any pain. They recall Dr C saying that Master B would not be put to sleep but that local anaesthetic would be used to numb the area and that Master B would not feel any pain.

Dr C initially advised HDC that he did not discuss with Mr and Mrs B the option of general anaesthetic, but if they had raised the issue he would definitely have discussed it with them. He did not have any written policies regarding circumcisions, associated risks and quality of care as:

> "We have been doing [circumcisions] for quite sometime and I did it [overseas], I did it here, I did it in [another country] and there is a set protocol because all the Muslim families know they have had [circumcisions] or their kids … It's a well known process … And we discuss with them, bleeding, infection is a complication of any operation …"

Dr C subsequently advised HDC that he is unable to recall whether he gave Mr and Mrs B advice on the anaesthesia options, but it was his usual practice to discuss the advantages and disadvantages of each option, including the advice that general anaesthetic was preferable for boys aged between six months and 14 years. In support of this, Dr C provided HDC with a "Checklist for Circumcision"[1] which he advised was kept in his consulting room. The second point on the checklist reads:

> "Options of Local Anaesthetic & General Anaesthetic and complications to be discussed"

Nonetheless, Dr C "does not contest [Mr and Mrs B's] denial that such advice was given".

At the end of the appointment Dr C discussed with the family the cost of the surgery and arranged for them to sign a consent form. The consent form included an acknowledgement from Mr and Mrs B that Dr C had discussed the procedure, implications and possible risks, and that they agreed to the circumcision being performed on Master B. Mr and Mrs B then made an appointment with Dr C to perform the circumcision on Friday 23 January 2009 at 5.30pm.

[1] This was not provided to HDC until after Dr C had reviewed the provisional opinion, despite requests by HDC for copies of any written policies regarding circumcisions, associated risks and quality of care.

Consultation on 9 January
On 9 January, Master B was seen by Dr C because he was experiencing stomach pains. Dr C advised HDC that he took the opportunity to further examine Master B's testes and penis and advise his parents about how to prepare Master B for the circumcision. He states that the foreskin remained adhered to the penis. However, apart from a note "Testis in normal place", the examination and advice are not noted in the medical record.

The circumcision
On the evening of 23 January 2009 Mr and Mrs B, together with two of Mrs B's brothers, brought Master B to the Medical Clinic to be circumcised. The family arrived early, at approximately 5.05pm, and were advised that Dr C was currently doing a circumcision on a 14-year-old boy but they would be next. Mrs B became anxious after hearing the 14-year-old boy yelling out in pain, but she was reassured by Dr C's wife, Ms D (who is the practice manager), that the boy had been given the "maximum anaesthetic and morphine", but that he was "too sensitive and could not handle the pain". One of Mrs B's brothers recalls Ms D saying that the 14-year-old was not numb, but this was very rare and they had nothing to worry about.

Mr and Mrs B recall what happened next:

> "We took our son inside the room [at] approximately 5.45pm and were holding his hands when the doctor gave him the local anaesthetic. Immediately after that they started cutting his skin off to which our son just could not handle the pain not even allowing time to numb. I (mum) started crying seeing my son in so much pain … I was chased out of the room by the doctor saying that I am passing my anxiety on to my son. My husband was inside with my son for at least 10 minutes before he was also sent out. We were not allowed to go inside after that. We could hear our son crying for help and begging us not to leave him there by himself. He kept asking them to let us in but they wouldn't listen … it was more than an hour, and the last thirty minutes, all they were saying was it's the last stitch they were doing. My husband walked in the room and found the doctor talking to another doctor over the phone to come in as there was a complication and he didn't know what was going on. Until then the doctor, his wife and unlicensed man were holding my son as if they were holding a wild animal. His thighs were all painful … My son was bleeding vigorously. While my husband was inside [Ms D] came out and told me that if the bleeding doesn't stop then they might have to call an ambulance. They said if my son would let them do one last stitch. I told them to get their hands off my baby … The doctor referred my son to [the public] Hospital. Ambulance arrived at about 7.15pm."

Mr B and Mrs B's brother state that at one stage during the procedure they returned to the operating room to comfort Master B. They were asked to help hold Master B down as he was moving around too much.

Mrs B also recalls that when she re-entered the operating room she noticed a bowl full of blood-soaked cotton in the room.

Dr C recalls the events differently:

> "Both parents accompanied [Master B] into the surgery. The mother of the patient was emotional and in tears, I once again explained the procedure to both the parents and the Dad tried in va[in] to subdue the mother. She decided to step out of the surgery and walked outside. At this stage the patient was already extremely restless and crying for his mother. Dad stepped out of the room; I then proceeded with giving the patient the local anaesthetic. The patient was becoming frightened and restless and I called the father of [Master B] into the room. He held the child's hand and I was able to give him the local anaesthetic. The patient was subdued and calm thereafter meanwhile the dad himself complained of dizzy spells and was pale in the face. He was offered water and I then requested him to relax in the next room as I was afraid of him collapsing during the procedure which I was about to commence."

Dr C admits that he had difficulty keeping Master B still from the beginning of the procedure and accordingly he sought assistance from Ms D, and Dr E (whose involvement is discussed below) to hold Master B's legs still. Despite their assistance Dr C continued to find Master B "extremely difficult to handle":

> "… [Dr E] held the buttocks together and the knee but in spite of that it was hard, he's not a really strong guy. It is really difficult because the pelvic muscles are tough and forearm muscles are not that strong."

Towards the end of the procedure, while Dr C was attempting to insert stitches (to stem the bleeding from the frenular artery, which had been cut as a routine part of the surgery), Master B was moving erratically. Dr C decided that, despite the need to control the bleeding, Master B's restlessness made it too risky to continue stitching as damage could be caused to the nearby glands.

Transfer to Hospital

Dr C eventually telephoned a colleague, Dr H,[2] for support. However, as Dr H was 45 minutes away, Dr C decided that Master B would need to be asleep (under general anaesthetic) in order to have the last stitches put in. Dr C phoned the public hospital Emergency Department and was put through to paediatric surgical registrar Dr F, who recalls the following:

> "The referring doctor relayed their problem of the child they were circumcising becoming restless during the procedure. I enquired how much local anaesthetic had been used. The GP replied and the anaesthetic registrar relayed that he could use a certain amount more. I cannot remember the amounts stated.
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> The GP then relayed that they were having problems with bleeding during the procedure and that they could not continue with the procedure and the parents were becoming upset. I asked how much blood had been lost and if the child

[2] Dr H was available to Dr C if a complication arose during a circumcision procedure.

> was tachycardic.[3] I cannot recollect the response. However, based on this information, I accepted the referral and I advised the GP to send the child to [the] emergency department in an ambulance with a pressure dressing on the penis for further assessment and surgical input."

An ambulance was dispatched at 7.37pm and arrived at the Medical Clinic at 7.45pm. Master B arrived at hospital at 8.09pm where Mr and Mrs B were told to apply pressure to the wound and Master B was given intravenous fluid until he could be reviewed by a surgeon. Dr G, a paediatric surgical fellow, reviewed Master B and formed the opinion that the bleeding was too profuse to be stopped with local pressure alone. Dr G advised HDC that "several large clear monofilament sutures (possibly about 2.0)" had been inserted at the main bleeding point,[4] and commented that "the use of such large sutures was unusual …". Dr C later clarified that he had in fact used 3.0 chromic catgut sutures. Master B underwent haemostasis and a revision of the circumcision under general anaesthetic at approximately 1.30am on 24 January. He made a good postoperative recovery and was discharged later that morning.

Effectiveness of local anaesthetic

Although it is not disputed that Master B was extremely distressed and anxious throughout the surgery, there is disagreement as to whether it was pain or anxiety that caused Master B to become so distressed.

Mrs B recalls that she held her son's hand while the doctor gave Master B the local anaesthetic[5] and does not believe that the doctor allowed sufficient time for the anaesthetic to work (she estimated that two to three minutes elapsed between Master B receiving the anaesthetic and the doctor cutting Master B's skin). During the procedure, Mrs B sat in the waiting room and she recalls hearing her son yelling out, in what she believed was pain. She became so distressed by this that her brother took her out to his van so she could not hear Master B's cries. Mr B recalls Master B telling him during the procedure that he "could feel everything they are doing and it is really painful". Mr B also claims that, in response to Dr C "yelling and shouting at [Master B] for shaking his legs", Master B asked his father, "But dad what can I do, it's really painful". According to Mr B, Master B was begging and crying with pain. Mr B asked Dr C why Master B was in so much pain and recalls Dr C then giving Master B another injection, which Mr B believes was more anaesthetic.

Dr C believes that Master B was fearful and anxious but not in any pain. Dr C advised HDC that he waited eight to 10 minutes for the local anaesthetic to take effect, and before commencing the procedure he checked the effectiveness of the anaesthetic by touching Master B's foreskin with forceps to see if he winced. Dr C explained that he again checked the effectiveness of the anaesthetic part way through the operation using this method, and satisfied himself that the anaesthetic was working. He admitted that he found it difficult to ascertain whether Master B's reaction was due to pain or anxiety, but he was confident that the anaesthetic had worked.

[3] Rapid heart rate.
[4] Dr G's operation notes state: " … the large ?monocryl sutures which have been employed were removed …".
[5] Dr C does not recall Mrs B being present when he administered the anaesthetic.

Dr C believes Master B's anxiety and distress was due to fear of the unknown and his parents' reaction to the situation:

> "During the procedure [Master B] sat up and was shouting 'what are you doing with me' which was more of fear of the child than the pain. Throughout this time, [Master B] was looking around and highly anxious and irritable, which I believe was primarily caused by the conduct of both the parents."
>
> …
>
> "Obviously I could not have started the procedure immediately [after injecting the anaesthetic] save to say that no child could have allowed a doctor to commence the procedure had he not been numb, not to talk about cutting and suturing, an ordeal as portrayed by these complaints. I checked the reaction and the numbness with the forceps on the foreskin looking at the face of the child if he is wincing with pain as it could not be judged due to his irritable behaviour. This is the normal procedure after giving the child a ring block with Xylocaine."

When asked whether he thought the anaesthetic might have worn off during the procedure, Dr C was initially adamant that the anaesthetic worked throughout the procedure and did not wear off at any point. However, in his clinical notes it states "… the effect went off, local given again …". Dr C subsequently advised HDC that he administered a second dose of anaesthetic after he inserted three stitches because "it was at this point that Master B was becoming particularly distressed".

Dr E

Dr E was also involved in the procedure, but there are conflicting accounts of his exact role.

Dr E is an overseas registered doctor who is not registered in New Zealand. He graduated with a Bachelor of Medicine and Bachelor of Surgery. After nine years working, he commenced studying towards a Masters in Urology. He moved to New Zealand to join his wife, a student. As Dr E was not a registered doctor in New Zealand he worked in a non-medical position while he studied towards his Australian Medical Council examination. It was at this time that he was introduced to Dr C by a neighbour, who suggested Dr C might be able to provide him with valuable support and advice in preparation for the exam.

Dr C provided the following information about Dr E:

> "[Dr E] is currently sitting for his AMC [Australian Medical Council] examination. I as a fellow colleague am supporting and acting as his mentor for the examination. I offered my Saturday afternoons to assist him in the preparation for [his] AMC examination. He is not associated or connected to

> this practice at all. On that day, being a Saturday,[6] [Dr E] was here as usual at 2pm when the surgery usually closes and then I sit with him with a view to assist in preparation for his upcoming examinations."

Dr C explained that Dr E became involved early on in the procedure, when Master B became restless during the administration of the local anaesthetic. Dr C advised HDC that he called Dr E into the room to hold Master B's legs still, so that he could complete the administration of the anaesthetic, and that Dr E remained in the room until the end of the procedure. Dr C describes Dr E's role as follows:

> "In normal circumstances I utilize the parents to assist in calming the patient during the procedure.[7] In this instance as I was unable to get any help from the parents due to the anxious state of both the parents I asked [Dr E] to assist in calming the patient down. I performed the surgical procedure and at no time was [Dr E] doing anything other than holding the patient's leg still under the supervision of myself …"

Dr C advised HDC that the "golden rule of thumb" is for the surgeon to stand on the patient's right-hand side. He advised that he stood on Master B's right-hand side throughout the procedure and Dr E stood immediately opposite him, on Master B's left-hand side. Dr C is "unequivocal that he alone carried out the surgical procedure".

Dr E claims that he was called into the room by Dr C after Master B had been in there for "about half an hour". He states that at this point "[Dr C] had almost completed the procedure" and he assisted for five to six minutes. He also recalls that when he entered the room, Mr and Mrs B were not present.

Mr and Mrs B, who were not aware of Dr E's identity at the time, described Dr E as follows:

> "There were two people doing the operation. One was the doctor himself and the second person was an unprofessional person who didn't look like a doctor in any way and we just found out today 27th January 2009 that he was not a New Zealand registered practitioner. He is not even working at any of the clinics in New Zealand. I assure [you] that he was the main man doing the operation who shouldn't be doing it if not registered. We were definitely not told about him."

While the family are certain that Dr E was the actual person doing the operation, a curtain dividing Master B's top and bottom half prevented them from seeing exactly what he was doing. Mr B described how he and Mrs B stood at the top half of the curtain by Master B's head and the two doctors stood lower down the bed on the other

[6] Master B's procedure took place on a Friday evening. This was put to Dr C, who then explained that Dr E would normally come to the clinic on a Saturday, but on this particular week he had asked him to come in on Friday as he was going to be busy that Saturday.

[7] Mr and Mrs B advised HDC that Dr C told them that he does not normally allow parents in the operating room while carrying out circumcisions; however, at Mr B's insistence, he allowed them into the room.

half of the curtain. Mr B recalls that Dr C was standing on Master B's left side, by Master B's feet, and the "other man" was facing Dr C on Master B's right side.

Mrs B recalls seeing Dr E leaning over Master B and then standing back up. She suspects he injected the local anaesthetic and started the cutting. She also recalls seeing Dr E holding a needle and blood on his hands. Dr E advised HDC that Dr C gave him the needle to hold so Dr C could "relax the mother", who was crying. He advised HDC:

> "Some blood was … [stuck] on my hand while [Dr C] asked me to sweep the blood with a gauze piece."

Dr C also provided an explanation for the blood on Dr E's hands. He advised HDC that if Dr E had bloodied hands:

> "this could only have been as a result of him clearing away bloodied bandages … or perhaps from picking up a surgical implement which may have fallen to the floor".

Mr B recalls seeing Dr E leaning over Master B, at which point Master B started crying. Mr B asked Dr E why Master B was crying. Dr E advised that he did not know as he had not done anything yet. Mr B also recalls seeing Dr E moving around the room and going to the bench with the operating equipment on it and returning to where Master B was. It looked to Mr B as though Dr E was doing most things while Dr C was "just standing there". Master B's uncle, who was in the operating room for a short while helping Mr B comfort Master B, claims that he saw Dr E put in two stitches.

Mrs B recalls being phoned by someone at the Medical Clinic on the day of the appointment (23 January). She was told that another person would be present at the operation but she was not provided with any information about the role of the second person, his qualifications or that he would carry out procedures on their son.

However, Dr C advised HDC that Dr E was not mentioned to the family prior to the appointment because there was no expectation that he would have any involvement in the procedure. Dr E was at the clinic pursuant to the mentoring arrangement he had with Dr C, and he became involved with the procedure only once it became clear that Mr and Mrs B would be unable to provide Dr C with the assistance he required to hold Master B still.

Length of the procedure

In their letter of complaint, Mr and Mrs B stated that the procedure took over an hour. Dr C initially advised HDC he thought the procedure took 28–30 minutes, but subsequently advised that the procedure took no longer than 45 minutes.

The ambulance that was called to take Master B to hospital was dispatched at 7.37pm. This was nearly two hours after the procedure commenced.

Contact after the event
Mr B telephoned Dr C the following day and Dr C apologised to him. Mr B advised that he intended to make a complaint and asked Dr C about the other man in the operating room. Dr C refused to give any details, and advised that the "other man" was "practising under my umbrella". When Mr B enquired whether the "other man" was a registered New Zealand doctor, Dr C advised that he was not.

Dr C called Mr and Mrs B on or about 21 February 2009. Dr C asked if he could meet with them to discuss the event. Mr and Mrs B declined as they did not wish to see Dr C. Dr C apologised, saying he was very sorry for what had happened.

Dr C initially advised HDC that, in future, if he is not familiar with the child, he will ask parents wanting a circumcision for their son to see their own GP. He also stated that this case has highlighted the impact a parent's anxiety can have on the patient and that "all future circumcision consultations will highlight this point to prevent a repeat of the transfer of anxiety from parent …". Dr C advised that since this event he has adopted a new technique that reduces bleeding.

However, Dr C commented that the procedure carried out at the clinic was "successful and done in the manner prescribed". He advised HDC:

> "The patient in question is fine and once the bleeder was secured everything was fine. In fact it was not a procedural problem of any kind whatsoever, merely the inability of the patient to remain calm for the last stitch all of which was aggravated by the anxiety of the parents …"

The family disagree with Dr C that the procedure was a "success". In making their complaint they stated:

> "… [T]he only request and plea we have for the Commissioner is to investigate this matter and stop [Dr C] from practising circumcisions completely. He has no right to [cause] pain and grie[f] to people if he does not know how to do his job properly."

Dr C's response
After reviewing the provisional opinion, Dr C acknowledged that he should not have performed the circumcision in the circumstances; and that he failed to provide Mr and Mrs B with adequate information regarding the options for anaesthesia and the associated complications. He also advised HDC that he has stopped performing circumcisions, and that he has provided a voluntary undertaking to the Medical Council of New Zealand to refrain from undertaking circumcisions.

Dr C "is deeply distressed by, and sincerely regrets the trauma suffered not only by Master B, but also by his parents". He advised HDC that he "continues to reflect on this whole incident and the implications for his clinical practice generally".

Dr C has also recently been subject to a competence review undertaken by the Medical Council. The review focused on issues of communication with patients and consenting procedures, but did not assess his surgical techniques relating to

circumcision. Dr C's performance was rated as acceptable. The Performance Assessment Committee noted:

> "[Dr C] has a large practice and the corresponding workload is high. The review found minor issues relating to incomplete documentation in the clinical notes and more substantial issues relating to inadequacy of a generic consent form."

Dr C advised that "he will be amending the generic consent form to incorporate the additional elements which the Committee recommended".

Relevant standards

1. The Royal Australasian College of Physicians Policy Statement on Circumcision (2004)[8]

2. Guidelines for Circumcision — The Australasian Association of Paediatric Surgeons (1996)[9]

Opinion: Breach — Dr C

Standard of care

On 23 January 2009 Dr C, assisted by Dr E, performed a circumcision under local anaesthetic on Master B (aged four years). Master B was distressed throughout the procedure and Dr C was unable to complete the surgery owing to Master B's anxious state.

There are two issues for determination: whether the decision to perform the circumcision in the first place was reasonable; and whether the procedure was carried out in accordance with appropriate standards.

Decision to perform a circumcision under local anaesthetic

When assessing the "reasonableness" of decisions or actions, the starting point involves a consideration of what the generally accepted practice is amongst the health practitioner's peers.

In the case of circumcisions on boys aged between approximately six months and eight years old, the generally accepted practice is for the procedure to be carried out

[8] Attached as **Appendix 2**.
[9] Attached as **Appendix 3**.

under general anaesthetic. As the Royal Australasian College of Physicians Policy Statement on Circumcision[10] states:

> "In Australia circumcisions undertaken in boys older than six months are mostly performed under a general anaesthetic, with local anaesthetic often being administered during the general anaesthetic."

Dr Young advised that the usual practice is the same in New Zealand and explained why this practice applies:

> "… [I]t is very difficult to satisfactorily administer local anaesthetic to a child outside the infant period, especially after one year of age. A young infant can be easily controlled while local anaesthetic is administered to make the penis numb. Over one year of age the ability to adequately control the child to get a satisfactory penile block becomes much more difficult. At four years of age it is usually extremely difficult. The reason for this being that a four year old will be quite strong physically and will struggle against the pain of the penile injections. At the age of four years they are usually not old enough to understand the implications of getting a local anaesthetic so therefore will not voluntarily cooperate with the giving of local anaesthetic by injection. This lack of cooperation can lead to an incomplete penile block. This in turn would result in pain being felt during the procedure, with probable further struggling and increased risk of complications during the procedure. Even if the penile block has worked they still may be so upset by the injection procedure as to be completely non cooperative for the remainder of the procedure."

Dr G, the paediatric surgeon who operated on Master B at the hospital, agrees with Dr Young's reasoning:

> "In my opinion, performing circumcisions without general anaesthetic on children would be problematic in view of the distress of young children, which would make their compliance with the procedure difficult."

It is clear that Dr C's decision to proceed under local anaesthetic on a four-year-old was outside generally accepted practice. However, this alone is not conclusive of unreasonableness (although it is strongly suggestive of it). It is necessary to consider Dr C's decision in the context of the surrounding circumstances.

Surrounding circumstances

When asked about his knowledge of the Royal Australasian College of Physicians' Policy Statement on Circumcision, Dr C replied that he had read it but did not know the whole process because he is more of an "[Emergency Department] person". This is of concern given his statement that he performs around 60 circumcisions per year.

Dr C failed to advise Mr and Mrs B that his decision to carry out the procedure on Master B under local anaesthetic was in contravention of generally accepted practice

[10] See Appendix 2 at page 35. The Policy Statement represents an agreed position adopted by a number of organisations including the New Zealand Society of Paediatric Surgeons, the Paediatric Society of New Zealand, and the Urological Society of Australasia.

(discussed further below under "Information"). I agree with Dr Young's advice that Dr C should have specifically advised the family that the recommended practice for boys of this age was for the procedure to be performed under general anaesthetic, and explained the reasons for this recommendation.[11] As Dr Young notes, if Mr and Mrs B still wished to proceed using local anaesthetic, Dr C should have clearly documented his advice to the family and the reasons for their decision.

I am also concerned that more care was not taken by Dr C when determining whether Master B was a suitable candidate for the proposed procedure. I note Dr Young's advice that, in deciding whether to proceed with a circumcision under local anaesthetic (as opposed to general anaesthetic), it is common to have age-based selection criteria to guide decision-making.

Dr C advised that while he does not refer to specific selection criteria, he does have a process which he follows when deciding whether a particular child is suitable to undergo the procedure. Dr C identified children aged seven months to 12 years as a "very vulnerable age group". In those cases, he requires the child to come in for an assessment prior to the circumcision. At the preoperative assessment Dr C undertakes a physical examination of the child and obtains a clinical history to ensure there are no risk factors that would rule out or contraindicate the child as a suitable candidate for circumcision. Dr C also takes into account what he knows about the child's demeanour from the months or years that he has known the child, as the potential for difficulties and complications are greatly reduced if the child is cooperative throughout the procedure.

In this case, Dr C considered Master B to be suitable for the procedure. This was despite Master B's foreskin being "very much adherent" and Dr C not knowing Master B or his parents. As Dr Young notes, this was inconsistent with Dr C's selection criteria. Dr C had no way of knowing how Master B would react. In these circumstances, Dr C should either have refused to carry out the procedure (and discussed alternative options with the family) or at least ensured Mr and Mrs B were aware of the increased risk of complications should Master B not cooperate.

If Mr and Mrs B still wished to proceed after being made aware of the potential difficulties, Dr C had a duty to ensure he had adequate back-up support should complications arise. Dr C advised HDC that he received surgical back-up support from Dr H. However, Dr H is not vocationally registered in New Zealand as a specialist and is only permitted to practise in New Zealand in a collegial relationship.[12] Accordingly, he is not qualified to provide collegial support to Dr C under Medical Council of New Zealand rules.

In these circumstances, I consider that Dr C's decision to proceed with the operation was unreasonable. It was in contravention of generally accepted practice, and he failed to advise Mr and Mrs B of this. Dr C also failed to follow his own selection criteria when assessing whether Master B was a suitable candidate (which resulted in

[11] The seriousness of Dr C's omission is exacerbated by the fact that Mrs B specifically raised the possibility of general anaesthetic with Dr C, but this option was dismissed by him.
[12] Dr C advised HDC that he mistakenly believed Dr H was vocationally registered in New Zealand.

an inappropriate selection), and he did not ensure he had adequate support should complications arise during the procedure. I consider that Dr C breached Rights 4(1),[13] 4(2)[14] and 4(3)[15] of the Code, as he himself accepts.

The procedure itself

I am not convinced that Master B was adequately anaesthetised. Both Mr and Mrs B have described Master B yelling out in pain, and telling his father that he "could feel everything they are doing and it is really painful".

In addition, Dr C has described how Master B was restless before and during the administration of the local anaesthetic. As pointed out by Dr Young, this lack of cooperation can lead to an incomplete penile block, resulting in pain being felt during the procedure.

Dr Young has also questioned the adequacy of Dr C's method for determining whether the anaesthetic had worked, referring to Dr C's own account:

> "[Master B was pining] and fearful and moving his legs erratically. I checked with the forceps whether the foreskin was anaesthetised and was satisfied that was the case which was difficult in this case but I check[ed] if the child was wincing …"

Dr Young does not believe that it would have been possible to be confident in these circumstances "that the child is completely pain free, and even if the penile block is working".

Furthermore, in reference to the anaesthetic, Dr C's clinical notes state that "… the effect went off, local given again …".

I conclude that Master B was inadequately anaesthetised for the procedure and, as a consequence, suffered pain that contributed to his lack of cooperation during the procedure. Given Master B's clearly agitated state, I agree with Dr Young's conclusion:

> "It would have been reasonable to consider the options; whether it was clinically appropriate and safe to continue and … at least ask the parents if they wished to continue at this point."

By choosing to continue with the procedure, despite Master B's obvious pain and distress, Dr C gave insufficient consideration to Master B's physical and emotional needs.

Another issue of concern is the amount of force used to keep Master B still during the procedure. Dr C admits that he sought assistance from Dr E to hold Master B's legs

[13] "Every consumer has the right to have services provided with reasonable care and skill."
[14] "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[15] "Every consumer has the right to have services provided in a manner consistent with his or her needs."

still during the procedure, and it can be inferred from his account that Dr E had to use all his strength to try to restrain Master B:

> "… [Dr E] held the buttocks together and the knee but in spite of that it was hard, he's not a really strong guy. It is really difficult because the pelvic muscles are tough and forearm muscles are not that strong."

As Mrs B describes it, Master B was being held "as if they were holding a wild animal. His thighs were all painful …"

The point of excessive force is discussed by Dr Young in the context of Dr C's training:

> "[Dr C's] surgical training was outside New Zealand and what may be an acceptable standard outside New Zealand with respect to paediatric circumcisions using local anaesthetic may not be an acceptable standard in New Zealand. In particular the amount of 'force' that is reasonable to conduct the procedure under local anaesthesia and the rights of the patient/parents to be fully informed as part of the consent process."

I agree that the force used to keep Master B still was not reasonable. Dr C should have consulted preoperatively with Mr and Mrs B about the appropriate level of force to be used and what the options were if more force was required to restrain Master B.

Another matter of concern is Dr C's choice of sutures for the procedure. Although it is unclear exactly what type of sutures were used, Dr G recalls (and this is confirmed by his operation notes) that the sutures were unusually large for the procedure. Dr Young advised that the sutures used by Dr C (as described by Dr G) were "inappropriate for childhood circumcision", causing him to question Dr C's knowledge of basic surgical principles:

> "The use of such large sutures in attempting to secure haemostasis in the fine tissue that is found in the frenulum area of the penis of a [four-year-old] had a very high likelihood of failure. It indicates to me a lack of basic understanding of surgical technique and principles involved in securing bleeding during circumcision."

This raises questions over Dr C's surgical knowledge and competence, which require further investigation.

Dr C's response to the initial complaint was that the operation had been a success and that he acted reasonably, stating that "the procedure was successful and done in the manner prescribed". As Dr Young rightly points out, the procedure could not be described as a success, if only for the fact that Dr C was not able to complete the procedure himself.

Yet Dr C initially claimed that he was not responsible for the difficulties encountered during the procedure:

> "The procedure that I am doing I have been doing all this time in fact, the results speak for itself. The patient in question is fine and once the bleeder was secured everything was fine. In fact it was not a procedural problem of any kind whatsoever, merely the inability of the patient to remain calm for the last stitch all of which was aggravated by the anxiety of the parents …"

I agree with Dr Young that it is inappropriate to hold Master B or his parents responsible in this case:

> "The surgeon performing circumcision under local anaesthetic is responsible for all aspects of the surgery including anticipating the problems that may be faced at all steps of the procedure and how to adequately deal with each potential problem that may be encountered. All this I would consider part of the 'procedure'. It is unfair to attribute any blame whatsoever for the procedure not going to plan to the patient or the parents in this case."

To his credit, Dr C later acknowledged, after reviewing the provisional opinion, that he had breached the Code by opting to carry out the procedure under local anaesthetic, given Master B's age and the adherence of his foreskin.

In summary, Dr C failed to provide services of an appropriate standard. He was unable to obtain a penile block; his method for determining whether the anaesthetic had worked was inadequate; he failed to consult Mr and Mrs B and reassess the situation once it became clear that Master B was in pain, distressed and was not going to cooperate; he used unreasonable force to restrain Master B during the procedure; and he used inappropriate sutures in his attempts to stem the bleeding. Accordingly, Dr C breached Rights 4(1), 4(2) and 4(3) of the Code, as he himself accepts.

Information

Rights 6(1)[16] and 6(2)[17] of the Code place duties on providers to give the consumer[18] the information that a reasonable consumer, in that consumer's circumstances, would expect and would need to receive to make an informed decision.

The reason why informed consent matters is well explained by the Medical Council in its Statement on Information and Consent:[19]

> "Trust is a vital element in the patient–doctor relationship and for trust to exist patients and doctors must believe that the other party is honest and willing to provide all necessary information that may influence the treatment or advice. The doctor needs to inform the patient about the potential risks and benefits of

[16] "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"
[17] "Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent."
[18] As Master B was an incompetent minor, his parents could consent to medical treatment on Master B's behalf. Therefore the "consumer" for the purposes of informed consent was Mr and Mrs B.
[19] Medical Council of New Zealand. *Information and Consent*. Wellington: Medical Council of New Zealand; 2002.

> the proposed treatment and let the patient know that his or her welfare is the paramount concern."

It is not known exactly what was said at the preoperative appointment on 7 January, but it is likely that Dr C touched on the general risks of any surgery (infection and bleeding), as he does "for every patient". However, he did not draw to the family's attention the fact that, given Master B's age, there was an increased risk of complications occurring during the procedure, nor what those complications were. Nor did he advise the family that it is usual practice for boys aged over six months to have the procedure carried out under general anaesthetic. This was despite Mrs B requesting that Master B be "put to sleep" for the operation as she did not want him to suffer any pain. Rather than use Mrs B's request as an opportunity to discuss the option of general anaesthetic, Dr C told the family that Master B would not be put to sleep and that local anaesthetic would be used to numb the area, and he reassured them that Master B would not feel any pain.

Dr Young advised what further information Dr C should have given Mr and Mrs B in these circumstances:

> "Pre-operatively [Mr and Mrs B] should have been specifically advised that circumcision on a [four-year-old] under local anaesthetic is not recommended and the reasons for this detailed. If [Mr and Mrs B] still wished to consider proceeding under local anaesthetic then [Dr C] should have clearly explained the critical clinical hurdles that would have to be achieved before proceeding."
>
> …
>
> "[The information provided to the family] should have included specific reference to the difficulty in injecting local anaesthetic into a [four-year-old] to achieve satisfactory penile block, [h]ow a successful penile block would be determined, and the options if successful block was not achieved and/or [Master B] was too upset to proceed."
>
> …
>
> "They were not adequately prepared for the possibility that their son may struggle and need to be restrained through the procedure. They were not informed of their options if they felt that continuing the procedure would be too traumatic for their son or themselves. They were not fully informed that one of the complications of proceeding with circumcision on a less than fully cooperative child may be the inability to achieve adequate control of bleeding."

These are significant issues about potential risks and alternative options that would clearly have had an influence on Mr and Mrs B's decision. It is information that reasonable parents, in the family's circumstances, would expect, or need, to be made aware of, in order to make an informed choice, and give informed consent. It is no answer to say Mr and Mrs B had signed a consent form acknowledging that they were

"welcome to ask for more information if they wish". As Dr Young points out, the family could not be expected to have anticipated or considered any of these potential problems unless they were specifically brought to their attention.

In these circumstances, Dr C had a duty to inform Mr and Mrs B of the increased risk of complications and what those complications were, and bring to their attention the recommendation that the procedure be carried out under general anaesthetic. He accepts that he failed to do so. Accordingly, Dr C breached Rights 6(1) and 6(2) of the Code. It follows that Mr and Mrs B did not give informed consent for Dr C to operate on Master B, and Dr C also breached Right 7(1)[20] of the Code. Dr C accepts that he breached these provisions of the Code.

Opinion: Breach — The Medical Clinic

Pursuant to section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for an employee's failure to comply with the Code. Section 72(5) of the Act provides a defence where the employing authority can prove that it took such steps as were reasonably practicable to prevent the acts or omissions in question.

Dr C is employed by the Medical Clinic, and accordingly the company is vicariously liable for Dr C's breach of the Code unless it can prove that it took such steps as were reasonably practicable to prevent Dr C from breaching the Code.

I received no evidence from Dr C or the Medical Clinic to suggest that the company took any steps to prevent Dr C's breaches of the Code in relation to his standard of care. In relation to the issue of informed consent, I am not satisfied that the consent form used by Dr C was adequate to ensure Mr and Mrs B were provided with sufficient information to give their consent to the procedure. In these circumstances, I conclude that the Medical Clinic is vicariously liable for Dr C's breaches of the Code.

[20] "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

Opinion: Breach — Dr E

I have received conflicting accounts as to the extent of Dr E's involvement in the procedure. Dr C claims Dr E did nothing more than restrain Master B once it became apparent Mr and Mrs B would not be able to assist. Mr and Mrs B claim Dr E was "the main man doing the operation".

I have carefully considered all the information provided to me. A number of points suggest that Dr E provided medical services during the procedure, and that his role was not limited to assistance in restraining Master B.

1. There are four witnesses (Mr and Mrs B, Mrs B's brother and Ms D) who claim Dr E was in the operating room from the beginning.[21] Three of these four are sure Dr E was the "main man doing the operation".[22]

2. It is difficult to see why Mr and Mrs B would manufacture this information. It is clear from their letter of complaint that their only concern is to ensure that other boys and their families do not have to go through what they went through:

   "… [T]he only request and plea we have for the Commissioner is to investigate this matter and stop [Dr C] from practising circumcisions completely. He has no right to [cause] pain and grie[f] to people if he does not know how to do his job properly."

3. Dr C and Dr E have given differing accounts of when Dr E became involved in the procedure. Dr E said he was called in to hold Master B's legs at the end of the procedure when Dr C was attempting to insert the stitches (after Master B had been in the operating room for about half an hour), and that he was in the room for five to six minutes. Dr C, on the other hand, said he had to call Dr E in to hold Master B's legs so he could administer the local anaesthetic (at the start of the procedure) and that Dr E remained in the room from that point on.[23]

4. The day following the surgery, Mr B telephoned Dr C to find out Dr E's details. Mr B claims that Dr C refused to give him Dr E's name or other details and said that Dr E was "practising under my umbrella". The refusal to be open and frank with Mr B about Dr E's identity suggests that Dr E's involvement

[21] Dr C and Dr E claim that Dr E did not enter the room until after the procedure had started.
[22] Mrs B's brother claims he saw Dr E with a needle in his hand and that Dr E put in two stitches. Mr B claims that he saw Dr E lean over Master B (his view was obscured by a curtain) at which point Master B started crying. He also recalls seeing Dr E moving around the room to get "operating equipment" from a bench and returning to Master B. Mrs B also recalls seeing Dr E leaning over Master B and noted that Dr E had blood on his gloves and was holding a needle. Ms D recalls Dr E being in the operating room from the beginning; however, she believes he was only in there to "observe" as a "case study" in preparation for his exams.
[23] Further questions are raised when Dr E's account is read with Dr C's statement that Dr E stayed in the room until the end of the procedure. This suggests that the procedure took only 35–36 minutes. Yet the procedure took nearly two hours (evidenced by when the ambulance was called).

was not as innocent as Dr C claims. The words "practising under my umbrella" also suggest that Dr E was doing more than helping out when a difficulty arose.

5. Mr B recalls that Dr E was standing on Master B's right-hand side. Dr C advised that the "golden rule of thumb" is that the person doing the procedure stands on the patient's right-hand side.

6. I have some reservations about Dr E's credibility. Dr E claimed that when he became involved, the procedure had been completed, and that "there was some oozing but no bleeding". He did not think there was any medical problem and claimed that the only reason help was sought was because the parents demanded that an ambulance be called. However, this is not consistent with the operation notes from the Hospital, which state the following:

   "Findings: Significant bleeding particularly from the frenulum which was not amenable to conservative management with pressure dressing."

   In addition, Dr G, the paediatric surgical fellow at the Hospital who operated on Master B, noted the following:

   "I judged that the bleeding was too profuse to be stopped with local pressure alone and hence arrangements were swiftly made to proceed to perform haemostasis under general anaesthetic."

Finding of fact

Taking into account all the above factors, I consider that Dr E's involvement in Master B's circumcision procedure was greater than providing assistance to keep Master B still. I conclude that he took an active role in the procedure and, specifically, that he provided medical services, even though he was not registered as a medical practitioner in New Zealand.

Other than Mrs B's recollection that she was told another person would be present, Mr and Mrs B were not informed that Dr E would be in attendance during the operation, what his role would be, or that he was not registered in New Zealand. Consequently, they were not able to make a choice about his involvement.

Referral to Medical Council

I will refer this report to the Medical Council of New Zealand and the Ministry of Health to consider what further action is necessary in light of my finding that Dr E provided medical services to Master B even though he was not registered as a medical practitioner in New Zealand.

Referral to Director of Proceedings

Under section 44(2) of the Health and Disability Commissioner Act 1994, I am required to consider the wishes of the complainant, any comments from the provider, and the public interest (including public safety) before referring a provider found in breach of the Code to the Director of Proceedings.

Mr and Mrs B support referral of Dr C to the Director of Proceedings.

Dr C accepts that he breached the Code, but invited the Commissioner to refrain from referring him to the Director of Proceedings. His legal counsel, Bill Manning, submitted:

> "The following matters may … be relevant to the Commissioner's review:
>
> 16.1 [Dr C's] initial written response to the Commissioner was provided on the advice of a layperson at a time when [Dr C] was very distressed by the complaint and the ensuing investigation. In hindsight he deeply regrets the intemperate tone and contents of that letter. He now has an insight into the matter, prompted it would seem by his review of the Commissioner's provisional report including Dr Young's advice.
>
> 16.2 [Dr C] has provided a voluntary undertaking to the Medical Council to refrain from performing circumcisions.
>
> 16.3 The Medical Council has undertaken a competency review of [Dr C's] general practice. The report of the review is expected shortly.
>
> 16.4 [Dr C] is deeply distressed by, and sincerely regrets the trauma suffered not only by [Master B], but also by his parents.
>
> 16.5 Although he has terminated his circumcision practice, [Dr C] continues to reflect on this whole incident and the implications for his clinical practice generally."

Mr Manning also submitted:

> "One important factor which the Commissioner must consider when addressing the question of referral to the Director of Proceedings, is the safety of the community served by the doctor. It is submitted that the combination of the [Medical Council Performance Assessment Committee] report, [Dr C's] willingness to provide a permanent undertaking to refrain from circumcision surgery, and the insight he has demonstrated, provides substantial reassurance in terms of the safety and quality of [Dr C's] general practice. Indeed, the report is testament to the value of his practice (which has grown from 700 to

> 1200 patients) to what the Committee described as a 'multicultural area of low decile demographics'."

I accept that a referral to the Director of Proceedings is not necessary for public safety reasons, given the outcome of the Medical Council's competence review of Dr C's general practice, and his voluntary undertaking not to perform circumcisions.

However, the breaches in this case were serious. I note in particular the lack of adequate preoperative information for the parents, the inappropriate decision to perform a circumcision on a four-year-old boy under local anaesthetic, and the poor quality of the surgical and anaesthetic services provided during the procedure. Nor did Dr C's initial response to the complaint and investigation do him credit.

I accept that Dr C is now genuinely contrite and willing to put things right. Nonetheless, I consider that there is an important public interest in consideration by the Director of Proceedings of the case for further proceedings against Dr C — both for purposes of accountability and for setting standards.

Accordingly, I intend to refer Dr C to the Director of Proceedings.

Recommendations

I recommend that Dr C:

- review his informed consent procedures to ensure patients and their parents are made aware of the options available to them and the risks of each option;
- if he intends to resume undertaking circumcisions, review his patient selection process for circumcision in conjunction with the Royal Australasian College of Physicians Policy Statement on Circumcision, giving particular consideration to whether he should undertake circumcisions on boys aged older than six months.

Follow-up actions

- Dr C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Medical Council of New Zealand to consider what further action is necessary in relation to Dr C and Dr E.

- A copy of this report will be sent to the Ministry of Health to consider what further action is necessary in relation to Dr E.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal New Zealand College of General Practitioners, the DHB, and the Primary Health Organisation for the Medical Clinic, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to issue proceedings.

Appendix 1 — Independent general practice advice

The following expert advice was obtained from general practitioner Dr Gerald Young:

"I have been asked to provide an opinion to the Commissioner on case number 09/00810. I declare that I have read and agree to follow the 'Guidelines for Independent Advisors'.

In preparing independent advice on this case to my knowledge I have no personal or professional conflicts of interest.

My qualifications are B.H.B, MB,Ch.B.(Auckland), FRNZCGP. My training included 3 years as a surgical registrar in the Auckland Surgical training programme. I have been in general practice for 20 years. I have a special interest in surgical procedures in general practice, including circumcisions under local anaesthetic.

I have been asked to consider the issues as listed below:

- To provide independent expert advice about whether [Dr C] and [the Medical Clinic] provided an appropriate standard of care to [Master B].
- The appropriateness of the care provided by [Dr C] and [the Medical Clinic] to [Master B] on 23 January 2009.
- The adequacy of the information provided by [Dr C] to [Mr and Mrs B].

[At this point in his report, Dr Young sets out the questions asked of him, which he repeats in his report. This detail has been omitted for the purpose of brevity.]

My opinions and advice to the Commissioner on this case has been based on the documents supplied:

1. Complaint (pages 1–6)
2. Notification letter to [Dr C] (pages 7–9)
3. Notification letter to [the Medical Clinic] (pages 10–11)
4. Response from [Dr C] (pages 12–28)
5. File note of interview with [Dr C] (pages 29–43)
6. File note of interview with [Mr and Mrs B] (pages 44–47)
7. Clinical records from [the] DHB (pages 48–84)
8. Letter to [Dr G] (paediatric surgeon at [the hospital]) requesting information and his response (pages 85–87)
9. Statement from [Dr F] (on call surgical registrar at [the hospital]) (pages 88–89)
10. [Master B's] incident report form from [the] Medical Clinic (page 90)
11. Complaints procedure for [the] Medical Clinic and [the] PHO (pages 91–103)

Additional documents used for reference

12. Policy Statement on Circumcision Paediatric and Child Health Division, The Royal Australasian College of Physicians Sept 2004
13. New Zealand Medical Council Registration Register (on-line)

[At this point in his report, Dr Young sets out the facts of the case. This detail has been omitted for the purpose of brevity.]

Specific expert advice requested:

1. **Comment generally on the standard of care of care provided by [Dr C] and [the Medical Clinic] to [Master B] on 23 January 2009.**
Based on the information available an appropriate standard of care was not provided to [Master B]. There was a moderate departure from the standard of care that would be expected. The reasons for this finding are further detailed in the answers to the additional questions below.

2. (a) **The decision to perform a circumcision on a four-year-old under local anaesthetic.**
The decision to perform a circumcision on a four year old under local anaesthetic is outside the general guidelines as outlined in the "Policy Statement on Circumcision" by the Royal Australasian College of Physicians 2004. The clinical reason for this recommendation is that it is very difficult to satisfactorily administer local anaesthetic to a child outside the infant period, especially after one year of age. A young infant can be easily controlled while local anaesthetic is administered to make the penis numb. Over one year of age the ability to adequately control the child to get a satisfactory penile block becomes much more difficult. At four years of age it is usually extremely difficult. The reason for this being that a four year old will be quite strong physically and will struggle against the pain of the penile injections. At the age of four years they are usually not old enough to understand the implications of getting a local anaesthetic so therefore will not voluntarily cooperate with the giving of local anaesthetic by injection. This lack of cooperation can lead to an incomplete penile block. This in turn would result in pain being felt during the procedure, with probable further struggling and increased risk of complications during the procedure. Even if the penile block has worked they still may be so upset by the injection procedure as to be completely non co-operative for the remainder of the procedure.

   (b) **The circumstances in which a patient should be referred to a urologist to perform a circumcision.**
Referral to a urologist to have circumcision done under general anaesthetic should be discussed as an option in all circumcisions. It should become a recommendation when the parents still wish to proceed with a circumcision when local anaesthetic is not advised. Circumcision on a four year old would generally fall into this category.

(c) The adequacy of [the] Medical Clinic's selection process for circumcision procedures.

In the information reviewed from [the] Medical Clinic there was no documentation of any general selection or exclusion criteria based on the age of the child. It is common to have general age-based criteria for determining the suitability of a child for circumcision under local anaesthetic.

At the interview with [Dr C], he appeared to identify the age group of 7 months to 12 years as a 'very vulnerable age group.' [Dr C] advised that he still performed circumcision in this age group, in particular 'when I know the child' however [Master B] was a casual '… walk in patient.'

There appears from the information reviewed, a degree of inconsistency in the selection process of appropriate cases for circumcision under local anaesthetic by [Dr C]. In this case this inconsistency has resulted in an inappropriate selection.

(d) The adequacy of [the] Medical Clinic's clinical support available in the event of a complication during a circumcision procedure.

[Dr C] stated that he has clinical support from Dr H, '… a paediatric plastic surgeon'. I note that from the New Zealand Medical Council records, [Dr H] is not vocationally registered in New Zealand as a specialist and must only practice in New Zealand in a collegial relationship. [Dr I][24] is also not vocationally registered in New Zealand and must only practice in New Zealand in a collegial relationship. I am not able to independently verify their clinical experience or skill in New Zealand or overseas. However both [Drs H and I] are not vocationally registered and therefore they are not qualified to be providing collegial support to [Dr C] under New Zealand Medical Council rules. Under Medical Council rules this level of support is not appropriate.

The fall-back position of using the specialist services at the Public Hospital is available to all practitioners.

(e) The adequacy of [Dr C's] training and experience in circumcisions.

The only independent verification of paediatric surgical training is from the Institute of Medical Sciences. This letter verifies that [Dr C] worked as a 'junior Resident in Paediatric Surgery from 1-1-1983 till date' which was dated 23-07-1983, a period of 7 months. There was no specific indication of circumcision training. The other information regarding surgical training has been provided by [Dr C] himself.

Therefore I am unable to comment on the adequacy of his circumcision training and experience based on the information provided.

(f) The adequacy of [Dr C's] professional development / continuing education of circumcision procedures.

I have a number of concerns relating to [Dr C's] surgical skills in this case. In particular it was reported by the Paediatric surgical Fellow, [Dr G] that he

[24] Dr C advised HDC that Dr H and Dr I are the medical practitioners available to him if he requires support during a circumcision procedure.

noted 'several large clear monofilament sutures (possibly about 2/0)' were used in the frenulum area. The use of such large sutures is not appropriate for childhood circumcision. The use of such large sutures in attempting to secure haemostasis in the fine tissue that is found in the frenulum area of the penis of a four year had a very high likelihood of failure. It indicates to me a lack of basic understanding of surgical technique and principles involved in securing bleeding during circumcision.

The other concern that I have is that [Dr C's] surgical training was outside New Zealand and what may be an acceptable standard outside New Zealand with respect to paediatric circumcisions using local anaesthetic may not be an acceptable standard in New Zealand. In particular the amount of 'force' that is reasonable to conduct the procedure under local anaesthesia and the rights of the patient/parents to be fully informed as part of the consent process.

3. The adequacy of the information provided to [Mr and Mrs B] by [Dr C] (before, during, and after surgery).

The standard of the information provided to [Mr and Mrs B] was not adequate. Pre-operatively [Mr & Mrs B] should have been specifically advised that circumcision on a four year old under local anaesthetic is not recommended and the reasons for this detailed. If [Mr & Mrs B] still wished to consider proceeding under local anaesthetic then [Dr C] should have clearly explained the critical clinical hurdles that would have to be achieved before proceeding. If these clinical steps were not achieved what the options for the parents and [Dr C] would be. Because proceeding with circumcision under local anaesthetic in this case would have been outside generally accepted guidelines the clinical notes should have documented the reasons for this decision.

This should have included specific reference to the difficulty in injecting local anaesthetic into a four year old to achieve satisfactory penile block, how a successful penile block would be determined, and the options if successful block was not achieved and/or [Master B] was too upset to proceed.

During the procedure whilst freeing of the foreskin off the glans penis, before the actual surgery commenced, [Master B] became upset, [Dr C] stating he was " … [pining] and fearful and moving his legs erratically. I checked with the forceps whether the foreskin was anaesthetized and was satisfied that was the case which was difficult in this case but I check if the child was wincing…" It does not seem possible that you can be confident that the child is completely pain free in this circumstance and even if the penile block was working, the child was clearly agitated and non-cooperative. It would have been reasonable to consider the options; whether it was clinically appropriate and safe to continue and/or at least ask the parents if they wished to continue at this point.

4. Were [Mr and Mrs B] able to give informed consent to the procedure on the basis of the information provided to them?

Clearly [Mr and Mrs B] were able to understand that they were consenting to a request to have an elective circumcision for their son [Master B]. However in my opinion I do not believe that they were fully briefed on the potential

difficulties and complications of attempting a circumcision under local anaesthetic on a four year old child. They should have been specifically advised that at four years of age, [Master B] falls outside the generally recommended age group for circumcision under local anaesthetic. They were not adequately prepared for the possibility that their son may struggle and need to be restrained through the procedure. They were not informed of their options if they felt that continuing the procedure would be too traumatic for their son or themselves. They were not fully informed that one of the complications of proceeding with circumcision on a less than fully cooperative child may be the inability to achieve adequate control of bleeding.

Although a consent form was signed by [Mr and Mrs B] which stated that they were "… welcome to ask for more information if I wish" they would not have anticipated or considered any of these potential problems unless they were specifically brought to their attention for discussion by [Dr C]. In this circumstance it was [Dr C's] duty to fully inform [Mr & Mrs B] of the risks and potential consequences of circumcision under local anaesthetic on a four year old child.

5. Comments on the appropriateness of any changes made by [Dr C] since this event.

[Dr C] has stated that he would not be operating on 'particularly this age group', although he has not been specific of the age range he was considering in his statement. He apparently is considering adopting a new circumcision technique that would help reduce circumcision bleeding.

It is appropriate that [Dr C] reviews the ages of children that he will be offering to perform circumcision on under local anaesthetic. I am not sure exactly what the new technique he is considering adopting to improve performing circumcision under local anaesthetic but irrespective of technique it will be important that [Dr C] be fully trained in using this new procedure.

6. Are there any aspects of the care provided that you consider warrant additional comment?

I cannot agree with [Dr C's] remarks in his response '… that the procedure was successful and done in the manner as prescribed …' Clearly [Dr C] was not able to complete the procedure himself and as discussed previously the parents were not warned of the specific significant issues encountered.

I cannot agree with [Dr C's] assertion in his response to question 9 that 'in fact it was not a procedural problem of any kind whatsoever, merely the inability of the patient to remain calm for the last stitch all of which was aggravated by the anxiety of the parents'. The surgeon performing circumcision under local anaesthetic is responsible for all aspects of the surgery including anticipating the problems that may be faced at all steps of the procedure and how to adequately deal with each potential problem that may be encountered. All this I would consider part of the 'procedure'. It is unfair to attribute any blame whatsoever for the procedure not going to plan to the patient or the parents in this case.

With an increasing Muslim population in New Zealand there is increasing demand to perform circumcisions for religious/cultural reasons, particularly the desire to have circumcision performed under local anaesthetic for reasons of cost. What may be acceptable overseas with respect to the standard of information disclosure and the circumcision procedure itself, especially the amount of physical force used to restrain the child, may not be acceptable in New Zealand.

I believe it is important that overseas qualified doctors as part of their orientation to the New Zealand medical system understand these differences."

Further expert advice to Commissioner

Dr Young provided further expert advice, which is detailed below.

1. **Whether, from the description provided by [Dr C], the circumcision method employed by him was appropriate i.e. was it in accord with relevant professional standards?**
   The circumcision method described is a reasonably standard "freehand" circumcision technique.

2. **Is the cutting of the frenular artery a "consequence of circumcision"?**
   The division of the frenular artery is performed in standard "freehand" circumcisions.

   An issue would be how appropriate was the technique to secure the bleeding artery, as the Paediatric Surgical Specialist noted "several large clear monofilament sutures (possibly about 2/0)" were used in the frenulum area, as I stated in my initial report the use of such large sutures to secure the fine frenular artery was not appropriate and unlikely to succeed.

3. **Whether you have any further comment, generally speaking, on the adequacy of the surgical procedure (in regard to the technique) carried out by [Dr C].**
   Apart from the use of inappropriate sutures the circumcision technique, as described was reasonably standard. A concern would be how proficient is [Dr C] at circumcisions if inappropriate sutures were used?

Appendix 2 — Policy Statement on Circumcision from the Royal Australasian College of Physicians

Paediatrics & Child Health Division
The Royal Australasian College of Physicians

Policy Statement On Circumcision

This revised policy has been developed at the instigation of the Paediatrics and Child Health Division of The Royal Australasian College of Physicians, following critical literature analysis by a working party of representatives from a number of professional organisations.

The policy represents an agreed position adopted by the following:

- Paediatrics & Child Health Division of The Royal Australasian College of Physicians
- Australasian Association of Paediatric Surgeons
- New Zealand Society of Paediatric Surgeons
- Urological Society of Australasia
- Royal Australasian College of Surgeons
- Paediatric Society of New Zealand

The purpose of this document is to assist clinicians in their discussions with parents who are considering having this procedure undertaken on their male children. A separate parents' brochure can be purchased from the Paediatrics and Child Health Divisional Office, by email: paed@racp.edu.au or phone: (02) 9256 5409.

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ROUTINE CIRCUMCISION OF MALE INFANTS AND BOYS - SUMMARY STATEMENT

The Paediatrics and Child Health Division, The Royal Australasian College of Physicians (RACP) has prepared this statement on routine circumcision of infants and boys to assist parents who are considering having this procedure undertaken on their male children and for doctors who are asked to advise on or undertake it. After extensive review of the literature the RACP reaffirms that **there is no medical indication for routine neonatal circumcision**.

Circumcision of males has been undertaken for religious and cultural reasons for many thousands of years. It remains an important ritual in some religious and cultural groups. In Australia and New Zealand, the circumcision rate has fallen considerably in recent years and it is estimated that currently only 10%-20% of male infants are routinely circumcised. Circumcision is now generally performed with local or general anaesthesia, and when the procedure is carried out for a medical indication this is usually outside the neonatal period. The best recognised medical indication for circumcision is phimosis.

In recent years there has been evidence of possible health benefits from routine male circumcision. The most important conditions where some benefit may result from circumcision are urinary tract infections, HIV and later cancer of the penis.

- Urinary tract infections affect 1%-2% of boys, and may be about 5 times less frequent in circumcised boys, whilst circumcision has a complication rate of 1% to 5%. On current evidence routine neonatal circumcision cannot be supported as a public health measure on this basis.
- While there is some evidence, particularly from sub-Saharan Africa, that male circumcision reduces the risk of acquisition of HIV, evidence is conflicting and would not justify an argument in favour of universal neonatal circumcision in countries with a low prevalence of HIV.
- Penile cancer is a rare disease with an incidence of around 1 per 100,000 in developed countries. Even though the evidence suggests neonatal circumcision may reduce the risk 10-fold, the rarity of the condition and its other recognised predispositions are such that universal circumcision is not justified on these grounds alone.

The complication rate of neonatal circumcision is reported to be around 1% to 5% and includes local infection, bleeding and damage to the penis. Serious complications such as bleeding, septicaemia and meningitis may occasionally cause death.

The possibility that routine circumcision may contravene human rights has been raised because circumcision is performed on a minor and is without proven medical benefit. Whether these legal concerns are valid will be known only if the matter is determined in a court of law.

If the operation is to be performed, the medical attendant should ensure this is done by a competent operator, using appropriate anaesthesia and in a safe child-friendly environment.

In all cases where parents request a circumcision for their child the medical attendant is obliged to provide accurate information on the risks and benefits of the procedure. Up-to-date, unbiased written material summarising the evidence should be widely available to parents.

Review of the literature in relation to risks and benefits shows there is no evidence of benefit outweighing harm for circumcision as a routine procedure in the neonate.

1. RECENT LITERATURE AND POLICY STATEMENTS

There is an extensive literature on circumcision in general, and male neonatal circumcision in particular. This includes a number of books[1,2] and recent reviews[3] including those by the Canadian Paediatric Society (CPS)[4] and the American Academy of Pediatrics (AAP)[5,6].

The CPS recommended "Circumcision of newborns should not be routinely performed" (reaffirmed February 2001: (www.cps.ca/english//statements/FN) and the AAP concluded "we can not recommend a policy of routine newborn circumcision". (www.aap.org/mrt/factscir.htm).

Following the present review of the evidence, the RACP concurs with these statements and endorses the 1996 statement of the Australian College of Paediatrics (now the Division of Paediatrics and Child Health of RACP) and Australasian Association of Paediatric Surgeons that "Neonatal male circumcision has no medical indication".

2. HISTORY OF CIRCUMCISION

Circumcision of males has been undertaken for religious and cultural reasons for many thousands of years. It probably originated as a hygienic measure in communities living in hot, dusty and dry environments. It remains an important ritual in several religious and cultural groups.

Medicalisation of male circumcision seems to have occurred in the 19th century in English speaking countries. Being circumcised was a sign that the individual had been delivered by a doctor rather than by a midwife[1]. Over the years, circumcision has been seen as a cure or preventative measure for all manner of conditions including paralysis, insanity, epilepsy, tuberculosis, enuresis, masturbation and phimosis and more recently for prevention of urinary tract infections in boys, and penile cancer and sexually transmitted diseases in adult males.

During the last 50-100 years, routine neonatal male circumcision became widespread in many English speaking countries. Until the late 1960's or early 1970's, it was generally performed without any form of anaesthesia.

The rates of circumcision vary from country to country, being about 60% in the USA (with recent data suggesting falling rates, particularly amongst the growing Hispanic population), 30% in Ontario, Canada, 6% in the UK (rates fell when circumcision became unavailable on the NHS), and less than 2% in Scandinavia. Estimates for Australia range between 10%-20% and for New Zealand somewhat less than that. Most circumcisions for a medical indication are performed under general anaesthesia well beyond the neonatal period. The procedure is more common in Pacific Island communities where traditional circumcisers are often used.

3. ANATOMY OF THE FORESKIN

3.1 BACKGROUND

The foreskin is a redundant fold of penile skin which overlaps the glans penis[7]. It first appears at eight weeks of fetal life and soon grows forwards over the glans penis. By 16 weeks it covers the glans. At this stage the epidermis of the under-surface of the foreskin is continuous with the epidermis covering the glans. Both consist of squamous epithelium. The foreskin (prepuce) and glans penis enclose a potential cleft, the preputial sac. A preputial space is then formed by a process of desquamation, and the prepuce increasingly separates from the glans[8].

At the time of birth this process is incomplete in the vast majority of boys, and the foreskin is non-retractable. Complete separation of the foreskin with full retractability occurs in almost all boys by the time of puberty[9].

3.2 CARE OF THE FORESKIN

It is normal for the inner surface of the foreskin to be fused to the glans in newborn males. Separation of the foreskin from the glans occurs spontaneously during childhood. By five years of age most of boys are able to retract their foreskin[9]. A small percentage of boys are unable to fully retract their foreskin until puberty.

The foreskin requires no special care during infancy. **It should be left alone**[10]. Attempts to forcibly retract it are painful, often injure the foreskin, and can lead to scarring and phimosis.

Later in childhood, the foreskin can be gently retracted to the point where resistance is met and the distal portion of the penis and the urethral meatus become visible. The glans and the inner-surface of the foreskin can be cleaned along with the rest of the body once separation has occurred and the foreskin is fully retractable[11].

By around the time of puberty, all uncircumcised boys should be able to retract their foreskin and clean underneath it in the bath or shower. It is important that they always return the foreskin to its original position after they have finished. If the foreskin is left retracted behind the glans, it may swell up and become painful (paraphimosis).

As the foreskin separates from the glans, dead skin cells will collect between the two layers. These dead cells appear as white crumbly or cheesy material and have been termed smegma. Smegma may produce a noticeable (and often asymmetrical) swelling beneath the foreskin. This material rarely causes problems and usually discharges spontaneously. Accumulation of smegma assists the normal process of separation of the inner surface of the foreskin to the glans of the penis in the young boy. Infection of smegma as it is released may cause inflammation.

Although there is evidence that boys who are uncircumcised have a higher incidence of urinary tract infections, there is no evidence that the increased incidence of infection is due to poor hygiene.

4. MEDICAL INDICATIONS FOR CIRCUMCISION

4.1 PHIMOSIS

Pathological phimosis, which needs to be distinguished from the normal non-retractile foreskin of early childhood[12], is an indication for circumcision[13,14]. The condition occurs in at least 1% of boys[15,16], is rare in the first five years of life and may be due to secondary cicatrisation of the foreskin due to balanitis xerotica obliterans (BXO)[17,18]. Topical application of steroid ointment may resolve phimosis in the majority of boys[19,20] except in those with BXO where steroids are rarely successful.

Physiological phimosis (normal narrowing of the foreskin that may make visualisation of the glans difficult during infancy) will normally resolve by the age of three to four years and requires no treatment. If pathological (ie non-physiological) phimosis fails to respond to steroid cream/ointment applied to the tight part of the foreskin two to four times a day for two to six weeks, there is a reasonable probability that it will cause problems in the future and the child may well benefit from circumcision. In a proportion of boys the phimosis redevelops after cessation of applications of steroid treatment.

4.2 RECURRENT BALANOPOSTHITIS

Recurrent balanoposthitis is a relative indication for circumcision. The condition needs to be distinguished from the more benign ammoniacal dermatitis[13]. Balanoposthitis affects 3%-4% of boys, and is recurrent in about 1% of boys[21]. Balanoposthitis and balanitis may also occur in adults. Diabetes may be a risk factor[22].

4.3 PARAPHIMOSIS

Recurrent paraphimosis is extremely rare and may represent a relative indication for circumcision. In children, the condition is usually secondary to forceful retraction of the foreskin and is associated with a minor degree of phimosis. In adults, paraphimosis typically occurs in the elderly. Men requiring frequent bladder catheterisation are particularly at risk[23]. Treatment in children involves manipulation of the foreskin forwards over the glans, and requires some form of analgesia (general or local). In a minority of children, after reduction of paraphimosis circumcision may be required, if topical application of a steroid preparation fails to resolve the underlying phimosis, or if paraphimosis recurs.

5. THE ROLE OF CIRCUMCISION IN PREVENTING OTHER CONDITIONS

5.1 URINARY TRACT INFECTIONS (UTIS)

The cumulative incidence of UTI in boys by the age of about 10 is 1-2% [24,25]. Ginsburg and McCracken[26] first reported a higher incidence of UTIs in uncircumcised boys. This is biologically plausible because uropathogens have been shown to bind to the foreskin and then gain access to the renal tract via the ascending route: removal of the foreskin would abolish this mechanism. Other factors may be important in determining the prevalent organisms. For example, rooming in with mother may favour colonisation with non-pathogenic bacteria[4,27], and breast feeding has been associated with lower rates of UTI than bottle feeding in one brief report[28].

There have now been ten case control and cohort studies published, which have evaluated the association between circumcision and UTIs[24,29-37], but no randomised controlled trials have been done. All have demonstrated a statistically significant reduction in risk of UTI in circumcised males compared with uncircumcised males, with most data concerning the risk of UTI during infancy. The magnitude of the reported protective effect varies from a three-fold reduction to a twelve-fold reduction in risk of UTI due to circumcision. These data may be used to assess possible benefits and harm from neonatal circumcision. Assuming an annual incidence of UTI of 1% during the first year of life for uncircumcised boys, the risk of UTI may be reduced from 10 per 1,000 to 1-3 per 1000, a difference of 7-9 per 1,000, or a need to circumcise between 110 to 140 boys to prevent one UTI during the first year of life.

On the other side of the equation, taking a mid-range figure of 2% (20 per 1,000) for major complications from circumcision, mainly from haemorrhage and infection (see earlier section), for every 1,000 infants circumcised, about eight fewer will develop a UTI but 20 will develop a significant complication. Assuming that the "harm" of a UTI is about the same as a complication, routine circumcision is difficult to advocate as a public health measure.

Other figures can be used to come to a different conclusion but even then many parents and caregivers would believe this should not be the only consideration[38].

The benefit-harm trade-off is also sensitive to the baseline risk of UTI. Assuming the same protective benefits of circumcision for the prevention of UTI extends to boys at higher risk of UTI, such as those with underlying renal tract abnormalities, then is it likely that a small group of boys, who continue to have symptomatic recurrent UTI despite conventional clinical care such as chemoprophylaxis, will benefit from circumcision. The risk of UTI in these boys is not 1% as it is in the general population, but closer to 30%[39,40] so that only 4-5 boys would need to be circumcised to prevent UTI, or 200-270 UTIs prevented for every 1000 circumcisions with about 20 complications.

In summary, routine circumcision in boys cannot be justified on the basis of preventing a UTI. On the other hand, there may be a role for circumcision in boys with recurrent symptomatic UTI and/or underlying renal tract abnormalities.

5.2 SEXUALLY TRANSMITTED INFECTIONS (STIS)

The published evidence concerning the relationship between circumcision and STI is often conflicting[41]. A history of intercourse with an uncircumcised man may be a risk factor for herpes simplex type 2 (HSV-2) infection in women[41a]. An Australian study from 1983[42] suggested herpes genitalis, candidiasis, gonorrhoea and syphilis were all more common in uncircumcised men. A more recent Australian study[43], however, suggested that circumcision has no significant effect on the incidence of common STI's. One study has suggested a higher risk of non-gonococcal urethritis among circumcised men than among uncircumcised men[44]. Genital ulcer disease, on the other hand, has been reported as being more common among uncircumcised men, and those with a genital ulcer are more likely to contract HIV.

There is increasing evidence, particularly from sub-Saharan Africa, which suggests an increased risk of female to male transmission of HIV in uncircumcised men[45-48]. However, how much circumcision could contribute to ameliorate the

current epidemic of HIV is uncertain[49]. Whatever the future direction of this debate it can not be seen as an argument in favour of universal neonatal circumcision in countries with a low prevalence of HIV.

5.3 HUMAN PAPILLOMA VIRUS AND CARCINOMA OF THE CERVIX

A recent international study reported an increased risk of human papilloma virus (HPV) infection in uncircumcised men who indulged in high-risk behaviours, compared with circumcised men[50]. Monogamous women whose male partners had six or more sexual partners and were circumcised had a lower risk of cervical cancer than women whose partners were uncircumcised. Public health measures aimed at early detection have been shown to decrease cervical cancer fatalities; targeting sexually promiscuous men to decrease risk taking and increase condom use may inhibit sexual transmission of HPV and prophylactic vaccination against HPV is being developed. At present it is not possible to know whether advocating neonatal circumcision would be of additional benefit to these strategies[51].

5.4 CARCINOMA OF THE PENIS

Carcinoma of the penis is a rare condition, with an annual incidence of approximately 1:100,000 men in developed countries, regardless of whether there is a high or a low circumcision rate[4,5,5a]. There is evidence that neonatal circumcision confers protection from carcinoma of the glans penis but not of the penis shaft[52-56]. Even though the evidence suggests neonatal circumcision does reduce the risk of carcinoma 10-fold, universal circumcision is clearly not justified on these grounds[46].

Other risk factors for penile cancer include phimosis (which is limited to uncircumcised men), genital warts, increased number of sexual partners and cigarette smoking[57,58]. It has been hypothesised that good penile hygiene may help prevent both phimosis and penile cancer[59].

6. COMPLICATIONS OF CIRCUMCISION

Apart from pain and distress, and the side effects of local anaesthesia, there have been many complications of circumcision reported[5,60,61]. Most complications are minor, but some can be more severe, such as penile amputation and even death. The overall reported rate of complications after circumcision varies between 0.06%[62] to 55%[63] depending on the situation in which it is performed and the precise definition of complication. Most series describe a complication rate of about 2%-10%[64-66]. A detailed summary of complications has been provided by Williams and Kapila[61], and includes the following:

- Haemorrhage
- Infection
- Glanular ulceration
- Meatal stenosis
- Inadvertent injury of the urethra (fistula)
- Too much skin removed
- Loss of penis (1 in 1,000,000)
- Anaesthetic complications
- Psychological trauma
- Secondary phimosis
- Secondary chordee.

The true incidence of **major** complications after newborn circumcision is unknown but is reported to be from between 0.2% and 0.6%[5] to 2%-10%[61]. The most frequent acute problem is haemorrhage, and may indicate an underlying vitamin K deficiency or haemophilia. Infection is usually minor, but rarely septicaemia and meningitis may occur. Longer term complications include meatal stenosis, cutaneous tags, poor cosmetic appearance, and psychological trauma. Children with prominent prepubic fat may have a concealed penis following surgery which tends to resolve at puberty.

6.1 ABSOLUTE CONTRAINDICATIONS TO NEONATAL CIRCUMCISION

Contraindications to routine neonatal circumcision include:

- Hypospadias and other congenital anomalies of the penis, e.g. epispadias
- Chordee (ventral angulation of the penis)
- Buried penis

- Sick and unstable infants
- Family history of a bleeding disorder or an actual bleeding disorder
- Inadequate expertise and facilities.

7. LEGAL AND BIOETHICAL ISSUES

The legal and bioethical issues surrounding male neonatal circumcision have been discussed in recent legal journal reviews[60,67]. Parents have the right, indeed duty, to make informed medical decisions on behalf of their children. It is equally established in law that parents may not make decisions about their child's medical care when such a decision is not in the child's best interests. Many legal precedents exist to establish that Courts will deny parents the right to refuse medically indicated procedures required by their child that are contrary to their religiousbeliefs.

The difficulty with a procedure which is not medically indicated is whether it may still be in the child's "best interests" (that is, in the case of circumcision, decreasing the risk of UTI and penile cancer, and ensuring acceptance within a religio-cultural group) on the one hand[60] or whether it may constitute an assault upon the child and be a violation of human rights on the other[67]. Arguments to justify the "best interests" case are based upon data to suggest a decreased risk of medical conditions later in life, none of which, with the possible exception of UTI's in boys, requires a decision in the neonatal period, and this could be seen to be an argument to defer a decision until the individual can express his own preferences. Generally the courts have avoided jurisdiction in this area[60]. However, there has been a 1999 UK case where separated parents disagreed on the question of circumcision with the court finding circumcision not to meet the "paramountcy of welfare" standard and not be in the best interests of the child[60]. One issue, which is agreed, is that before parents make a decision about circumcision they should have access to unbiased and clear information on the medical risks and benefits of the procedure. Whether this has always been the case in the past is uncertain, and many parents make such a decision on cultural and religious grounds alone[68].

8. ANALGESIA

Until recent times a majority of neonatal circumcisions were performed without analgesia. Stated justifications for not using analgesia include a belief that circumcision causes minimal pain, that rapid expert circumcision causes less pain than that engendered by local anaesthetic procedures and that newborns have no memory of pain. There are good experimental data to refute the first two of these contentions and, even though the third suggestion can not be considered a sufficient reason to withhold analgesia, there is an emerging body of evidence to show that painful neonatal experiences do have long term consequences, even if not rooted in conscious memory[69]. Taddio reported that circumcised boys had higher pain and cry scores during routine immunisation at 4-6 months of age than uncircumcised boys[70] and scores were again higher if circumcision was unaccompanied by analgesia compared with those receiving topical anaesthesia[71].

Newborn infants subjected to a variety of noxious stimuli have hormonal, physiological and behavioural responses[72]. There have been **two recent consensus statements on the prevention and management of pain in the newborn**[73,74] which should be used to guide the clinical approach to analgesia for circumcision *if such an operation should be deemed necessary*. Both statements emphasise that compared with older age groups newborns may experience a greater sensitivity to pain, such pain may have long term consequences, and a lack of behavioural response (for example lack of crying) does not necessarily indicate a lack of pain.

While general anaesthesia will often be used for circumcision beyond the neonatal period it has rarely been considered as an option for newborn circumcision. Local or regional anaesthesia for newborn circumcision has been provided by local application of a eutectic mixture of local anaesthetics (EMLA cream), dorsal penile nerve block (DPNB), penile ring block (PRB) and caudal epidural block.

Recent trials have demonstrated that combined analgesia and local anaesthesia (for example, pre- and post-operative paracetamol, EMLA cream to the abdomen and foreskin, oral sucrose, and DPNB or PRB[75]), are more effective than either alone[74,76,77]. In Australia circumcisions undertaken in boys older than six months are mostly performed under a general anaesthetic, with local anaesthetic often being administered during the general anaesthetic.

9. TECHNIQUE OF CIRCUMCISION

When a circumcision is performed in an older child it is usually performed under general anaesthesia and regional block[78].

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Paediatrics and Child Health Division

Appendix 3 — Guidelines for Circumcision from the Australasian Association of Paediatric Surgeons

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GUIDELINES FOR CIRCUMCISION

Preamble: The Australasian Association of Paediatric Surgeons does not support the routine circumcision of male neonates, infants or children in Australia. It is considered to be inappropriate and unnecessary as a routine to remove the prepuce, based on the current evidence available.

Due to religious beliefs, Jewish children are circumcised by the seventh day of life, as a mark of dedication to God. [sic] Children born into the Muslim faith will likewise be circumcised for religious reasons, although the timing for the procedure is less clearly defined. There are Christian groups in other parts of the world, who insist on ritual religious circumcision, as well as tribal or cultural customs promoting male circumcision.

We do not support the removal of a normal part of the body, unless there are definite indications to justify the complications and risks which may arise. In particular, we are opposed to male children being subjected to a procedure, which had they been old enough to consider the advantages and disadvantages, may well have opted to reject the operation and retain their prepuce.

Indications for male circumcision:

- Balanitis Xerotica Obliterans
- Recurrent Balanoposthitis
- Phimosis resistant to steroid cream
- Contraindications to male circumcision:
- Hypospadias and other congenital anomalies of the penis, e.g. epispadias, chordee.
- Sick and unstable infants
- Family history of a bleeding disorder or an actual bleeding disorder.

<u>Timing of surgery</u>
Neonatal male circumcision has no medical indication. It is a traumatic procedure performed without anaesthesia to remove a normal functional and protective prepuce. At birth, the prepuce has not separated from the underlying glans and must be forcibly

torn apart to deliver the glans, prior to removal of the prepuce distal to the coronal groove.

Balantitis Xerotica Obliterans, when diagnosed, should be treated by circumcision.

Timing of circumcision for recurrent balanoposthitis is difficult to define. Many infants and children will have an episode of preputial inflammation. If successive occurrences of dysuria with associated redness and purulent discharge from beneath the prepuce have been treated and the previously fully or partially retractable prepuce is less readily retractable after the subsidence of the inflammation, circumcision should be considered.

The physiological phimosis will normally resolve by the age of 3–4 years. If it fails to respond to steroid cream/ointment applied several times daily for 4–6 weeks, there is a reasonable probability that these boys will have problems in the future.

Infants and children who have a proven urinary tract infection and, on investigation, are found to have a significant urinary tract anomaly, e.g. posterior urethral valves or significant vesico-ureteric reflux, may benefit from circumcision. This will reduce the normal bacterial flora resident under the prepuce, which in the presence of a urinary tract anomaly may be associated with an increased risk of further upper tract infections with possible local and systemic damage.

The risk of carcinoma of the penis developing in the uncircumcised is very low. Lifetime penile hygiene is the key to penile health and a reduction in the incidence of carcinoma of the penis.

Personal sexual behaviour patterns will determine whether sexually transmitted infections with human papilloma virus, herpes simplex virus and the human immune deficiency virus are contracted. Routine or infant male circumcision is not justified in Australia to protect males from contracting diseases that some may acquire through their ignoring the recognized precautions to be taken during their sexually active life.

Consent for surgery: Parents requesting circumcision of their male children should have the complications both general and local, explained to them. These complications are usually minor but can be severe and may result in the death of the child. Time should also be spent discussing the advantages and disadvantages of the operation, both in the short and long term, as is currently applicable in Australia. There are many adults in the community who hold a very strong opinion as to the place of circumcision. This may be for religious reasons or for family "custom" or a claim of "cleanliness" or other reasons. In this event the procedure should be performed electively after six months of age. When performed, it should be carried out by a surgeon performing circumcisions on children on a regular basis with an anaesthetist using appropriate techniques. This would imply that the anaesthetist is fully trained in the art of paediatric anaesthesia, including the ability to perform caudal and penile regional or local anaesthesia. The operation should be carried out in a paediatrically orientated environment, designed to reduce the risk to the child and providing support to the parents or caregivers.

Points of Interest

Marshall in 1960, reporting to the Society of Paediatric Urologists in Philadelphia and quoted by John Duckett, a distinguished paediatric urologist in Philadelphia,

calculated that 140 boys a week for 24 weeks would need to be circumcised to prevent one case of carcinoma of the penis.

The Jewish Talmud stated that "the third child was excused from circumcision if the first two had died as a result of the circumcision".

Dr. Derek Llewellyn in his book "Everywoman" published by Faber and Faber Limited in 1971 stated that "Mothers demand it, doctors profit by it and babies cannot complain about it".

The 1989 United Nations Convention on the Rights of the Child states that "State parties should take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."

"Circumcision of male infants" was addressed in a research paper published by the Queensland Law Reform Commission in December 1993. The preface addresses the problem when it states "From the Commission's research to date, it is apparent that there are two quite vocal sides of the debate on routine male circumcision. One side advocates the practice, primarily on a preventative health basis or on religious grounds. The other side opposes the practice, primarily on human rights and preservation of bodily integrity grounds. Both sides rely on medical evidence and opinion to support their respective views". Having considered all the information the paper concludes with "The Commission has yet to decide what, if any reform of the law should be recommended in relation to infant male circumcision."

J. Fred Leditschke,
President, A.A.P.S.,
April, 1996

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