

How Medical Folklore Keeps a 19th-century ‘Zombie Meme’ on Life-support

John Geisheker

Abstract *PFFR*, premature, forcible, foreskin retraction of intact boys is a zombie descendant of the 19th-century, pre-germ-theory that touching the genitalia causes disease (the exact origin of those locker-room jokes). This iatrogenic injury persists—astonishingly—even in 2014.

Doctors Opposing Circumcision assists in over 100 PFFR cases each year, consoling distressed parents, providing first-aid advice for injured infants and toddlers, and reporting offenders.

Over 100,000 boys each year are likely affected, costing insurers and parents \$100 million or more of scarce resources, not to mention the misery of the boys' and their parents' anguish.

The notion that intact boys need aggressive internal hygiene is, of course, folkloric nonsense—fine-tuned to market circumcision. Our primate ancestors evolved nicely without genital scrubbing. Indeed, they were likely more concerned with food and shelter than worrying about genital hygiene. We are *their* progeny, with our self-defending and largely self-cleaning genitalia. It could hardly be otherwise.

Most consumers of medical care (those who give it a thought, anyway) arrive at their clinic confident that medical science is a dynamic discipline, constantly evolving, ever improving, always challenging the prevailing assumptions—with new miracles arriving every week as a result.

But the fact is that medical *practice* (as opposed to medical *science*) is driven as much by folklore as it is by cold, hard research—and this has always been the case. Partly this is human nature; we learn from each other—parent to child, mentor to protégé, preceptor to student clinician—generation after generation. And, to be fair, folk knowledge preserves many hard-won gems of ancient wisdom.

But—alas—obsolete, disproven, and injurious dross can be swept along with the better sort. This regrettable side-effect is regularly reinforced in clinical medicine by failures of imagination, perverse financial incentives, institutional intransigence, even sheer inertia and indolence.¹

For instance, even a school child learns that unwashed hands spread disease. Yet, hospital administrators everywhere struggle to get their clinicians to consistently observe basic hygiene. A Seattle, Washington, hospital has a sign in each exam room, addressed to the waiting patient, that seems comically contrite, a naïve admission of anticipated non-compliance, and a plea for help. The sign reads, “**Ask me if I washed my hands**”—as if the patient were calling a child to dinner, or it was the (socially

awkward) duty of the patient to police the antisepsis of the approaching stranger in the lab coat. (For those who study medical history, such fretting will surely be reminiscent of the struggles of Ignace Semmelweis, in the OB ward of a Vienna hospital in the 1840's.)²

Folkloric oddities and indignities abound in medicine. Most are more subtle than the legendary 45-minute wait in an exam room, sitting naked on a cold plastic chair. Notable examples: extracting a blood sample by pricking a finger tip, one of the most exquisitely sensitive, densely nerve-supplied structures on the human body –when there are plenty of less sensitive sites from which to draw the same blood. Or, withholding effective anesthesia and analgesia from infants and toddlers on the theory ‘their nerves aren’t developed yet, and besides, they cry either way’—despite growing evidence of permanent neurological harm.³

What follows is yet another oddity, a far more dangerous example of the chasm between hard science and clinical folklore. It is a tale of the pernicious effect in medicine of ‘zombie memes,’ inherited, legacy notions, passing unchallenged from clinician to clinician, that somehow evade scientific scrutiny and refuse to die.

At the 13th International Symposium on Genital Autonomy and Children’s Rights, held at the University of Colorado in 2014, our physicians’ group condemned the pending arrival of a new medical diagnosis and billing code that effectively puts all intact, (not circumcised) infants, toddlers, and boys—over one million per year in the US—at risk of painful, permanent, injury. This ‘new, improved’ code is a blatant, unapologetic extension of a very old medical folklore campaign to which parents and child-patients have long been subjected.

The campaign, over 150 years old, pre-dates germ theory and shows little sign of abating. One attendee at the Colorado conference, a medical professional with a life-long commitment to defending children, called it, wryly, “The Big Problem with the Little Hole.”

Our story must begin long ago:

Background History

In the 19th century, before germs were discovered, doctors invented a theory they called ‘reflex neurosis,’ or ‘reflex irritation,’ which claimed all disease was caused by the patient, who had recklessly ‘irritated’ his erogenous tissue.⁴ They claimed the exquisitely sensitive male foreskin was especially vulnerable to ‘neurosis,’ leading swiftly to the sorry result, the ‘reflex,’—the arrival of all manner of disease elsewhere in the body. Declaring the foreskin naturally unsanitary, doctors of that era urged regular, aggressive, internal hygiene, beginning at birth, lest the patient touch himself from itching, and contract, for instance, tuberculosis.⁵

If their advice to circumcise the male without anesthesia to send a painful warning⁶ was ignored, (or more likely in that era, the child, being born at home, escaped), the medical

establishment of the 1870's and 1880's urged mothers to tear back their child's foreskin, (in childhood, firmly fused to the glans by a normal connective membrane), for regular scrubbing.

A medical historian, Dr. Robert Darby, describes the scene:

...doctors believed that if the foreskin had not freed itself within a few days it would never do so, and surgical intervention of some sort was thus essential. This was a serious medical error responsible for pain, suffering, and mutilation on a monumental scale. It could have been corrected had the doctors gone back to the ancient and eighteenth-century texts or studied preputial development in normal boys in an empirical spirit. Instead, millions of boys were subjected to prolonged agony as grim-faced doctors, bustling nurses, and distraught mothers poked, stretched, and lacerated the most sensitive part of the boys' bodies. Even when amputation was not performed, their gruesome ministrations must have often destroyed the elasticity of the foreskin and prevented its sphincter from operating as the valve was meant to be, as well as causing a deformed appearance, scarring, and often the very adhesions (arising as the torn surfaces healed) they were supposed to cure. Many came to the conclusion that amputation was a kinder option.⁷

Europeans have known for centuries that such aggressive intrusion into a sterile, internal, space, justified by the Anglophone obsession for cleaning, is unnecessary, injurious, and ignorant. Forcible foreskin retraction destroys a natural protective membrane, the *balano-preputial lamina* ('glans-foreskin layer'), a feature of the still-developing, immature organ. Forcible retraction is a painful and permanent injury to the newborn, infant, or toddler, with no justification or medical benefit whatsoever.⁸ Aside from the immediate pain and trauma of tearing the sterile structures apart, (invariably performed without anesthesia or analgesia of any kind), internal 'cleaning' (sometimes called 'hygiene hysteria') strips the organ of protective immune-active emollients,⁹ exposes the child to infection, scarring, an inelastic foreskin –and worse.¹⁰

Darby notes the following about the delusional Anglophone suggestion of the need for aggressive or intrusive male infant hygiene—with its accompanying and invented notion of forced retraction—and the happy historical accident that females escaped similar treatment:

"To appreciate the scale of the error, consider its equivalent in women: it would be as if doctors had decided that the intact hymen in infant girls was a congenital defect known as 'imperforate hymen' arising from 'arrested development' and hence needed to be artificially broken in order to allow the interior of the vagina to be washed out regularly to ensure hygiene."¹²

Forcible foreskin retraction is officially forbidden by the American Academy of Pediatrics (AAP), and has been so for decades:

“Until separation occurs, do not try to pull the foreskin back—especially an infant’s. Forcing the foreskin to retract before it is ready may severely harm the penis and cause pain, bleeding, and tears in the skin. ” (From the AAP bulletin, *“Care of the Uncircumcised Penis”*)¹¹

...but this edict is routinely ignored even by board-certified ‘Fellows’ of the AAP, and has never been enforced by the AAP itself.

Hard Science Ignored

One-hundred and seventeen years after Lewis Sayre, Rudolph and Hoffman’s *Pediatrics* takes an unequivocal, empirical, ‘hard science’ view of this superstition:

"The prepuce, foreskin, is normally not retractile at birth. The ventral surface of the foreskin is naturally fused to the glans of the penis. At age 6 years, 80 percent of boys still do not have a fully retractile foreskin. By age 17 years, however, 97 to 99 percent of uncircumcised males have a fully retractile foreskin. Natural separation between the glans and the ventral surface of the foreskin occurs with the secretion of skin oils and desquamation of epithelial cells, smegma....No treatment is required for the lumps or smegma, and in particular, there is no indication ever for forceful retraction of the foreskin from the glans. Especially in the newborn and infant, this produces small lacerations in addition to a severe abrasion of the glans. The result is scarring and a resultant secondary phimosis. ***Thus it is incorrect to teach mothers to retract the foreskin.***"¹³]

...but their warning, and many other similar published warnings, have failed to slow the overwhelming momentum of 19th-century folklore still found in clinical practice today.

The very mention that, “Thus it is incorrect to teach mothers...” suggests that the invented practice of forced retraction was widespread and long-standing— and indeed, it was—and still is. Over the decades, tens of millions of living American men have been injured by forcible retraction, either at the doctor’s office, or at home by mothers who were obeying doctor’s strict orders.¹⁴ Millions of men, living and dead, have endured post-natal (later childhood) circumcisions, often without anesthesia, due to iatrogenic ‘phimosis, (an inelastic foreskin that cannot be retracted when needed) itself entirely due to the result of a prior injury by a doctor, or an injury-by-proxy, one based on doctor’s orders. This, despite known methods to treat phimosis, which do not require surgery.¹⁵

The folkloric impulse to forcibly retract boys to enable aggressive internal hygiene—bizarre on its face, as well as extremely unlikely in evolutionary terms, lingers even today as a ‘zombie meme,’ a 19th-century delusion that refuses to die. Sadly, it is a notion firmly and fervently held by tens of thousands of otherwise sensible North American pediatricians and primary care providers.

Doctors Opposing Circumcision (DOC) maintains a hotline for aggrieved families, and assists, *pro bono* (without legal or medical fees) in over 100 premature, forcible, foreskin retraction (PFFR) cases each year, the worst of the worst, over 80% of injuries occurring at well-baby visits of children younger than three years. We console distressed parents, provide first-aid advice, try to find a better-educated local clinician, and help the parents report offenders to the authorities.

Our injured patients have ranged in age from 48 hours to 12 years. We know we attend not one in a thousand of the injured, as most parents, like their great-great-grandparents before them, trusting the provider, assume the retraction injury is regrettable, but necessary. We estimate the incidence in the USA alone, conservatively, at over 100,000 traumatized children each year, squandering at least \$100 million annually in scarce medical resources.

The notion that aggressive cleaning under the foreskin is mandatory was also part of a historical marketing campaign that helped to sustain the lucrative practice of circumcision itself. It was child's play to conjure up fear in young parents reluctant to touch their own children's genitalia, especially in the latter half of the 20th century when intra-familial child sex abuse arose as a serious concern. To young parents even the standard, pseudo-humane suggestion to retract 'a little at each bath' seemed demanding, unpleasant—and yucky. Indeed, declaring to parents that their unborn son will need regular internal penis scrubbing which amputation would eliminate, is, even today, one of the standard marketing tactics ("it's cleaner and easier for you") for circumcision enthusiasts, who insert their infomercials early in pregnancy.

(Moreover, there is a subtle theme in play here that an injury to a part of the body that in US culture is regularly amputated, is not a 'real' injury in the strict sense, the highly erogenous¹⁶ structure being deemed 'optional.' Culturally, the boy is not entitled to keep his foreskin; it effectively belongs to the medical marketplace,¹⁷ and is preserved for him only by official indulgence or *noblesse oblige*. There is as well, a subtle, parallel theme that forced retraction is a form of unconscious retribution for any family with the temerity to defy Anglophone circumcision traditions. As a result, it has been said—flippantly, but accurately—that American boys 'take it in the shorts either way': circumcision or forced retraction, there being no apparent third alternative—as there would be in Europe.)

It is interesting, if melancholy, to study how 19th-century aggressive foreskin hygiene has become firmly imbedded into American medical folklore—fine-tuned, tweaked, updated with ever-newer disease fears—then passed from preceptor to student clinician, and how, up from the clinic level, the notion has invaded both the medical literature and the economics of primary care.

2014: Pre-Germ, 19th-Century 'Medicine' on Indefinite Life-Support

At the institutional level, premature, forcible, foreskin retraction has its own justifying diagnosis code, providing official *imprimatur* as well as billing-code 'immortality.' (The list of possible diseases and conditions that generate billing codes is always expanding,

of course; it never shrinks. The latest iteration of billing codes has jumped in 21 years from 13,000 to 63,000 entries.¹⁸

“PFFR” is sustained in 2014 within the ‘ICD,’ the International Classification of Disease, one of the holy books of medical economics, at ICD-9-605, which states: “**Redundant prepuce; Phimosis; Adherent prepuce; Phimosis Congenital; Paraphimosis; Tight Foreskin.**”¹⁹

This language draws from the title of a speech given to the embryonic American Medical Association in 1870, by an orthopedic surgeon, Lewis A. Sayre, an eventual AMA president, who claimed to have cured a five-year-old boy of paralysis (likely poliomyelitis) by circumcision. His speech announcing his highly unlikely triumph will sound familiar: “Partial Paralysis from Reflex Irritation, Caused by Congenital Phimosis and Adherent Prepuce.”²⁰

Without supporting pathology, ‘congenital phimosis and adherent prepuce,’ framed as disorders serious enough to cause polio, are overlapping 19th-century ‘zombie memes,’ kept on life-support by folklore passed around among medical professionals even today –less the unpersuasive, even laughable, paralysis claim.

The current ICD-9-605 entries are worth unpacking, and as ‘diseases’ or birth defects of healthy boys, are themselves mostly risible:

Redundant prepuce—There is no such thing as a prepuce (foreskin) that is too long or extra, as ‘redundant’ suggests; redundancy, like long arms, is not a disease. That boy is going to develop a long internal structure he will not complain about when mature. It will need a cover. He will grow into his long foreskin, and will be content he was allowed to keep it, (and, potentially, suffer lifelong painfully taut erections if it goes missing.)

Phimosis—(Greek: ‘trapped’); the foreskin cannot be retracted, a normal condition at birth, and for a decade or more thereafter. In later adulthood, possibly a pathologic condition often due to scarring from prior forcible retraction, potentially treatable without surgery, with topicals and stretching exercises.²¹

Adherent prepuce—a foreskin that has not yet fully separated from the glans; entirely normal in childhood, even adolescence.

Phimosis Congenital—a foreskin not retractile since infancy. This term is grossly misleading since the word ‘congenital’ suggests a birth defect. It should read “physiological/ developmental,” or better yet, being normal, not appear in the ICD at all.

Paraphimosis—the foreskin gets stuck behind the corona after retraction; often due to inelastic scar tissue from prior iatrogenic forced retraction; a urologic emergency, but solvable.

Tight Foreskin—(same as phimosis; entirely normal in infancy and childhood.)

Not only are all of these conditions normal in a newborn, but they are also potentially normal in an older child, even an adolescent. The only exception is *paraphimosis*, which qualifies as a genuine emergency (and is regularly caused by unnecessary, iatrogenic, septic ‘tampering,’ which causes infection, scarring, and inelasticity.) The average age for natural retraction is 10.4 years, but even a teenager might still be developing, presenting in clinic as non-retractile.²²

Premature, forcible, foreskin retraction, or PFFR, is lucrative, generating follow-up visits for bleeding and infection, antibiotic needs, trips to the ER, change of provider, new tests and work-up, second opinions, urology consults, etc. This includes repeat visits to the doctor so that the genuinely unnatural, true ‘adhesions,’ (the result of the trauma from forced retraction), can be painfully lysed by metal probe or manual separation, only to reappear and require a painful second or third lysing.

Even the claimed 1% urinary tract infection (UTI) incidence rate for intact boys, regularly quoted to justify circumcision, can easily be traced to non-therapeutic genital tampering. Not a single Anglophone UTI study ever published has factored for the incidence of forcible foreskin retraction, unnecessary “peeking” without surgical gloves or antisepsis, and other septic 19th-century genital manipulations.²³ In many years of intervention in PFFR cases, our physicians’ group has found only ER personnel—post-injury—wear gloves or are seen to wash their hands before handling the boy’s genitalia. Failure of primitive hygiene, let alone antisepsis, by itself, system-wide, easily accounts for the entire claimed incidence of UTI in intact boys. Could one clinician bare-handed, forcibly retract the foreskins of 100 boys in succession and claim no possible transmission of infection? Could 100 clinicians retract one boy each, bare-handed, and make the same claim, collectively?

Medical economists note that injurious care is perversely rewarded in the USA medical marketplace.²⁴ Few clinicians who make messes go unpaid, and of course neither do the more deserving who fix the messes. Thus the medical marketplace, considered overall, benefits from inappropriate, duplicative, excessive, and even injurious care. The income earned to attend a child injured by forcible foreskin retraction, and other non-therapeutic, septic, genital tampering, is a textbook example of counter-intuitive, perverse economic incentives at work.

Downhill Developments

Recently ‘605,’ the multi-million-dollar forcible-foreskin-retraction industry,²⁵ bad enough by itself, has become more shameless.

In September, 2012, the American Academy of Pediatrics issued their latest statement on circumcision. Among their recommendations was a discussion of how to care for the intact boy (a natural and normal condition with which they appear to be unfamiliar).²⁶ At one point, at page 763e,²⁷ referring to the natural BPL membrane of youth, they write:

“Most adhesions present at birth spontaneously resolve by age 2 to 4 months...”

To be fair, the AAP also warned against forced retraction at this age. But even if this is a typo, (they meant ‘years’ but hit the ‘months’ key), their ‘spontaneously resolve’ timing would still be wrong by a decade or more. Moreover, the protective membrane, the *balano preputial lamina*, is not an ‘adhesion’—the medical term for an unnatural fusion of traumatized tissue. The BPL is a natural and important detail of gross anatomy, expected of every healthy, normal, newborn boy, whose penis at birth is still developing.

This AAP nonsense broadcasts a regrettable message to millions of parents and provides temptation, as well as legal cover, for 80,000 AAP clinicians. A four-month-old boy whose foreskin is still ‘adherent’ is failing to observe the AAP’s accelerated schedule for penis development; i.e., the boy needs (19th-century) medical intervention.

Individual clinic websites all over the U.S. regularly quote the AAP at length, updating their websites at each new bulletin from the AAP home office in Illinois. The AAP advice at 763e, offered entirely without reference or documentation (especially when contrary scholarship is readily available), is unforgivably misleading. It exploits parental fears and provides an open invitation to fraud and injury by clinicians. Such advice, widely broadcast by a trade organization that claims to advocate for children—then copied and pasted to the websites of 10,000 U.S. clinics—risks the health, safety, and comfort of *millions* of boys.²⁸

By such means does pernicious 19th-century folklore survive unchallenged and become fixed in the medical firmament of 2014.

Unfortunately, the Situation is Going to Get Much Worse

If the foregoing were not collectively sorry enough, in October, 2015, a new edition of the International Classification of Disease, ICD-10, will be launched in the US. (It is already in use in other countries, and has been since 1992.)²⁹ The old, superstitious justifications for treatment of the entirely normal ‘tight foreskin’ of childhood have been retained in full, and—alas—upgraded to remove any ambiguity. The new code, at ICD-10-CM-N47.0, reads:

“Adherent Prepuce, Newborn”

This ‘disease’ code is both eye-stretching and jaw-droppingly ignorant—or rankly dishonest. While the old ‘605’ was silent as to the age of the patient, and could arguably apply to adult difficulties, the addition of “**adherent prepuce, newborn**” at 47.0 is folklore writ large, a giant step backwards into the 19th-century of Lewis Sayre and pre-germ-theory *reflex neurosis*. It is also an open invitation for ignorant, ill-trained, or dishonest primary care providers to defraud families, injure a child, and profit by it, exploiting the trusting nature of young parents.

As more and more parents reject the circumcision advertising campaign of the US medical marketplace, the number of intact boys is rising—a healthy trend.³⁰

But those boys are now, and will be even more so in 2015, vulnerable to a diagnosis of a 'birth defect,' an 'adherent prepuce or congenital phimosis,' a foreskin still naturally attached to the glans. This, coupled with circumcision marketing at its most craven and shameless, constitutes inarguable medical fraud.

As 'medicalized' circumcision, that most unnecessary of amputations, slowly fades away, as it is doing in all English-speaking countries where it began, there will be an ever larger, 'target-rich' cohort of vulnerable intact boys, over one million each year and rising, in the US alone. The misinformation campaign of the AAP, bolstered by the arrival of ICD-10-CM-N47.0, promises to embroil families, defraud naïve and trusting parents, injure boys, and even slip past the auditors of incautious medical insurers.

The Saving Grace, Sort-of, Maybe?

Oddly, while ICD-10 has not even arrived in the United States, the new ICD-11 is already available in *beta*, and is getting ready to be rolled out overseas.³¹

Curiously, the offending entry:

“Adherent Prepuce, Newborn”

...has totally disappeared from ICD-11 in the proposed version. Some large medical chains have hinted they are tempted to skip ICD-10 and go directly to ICD-11 from the current ICD-9, which would be—for N. American boys, anyway—a blessing of sorts. (The AMA, for various reasons, discourages skipping over 10).³² Whether some sensible committee knew 47.0 was patently ignorant or dishonest, or sensed it appeared a bridge too far, might never be known.³³

The bad news is that the USA medical coding system used ICD-9 for two decades after everyone else in the world had moved on. That means that ICD-10, with its suggestion of millions of disease-ridden newborn boys, might linger for many years, possibly even decades, well before ICD-11 comes to the rescue.

Such is the power of what we could call—oxymoronically—top-down, 'institutionalized,' zombie folklore.

The Takeaway

It is sometimes useful (well, actually, *regularly* useful) to take the long view backward and consider that we humans came from over 100,000 years ago. Natural selection made our various systems mostly self-cleaning and self-defending, or our particular strain of *homo sapiens* would have disappeared eons ago. Is it really likely that our primate ancestors scrubbed their children's foreskins every day at a nearby river, and the offspring of those who failed to do so perished, victims of parental neglect? Or were our forebears more interested in food, shelter, and avoiding predators, and, as evolutionary survivors, needed no such care?

If there were any actual need for the sort of 'hygiene hysteria' that the American Academy of Pediatrics and ICD-10-CM-N47.0 peddle, or our genitalia were as high-maintenance as clinical folklore claims, surely none of us would be here.

How could it be otherwise?

John V. Geisheker, JD, LL.M, Executive Director
George C. Denniston, MD, MPH, President
Doctors Opposing Circumcision
Seattle, Washington, USA

Endnotes

¹ [Waste in the U.S. Health Care System: A Conceptual Framework](#) Tanya G K Bentley, Rachel M Effros, Kartika Palar, Emmett B Keeler, *Milbank Q.* 2008 December; 86(4): 629–659. doi: 10.1111/j.1468-0009.2008.00537.xPMCID: PMC2690367.

² The 'Semmelweis Reflex,' a tendency to reject new medical science reflexively in favor of old folklore is named after him. Readers will soon appreciate that forcible foreskin retraction is a textbook example. See also: Wilson, Robert Anton (1991). *The Game of Life*. New Falcon Publications. ISBN 1561840505.

³ Babies Don't Feel Pain: A Century Of Denial In Medicine, David B. Chamberlain, Ph.D., Presented at The Second International Symposium on Circumcision, San Francisco, California, May 2, 1991. <http://www.nocirc.org/symposia/second/chamberlain.html>
Are There Long-Term Consequences of Pain in Newborn or Very Young Infants? Gayle Giboney Page, RN, DNSc, FAAN, accessed at:
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1595204/>

⁴ Glick, Leonard, *Marked in Your Flesh: Circumcision from Ancient Judea to Modern America*, New York: Oxford University Press, 2005:151.

⁵ Darby, Robert, *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain*. Chicago: University of Chicago Press, 2005:99]

⁶ "The operation should be performed by a surgeon without administering an anesthetic, as the brief pain attending the operation will have a salutary effect upon the mind, especially if it be connected with the idea of punishment. In females, the author has found the application of pure carbolic acid to the clitoris an excellent means of allaying the abnormal excitement." *Plain facts for old and young: embracing the natural history and hygiene of organic life*.

John Harvey Kellogg, I. F. Segner, Burlington, Iowa, 1890, c1886.

⁷ Darby, op cit., p234.

⁸ Rudolph, AM, and Hoffman, MD, *Pediatrics*, Appleton and Lange, Norwalk CT & Los Altos CA, 1987, Eighteenth Ed., Chap 23.13.1 "Penis" at p1205.

⁹ Fleiss, PM. Hodges, FM, Immunological functions of the human prepuce, *Sexually Transmitted Infections*, (London) vol 74, No. 5 (October 1998); pp. 364-367.

¹⁰ Robertson, N.R.C., "Care of the Normal Term Newborn Baby", in Janet M. Rennie and N.R.C. Robertson (eds) *Textbook of Neonatology*, 3rd edn., Edinburgh, Churchill Livingstone, 1999:378-9.

Osbourne's Pediatrics, 2005, eds Osborne, DeWitt, First & Zenel, (Elsevier Mosby), at pg 1925.

Avery's *Neonatology: Pathophysiology and Management of the Newborn*, MacDonald (ed) Lippincott, 2005:1088

¹¹ But beyond a mere pronouncement or two, the AAP has done absolutely nothing to enforce this prohibition among their membership. Many pediatricians believe the express AAP prohibition against forced retraction applies only to parents, not to them. What's not clear is how they think they would be able to avoid the permanent injury which the AAP warns that *parental* retraction will cause.

¹² Darby, op cit, p235.

¹³ Rudolph, AM, and Hoffman, MD, *Pediatrics*, Appleton and Lange, Norwalk CT & Los Altos CA, 1987, Eighteenth Ed., Chap 23.13.1:1205.

¹⁴ "Mothers of infants whose foreskins had been manipulated by physicians felt this practice was traumatic."

Osborn, LM et al, Hygienic Care in Uncircumcised Infants, *Pediatrics*, 1981;67:365-367.

¹⁵ <http://www.cirp.org/library/treatment/phimosis/>

¹⁶ Cold CJ, Taylor JR. The prepuce. *BJU Int* 1999;83 Suppl. 1:34>44.

Sorrells M L, Snyder JL, Reiss, MD, et al, 2007 Fine-Touch Pressure Thresholds in the Adult Penis. *BJU International* 99(4):864– 869.

¹⁷ "I have some good friends who are obstetricians outside the military, and they look at a foreskin and almost see a \$125 price tag on it. Each one is that much money. Heck, if you do 10 a week, that's over \$1,000 a week, and they don't take that much time."

Dr. Thomas Wiswell, quoted in the Boston Globe, June 22, 1987.

¹⁸ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/ICD-Coding/ICD-10-Changes-from-ICD-9.html>

¹⁹ <http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx>

²⁰ Partial paralysis from reflex irritation, caused by congenital phimosis and adherent prepuce: Extracted from the transactions of the American Medical Association, Lewis Albert Sayre, Collins, 1870. **ASIN:** B00088CAM0.

²¹ <http://www.cirp.org/library/treatment/phimosis/beauge/>

²² Urology News, Vol 14(6) Nov / Dec 2009.

Øster J. Further fate of the foreskin: incidence of preputial adhesions, phimosis, and smegma among Danish schoolboys. *Arch Dis Child* 1968;43:200-3.

Kayaba H, Tamura H, Kitajima S, et al. Analysis of shape and retractability of the prepuce in 603 Japanese boys. *J Urol* 1996; 156: 1813-1815.

²³ The wellspring for the suggestion that intact boys are uniquely susceptible to UTI (if 1% incidence easily cured with antibiotics can be thought of as a big problem) is Thomas Wiswell, a U.S. army physician who never corrected for septic, premature, forcible, foreskin retraction at a time when forced retraction was standard operating procedure for all intact boys. Likely 'septic tampering' accounted for the etiology in many if not most of his claimed UTI cases.

²⁴ <http://www.ajmc.com/publications/issue/2014/2014-vol20-n4/A-Novel-Approach-to-Minimizing-Adverse-Incentivization-in-Healthcare-Payment-Systems>

²⁵ In 2005, in Washington state, a FOIA demand showed \$500,000 'leaked' out of Medicaid using billing code ICD-9-605 that year, due to interventions upon infants who

had entirely normal anatomy. Washington would hardly be the only state with such a track record of clinical fraud.

²⁶ Avery's *Neonatology* suggests a possible, though feeble, excuse: "Because circumcision is so common in the United States, the natural history of the preputial development has been lost, and one must depend on observations made in countries in which circumcision is usually not practiced." *Avery's Neonatology: Pathophysiology and Management of the Newborn*, MacDonald (ed) Lippincott, (2005:1088)

²⁷ <http://pediatrics.aappublications.org/content/130/3/e756.full.pdf+html>

This latest policy, initiated September, 2012, has been firmly rejected by the medical societies of 17 developed nations, as culturally biased rather than scientific. The error of the AAP timetable for foreskin retraction is representative. See:

<http://www.circumstitions.com/Docs/aap-12-europe.pdf>

²⁸ Example: The 8th edition of *Weber's Nurse's Handbook of Health Assessment*, released in 2013, picked up the AAP error almost word-for-word.

²⁹ <http://www.webpt.com/blog/post/history-icd-10>

³⁰ http://www.cdc.gov/nchs/data/hestat/circumcision_2013/circumcision_2013.htm

³¹ The *beta* version of ICD-11 may be explored here:

<http://apps.who.int/classifications/icd11/browse/f/en>

³² AMA discussion of skipping ICD-10 may be viewed here: <http://www.ama-assn.org/assets/meeting/2012i/i12-refcomm-b-annotated.pdf>

³³ The new ICD-10 CM at N47.3 entry also lists the disease of "Deficient Foreskin." What might that mean? For instance, too short, entirely missing, or not missing enough?

John V. Geisheker, JD, LL.M, has practiced medico-legal law as an arbitrator, mediator, litigator, and law lecturer for over 30 years. He is the full-time *pro bono* Director and General Counsel for Doctors Opposing Circumcision, an international physicians' charity based in Seattle, Washington. D.O.C.'s members and supporters oppose cultural, non-therapeutic genital cutting of children, male or female, on human rights' and scientific grounds. John is a native of New Zealand, a country that fully abandoned medicalized male circumcision in the 1960's. He hopes his adopted USA will someday follow that principled example. Seattle, Washington, USA.