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Comment

The Ethical Dilemma of Childhood Male Circumcision—The Arguments Against Supporting Public Funding in Australia Remain Substantial. Comment on Ananthapadmanabhan et al. Privatisation of Request Infant Male Circumcision in Australia—An Equity-Focused Assessment of Impacts on Religious Communities in Greater Sydney. *Soc. Int. Urol. J.* 2026, *7*, 51

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An article in this issue on infant male circumcision argues that public healthcare funding should be directed to requests for infant male circumcision in Australia to address an inequity as a consequence of religious practice [1]. This editorial argues against that view.

When childhood circumcision is performed in an appropriate environment, it is generally considered a safe procedure. There are, however, risks of complications, mostly minor, but in rare situations they can be serious, including lifelong psychological impact and even death.

The current evidence from the Royal Australasian College of Physicians (RACP) [2], supported by the Urological Society of Australia and New Zealand (USANZ) [3], confirms that circumcision should only be offered when there is a medical indication.

While parental choice should be respected, the risk of complications from circumcision does not warrant routine childhood circumcision for non-medical indications in a system already under strain treating medically indicated care. Additionally, the benefits of circumcising a male child routinely do not outweigh the risks. Parents should be made aware of the potential risks of circumcision above and beyond a routine choice driven by personal, cultural or religious convictions. When performed, circumcision needs to be in a safe environment and performed by a competent practitioner with adequate anaesthesia and peri-operative aftercare.

It is accepted that religious rights may clash with the ethical issues surrounding childhood circumcision where the child is unable to give consent but there is culturally based community pressure to undertake the procedure. The ethical concerns are not relevant when there is a medical condition that warrants a procedure to protect the health of the child [4].

Suggesting that constrained public funding be responsible for routine (non-medically indicated) circumcision fails to accept that such a view impacts an already over-burdened public health system. Current benchmarks for elective surgery across Australia are rarely met. This leaves those in need, who are often suffering from ill-health, waiting longer than necessary. If a policy of supporting publicly funded circumcision is instituted, it would negatively impact the care of children who need therapeutic intervention for improved healthcare in place of an ethically contested non-therapeutic procedure on well, non-consenting individuals. There are potential further impacts on overall healthcare resources, with displacement of those who need surgical care and administrative challenges related to triage.

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Practitioners and parents are also reminded that they can be held liable for undertaking a non-therapeutic procedure without consent from an adult male who claims to have been harmed, suffering sexual dysfunction, psychological trauma and loss of bodily autonomy from a childhood procedure [5]. If public funds contributed to the procedure without consent, then the Commonwealth or State would also be liable, incurring costs further burdening the healthcare budget. Parental regret as a consequence of harm has also been documented [6].

The foreskin is not an innocent bystander of the penis. It is a normal structure with rich sensory nerve endings. Its removal can have deleterious impacts on the individual, who, as a child, is unable to understand the risk of adverse outcomes and thereby cannot give informed consent [7]. In an analogous way, female genital mutilation, also performed for cultural reasons, is prohibited in Australia. While the impact on a female is greater, the principles of protecting bodily autonomy still apply [8].

The argument that non-public funding is discriminatory to low-income families is real; however, private funding is used for any number of religious practices including baptism; bar mitzvah; religious education; dietary compliance; religious practice and communal celebrations in general, including travel, catering and accommodation. While means testing can be a counterargument for circumcision, it does not apply, nor is it argued by the authors, to any of the above cultural and religious practices.

There are other examples of non-public funded care including but not limited to: in vitro fertilization (IVF), gender affirming care, dental care, physical therapy and mental healthcare that lack adequate public funding.

The arguments for human immunodeficiency virus (HIV)/human papillomavirus (HPV)/sexually transmitted infection (STI) reduction, urinary tract infection (UTI) prevention and subsequent penile disease are either not relevant to the Australian environment or otherwise able to be treated when necessary as they medically arise. These often cited arguments are more related to under-developed nations or sub-Saharan conditions and not relevant to the case in Australia.

As argued by Earp, no child should have any healthy part of their body removed without direct consent unless there is a clear health-related indication [9]. This is the overriding ethical principle.

Parents have a right to choose to subject their male child to circumcision for personal, cultural or religious reasons. If they do, they should arrange doing so in an appropriate facility but must bear the cost, responsibility and consequences. This current policy acknowledges cultural and religious needs. To suggest that the cost should be borne by the public healthcare system ignores the significant impact on the children who already wait longer than necessary for their medically indicated healthcare, amongst other arguments made above. It is agreed that practitioners who offer circumcision should be accredited to do so and penalties must apply to unaccredited practitioners.

Data Availability Statement: No new data were created or analyzed in this study. Data sharing is not applicable to this article.

Conflicts of Interest: The author is a Past President of the Urological Society of Australia and New Zealand.

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