

Metzizah Be'Peh: Public Health Ethics and an Attempt to Regulate Religious Circumcision

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Abstract

In 2012, New York City passed a health code provision requiring that religious Jewish circumcisers, Mohelim, keep on file a signed parental consent that explains the position of the New York City Department of Health and Mental Hygiene ("the department") concerning risks of Metzizah be'Peh "with direct oral suction" (MBP). In MPB, the Mohel, a religious practitioner, very briefly places his mouth with wine on the wound to suck away a small amount of blood. The department claims this activity is responsible for a small number of cases of herpes simplex virus (HSV) in infants. This article reviews the department's claims, as well as the claims of its challengers, and applies five secular public health ethical constructs to the department's actions. After the analysis, the article concludes that the department has not made an ethical case to impose regulations on this religious practice.

INTRODUCTION

Metzizah be'Peh "with direct oral suction" (MBP), is believed by some Jewish authorities to be a biblically required part of the Bris Milah or circumcision on the 8th day of a Jewish boy's life. During the circumcision, the Mohel, a religious practitioner, very briefly places his mouth with wine on the wound to suck away a small amount of blood. It is this along with investigations of herpes simplex virus infections among a small number of infants who may have had MBP that has created a great deal of controversy. This controversy culminated in a New York City Health Code provision passed in 2012 requiring that Mohelim keep on file a signed parental consent that explains what position the New York City Department of Health and Mental Hygiene ("the department") takes on risks of MPB.

The regulation states:

(b) Written consent required. A person may not perform a circumcision that involves direct oral suction on an infant under one year of age, without obtaining, prior to the circumcision, the written signed and dated consent of a parent or legal guardian of the infant being circumcised using a form provided by the Department or a form which

shall be labeled "Consent to perform oral suction during circumcision," and which at a minimum shall include the infant's date of birth, the full printed name of the infant's parent(s), the name of the individual performing the circumcision and the following statement: "I understand that direct oral suction will be performed on my child and that the **New York City Department of Health and Mental Hygiene advises parents that direct oral suction should not be performed** because it exposes an infant to the risk of transmission of herpes simplex virus infection, which may result in brain damage or death (emphasis added)." 1

The code is in force but is still being challenged in the court based upon freedom of religious exercise and compelled speech challenges. Since this is a religious community, it should also be noted that the Mohelim's challenge to the code is not an anti-science one or anti-medical establishment one. This is not a community that is anti-science or anti-medicine in any way. The reality is quite to the contrary. For example, a very recent statement according to halacha (Jewish law) appeared on a very popular Crown Heights,

Brooklyn website, informing the Lubavitch community, one of the communities that practices MBP and is challenging the code, of a Jewish person's obligation under Jewish law to seek medical care, to be weary of alternative practices that conflict with medical advice, and, most importantly, to have their children receive appropriate vaccinations for the safety of their children and for the protection of others.^{2, 3}

FIVE PART TEST

Looking through the lens of at least one accepted approach to secular public health ethics, public health may infringe upon an individual's autonomy or a moral consideration if the infringement passes a five part test: (1) effectiveness, (2) proportionality, (3) necessity, (4) least infringement, and (5) public justification.⁴ Usually, in public health ethics, the autonomous individual is a person with an infectious disease or at risk of disease. However, in this case, the unlicensed religious practitioner is also an autonomous individual with constitutional rights and religious freedoms to which the infringement is targeted. Pursuant to the code presented above the Mohel is required to put forth the department's perspective with which he does not agree and he is required to obtain a written consent. Giving, requiring, or accepting the consent could communicate complicity if not agreement with the department's position. In this analysis I will also address the impact on the infant parents' decision making since ideally a true consent would provide accurate information to allow them to make a decision for their child.

EFFECTIVENESS

Effectiveness means that the infringement on a right or moral consideration should in actuality effectively protect the public's health.⁴ The department's approach does not pass this test.

This consent requirement is not likely to be effective as most Mohelim will refuse to follow it. In fact, the Chairman of the American Board of Ritual Circumcision has openly stated as much.⁵ Moreover, the parents may not want to sign a document that very well could be used against them. Given the required statement as written, a parent signing such a document could fear having their children removed or other government action for putting the child "at risk" and disobeying the public health authority's advice that MPB should not be performed at all.

Questions regarding the scientific accuracy of the department's position will be discussed further below. For now, let it suffice to say that in the required consent

language, the department does not qualify the magnitude of risk in anyway. The required language ignores the rarity of HSV infection and mentions no limitations or considerations regarding the quality of the data and study findings. It makes it appear as if the science is clear and conclusive. Thus the consent may be more misleading than it is at effectively providing information to the parents. The consent does not assist the parents in making their own decision about MBP for the child, but instead uses the authority of the department to warn them away from a religious activity the department has deemed to be harmful.

PROPORTIONALITY

To be proportional the public health benefits should be greater than the infringement. Much debate has centered on the benefits of the provision and the evidence about the degree of risk of HSV infection that MBP actually presents.

The Department's Position

The department's position is in the language of the health code stating that MPB "exposes an infant to the risk of transmission of herpes simplex virus infection, which may result in brain damage or death."¹ The department makes this argument based upon biological plausibility, along with a paper from Israel and Canada describing a very small number of case studies, and its own data.⁶ When the code was passed by the New York City Board of Health, the department claimed the following:

"During November 2000–December 2011, a total of 11 newborn males had laboratory-confirmed HSV infection in the weeks following out-of-hospital Jewish ritual circumcision, investigators from the New York City Department of Health and Mental Hygiene (DOHMH) learned. Ten of the eleven newborns were hospitalized; two died. In six of the eleven cases, health-care providers confirmed parental reports that the ritual circumcision included an ultra-Orthodox Jewish practice known as metzitzah b'peh...."⁷

Reportedly the department also has the support of medical organizations such as the Infectious Disease Society of America and the American Academy of Pediatrics even though according to the American Academy of Pediatrics, HSV infection as a circumcision complication is "so

infrequent as to be reported as case reports” that the cases were omitted from its own analysis for a 2012 Technical Report promoting the health benefits of circumcision.^{8, 9}

The department also conducted its own analysis and the results were published by the Centers for Disease Control (CDC). However, instead of convincing the affected communities about the degree of risk associated with MPB, the department’s analysis led to more doubt in the community about the actual degree of risk and to skepticism about the department’s real motives. Using data from the small number of reported cases, the department attempted to calculate the relative risk for HSV infection with “confirmed” and “probable” MBP. After making assumptions about who would be exposed (the population at risk) and who would not be exposed to MBP the department calculated a 3.4 times greater risk of HSV infection with direct oral suction.⁷ A recent peer reviewed article which surveyed religious practices and infection uncritically cited the 3.4 times greater risk as evidence that MPB causes HSV infection accepting the degree of risk as fact.¹⁰

The Critics’ Position

Those opposing the department in and out of court have criticized these findings. First, they criticize the accuracy of the broad and non-evidence based assumptions made by the department in its report to calculate the estimated number of infants subjected and not subjected to MBP during the study time period and the department’s assumptions that the small number of infants in question actually contracted HSV through MPB instead of through other routes.

But the critique is not only coming from the community and litigants. In addition to their own experts, the plaintiffs challenging the consent requirement in legal actions rely upon an unpublished report by the Penn Medicine Center for Evidence-Based Medicine. The report was not created to assist the litigants. The Penn authors reviewed four published studies including the department’s study.

Although there is some controversy surrounding how the plaintiffs received the report, which was not public, it reportedly concludes that there may be some risk for MPB but that the “evidence base is significantly limited by a very small number of reported infections, most of which were not identified or documented systematically. Other important limitations include incomplete data about relevant elements of the cases, the presence of confounding factors, and indirect data sources.” And specifically regarding the department’s study, the reviewers conclude that the findings

“are limited by methodological challenges in determining the total population at risk, limited information about some of the cases, and the small number of infected infants.” The report was later published in a peer reviewed journal and the authors conclude there that although they believe some cases of HSV have come from MBP, “further research is necessary to clarify the risk.”¹¹ None of the above limitations, considerations, or doubts are mentioned in the department’s required consent language.

Dr. Daniel Berman, who is an expert for the Mohelim plaintiffs in the ongoing legal action, has also criticized the department’s conclusions, including the connections between MBP and HSV infection in individual cases noting that evidence in the cases also point to other routes of exposure as well as a failure to link the infection to the Mohel as the source.^{11, 12} He also points to a 2012 Israeli government committee paper which concluded that “there is no necessity to cease this procedure unless there will be clear-cut scientific evidence for endangering the baby by MBP in a statistically significant rate. This has yet to be proven.”^{12, 13} The report’s purpose was to determine the status of continuing MPB under halacha, but the physician authors did critically review the department’s data and previous case reports from Israel and Canada before rendering an halachic opinion.¹³

The intention here is not to outline in great detail the scientific disagreements or evidence. However, the burden of justifying this infringement is ethically upon the department. Given the current state of the data and science, the public health benefits of the department’s action are not clear enough to conclusively justify this infringement, particularly an infringement on a religious practice, and the action of compelling religious figures to promote or act in acceptance of the department’s opinion and its warning to parents. Granted, it is tragic when a young Jewish child suffers from HSV infection, and that is one thing everyone agrees upon. However, this does not relieve public health authorities from having to demonstrate a stronger quantitative connection between the religious practice and the infection. Unless the department can do so, regulating religious practices in a way that may even mislead parents may be ethically precarious, unnecessary, and could distract from addressing other modes of transmission which could have a greater impact on disease transmission.

LEAST INFRINGEMENT AND NECESSITY

The department could argue that requiring written consent is

a least infringement. This is the department’s strongest ethical argument. After all, it is not a ban, only a written consent requirement.

However, the provision is not a less restrictive general consent requirement. Instead, the department requires specific risk language and its own warning that MBP should not be performed. It is clear that the required language is intended to convince parents to forego MBP. More than a consent requirement, it is a warning requirement targeted to a specific set of religious practitioners, or put another way, it is an attempt to stop MPB masquerading as consent.

Nevertheless, consent which lays out the benefits and risks of a given medical procedure has become a normal part of medical practice. The idea being that disclosure and discussion with the patient will allow for more autonomous decision making, though its effectiveness in doing so is not without critics.¹⁴ MBP, however, is essentially a religious procedure, not a medical one, with a safety record spanning over thousands of years. To force a consent process which only espouses the department’s opinions and warnings about MBP shows a lack of concern, knowledge, and sensitivity to the religious community that practices MBP.

In medicine, the state has clear authority to regulate the licensed secular medical practitioner. The medical practitioner in seeking the license has agreed to some degree of oversight. The medical practitioner also usually shares the truth in, or at least agrees with a reasonable certainty to the content of, the consent. The medical practitioner may see the consent as necessary to educate the patient and most often as a tool to protect the practitioner from liability.¹⁴

For the Mohelim the situation is very different. The department is imposing its beliefs on the unregulated religious practitioners who do not agree with the mandated consent language and the department’s conclusions about risk or its advice. From the perspective of the Mohelim, this is not just a medical or scientific disagreement with the department. On the contrary, to put forth the department’s opinion and to be complicit with a directive which they may believe to be inaccurate and written specifically to sway parents away from MBP or to refuse to perform MBP without a signed consent could be a religious transgression.

In addition, the department’s approach may not be necessary to reach the public health goal.⁴ Before passing the code, the department had already launched an “educational” campaign by creating literature for state regulated providers/hospitals

to give a newborn’s parents at birth warning the new parents about the department’s view of the risks of MPB with direct oral suction. Indeed, as part of its campaign it had also saturated the affected communities with its message and issued a letter from the Health Commissioner to the community. Despite concerns of the accuracy of the department’s position, such an approach is definitely a lesser infringement and would allow for parents to decide, the ultimate reason for consent, than would having them sign a document they fear may be used against them if they decide to disobey the department’s warning. The Mohelim have also expressed a willingness to develop, and have developed, procedures to help reduce potential risk without abandoning MBP. The community had been working with the NY State Department of Health on this before the NYC Department of Health and Mental Hygiene intervened.¹⁵

PUBLIC JUSTIFICATION AND THE VERY REAL SLIPPERY SLOPE

Public justification is not divorced from all of the above. In any public justification the department would need to show that the measures can be effective, are proportional and necessary, and represent the least infringement on the autonomy of the religious practitioner while enhancing parental decision making. Thus far, the department has failed to make an adequate justification. The department knew the community did not accept its justification before it took final action. In a letter prior to the passing of the provision, the group, Agudath Israel, sent a letter to the department stating that if adopted the proposal, would “poison” the Jewish community’s relations with the department, “destroying trust and undermining good will....It would foster the perception in the community that the DOH is heavy-handed, set on direct confrontation, and not interested in working with the community.”¹⁶

From an outsider’s perspective, MBP may seem like an odd, archaic practice of a small group of Jews clinging to old ways—and therein I believe lies the real rub—but from an insider’s perspective, it is a religious obligation and part of a most important moment in a Jewish boy’s life. Though saving a human life is paramount in Jewish law, the data for MBP do not rise to a level sufficient to convince the community and its religious practitioners that the practice of MPB creates a degree of risk that would permit a violation of a religious obligation.¹³ Instead,, given the department’s singling the community out with a lack of robust scientific evidence, the community is suspicious of the department’s motives. As one Rabbi put it:

“The greatest irony in all this,” Rabbi P. said, “is that there is no government or system anywhere in the world that places a higher value on life than the Torah. But for people hostile to Yiddishkeit, metzitzah b’peh sells well as a way of ridiculing Jews and the Torah.”¹⁶

One could argue that there is a very slippery slope here and that the consent requirement is just one step toward eventually banning MBP. This is not a theoretical slippery slope. The department’s own statements have demonstrated such an intent. The required language in the consent states the strong position that MBP “should not be performed.” Moreover, Dr. Thomas Farley, the Health Commissioner when the provision was passed, publicly advocated that direct oral suction should not be performed at all.¹⁷ Former Mayor Bloomberg also fed such suspicions by saying the practice puts a child’s life endanger and that the city “will not permit this practice to the extent that we can stop it.”¹⁵

Inflammatory rhetoric from public health authorities and political actors about such actions against a religious minority’s practices is ethically questionable, unjust, and can lead to a distrust of public health authorities, damaging public health’s authoritative voice when it comes to other public health issues which could have a greater impact at the population level. The rhetoric has even gone beyond public health authorities and political actors. Though not peer reviewed, at least one bioethicist has automatically assumed that a ban should be put into place without weighing the evidence and the facts or proposing an ethical analysis.¹⁸

However, given that the ethical basis for the department’s current consent requirement is questionable, there is certainly not a strong ethical basis for a ban. According to the Model State Emergency Health Powers Act (MSEHPA), which lays out what public health authorities would need to justify a use of police powers for infectious agents, such actions would require a “significant risk.” Given the state of the current science, a significant risk has not been shown.¹⁹ Interestingly, the MSEHPA standard is very similar to the one used by the Israeli Committee in its halachic conclusions:

Therefore, **according to those halakhic authorities who hold that MBP is an essential part of the mitzvah** (religious obligation or commandment) **of milah**

(circumcision), there is no necessity to cease this procedure unless there will be clear cut **scientific evidence** for endangering the baby by MBP in a **statistically significant** rate from the halakhic and scientific points of view.¹³

Calls for a ban would also need to address another issue. Much of the desire to stop MBP hinges on the fact that the cases are infants with an infection believed to be passed by a specific activity. However, if that is the justification, why only ban and try to stop MPB as an activity when there are so many other activities that put children at risk of grave harm including death? As was pointed out, by the Israeli Committee:

In general, there are situations in daily life, involving adults and children alike, that involve far greater risks than the assumed risks of MBP. Examples of these are: parents allow cosmetic surgery for their children even when there is no real medical indication; parents allow their children to participate in dangerous competitive sports; parents allow children to cross busy streets, etc. In such instances there is no demand to eliminate these activities even though they have associated risks which are far greater than those associated with MBP.¹³

Though these other activities are not associated with infectious disease, the department’s concern seems to be mainly for the individual infant not in containing a disease at the population level or to control an epidemic.²⁰ So the analogy of the risk of harms from these other activities fits to the MBP case with two exceptions: 1) unlike with the other activities, the number of HSV cases the department claims to be linked to MBP are very small; and 2) most of the other activities have a sociocultural value to the majority culture instead of to a religious minority.

CONCLUSION

MPB, from an outsider’s point of view, may seem strange, archaic, and of little value. But such views do not, absent a clear quantification of risk, justify the imposition of the strong arm of public health regulatory and legal interventions. Given questions surrounding the degree of risk which remain unanswered with reliable studies, public

health authorities should tread more lightly before making statements that a religious practice should not be performed or before requiring a consent document that on its face appears to be more of a warning drafted to stop MBP.

The department may have made its case to the general public and to its profession regardless of the state of the science. This acceptance could be more of a reaction to what seems to be an odd and unusual practice and a practice of low value to those who condemn it. Nonetheless, the acceptance by others does not relieve the department of its ethical responsibility to justify the effectiveness, proportionality, necessity, and degree of infringement of its actions to an easy to marginalize minority religious community and its religious authorities.

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