Additional guidance and prompts: non-therapeutic male circumcision

This guidance covers non-therapeutic circumcision of male children (NTMC), which we have developed with other professional organisations.

NTMC is often carried out in the community by non-medical representatives of faith communities. These individuals are not within the scope of CQC's regulation. However, if a registered healthcare professional wishes to carry out NTMC, they must be registered with CQC to carry out the regulated activity of surgical procedures. Even if a healthcare professional is acting in a religious or spiritual role, they cannot 'opt out' of their core duties and responsibilities. If they wish to carry out NTMC, they must be registered with CQC before doing so.

We have published information on consent for minor surgery in GP surgeries, which may be helpful for inspection teams considering therapeutic circumcision, and information on recognising female genital mutilation (FGM).

The British Medical Association has published guidance on this topic, including the following 'Ten good practice points':

1. Doctors must act in a child's best interests.
2. A child's best interests include not only a child's health interests but also a child's social and cultural interests.
3. Children who are able to express views about NTMC should be involved in the decision-making process.
4. Where a child (with or without competence) refuses NTMC, it is difficult to envisage a situation in which it will be in a child's best interests to perform circumcision, irrespective of the parents' wishes.
5. Parental preference alone does not constitute sufficient grounds for performing NTMC. It is the parents' responsibility to explain and justify requests for circumcision, in terms of the individual factors in relation to a particular child's best interests.
6. Consent for NTMC is valid only where the people (or person) giving consent have the authority to do so and understand the implications and risks.
7. Where a child lacks competence, and where there are two parents, both must give consent for NTMC.

8. Where people, and/or agencies, with parental responsibility for a child disagree about whether he should be circumcised, doctors should not circumcise the child without the leave of a court.
9. As with all medical procedures, doctors must act in accordance with good clinical practice and provide adequate pain control and aftercare.
10. Doctors must make accurate, contemporaneous notes of discussions, details of best interests assessments, consent, pre-operative clinical assessments, the procedure itself and its aftercare.

We will consider whether doctors undertaking NTMC are doing so in accordance with these principles and to the same standard required for medical therapeutic circumcision.

If we have evidence to show that a doctor is not acting in a way that satisfies the principles of best practice, or that they are failing to provide safe and effective care, we will consider whether we need to take regulatory action.

Additional prompts

These prompts are additional to, and should be read alongside, the assessment framework for healthcare services.

Safe
S1: How do systems, processes and practices keep people safe and safeguarded from abuse?
How does the provider ensure the environment and equipment used for circumcision is suitable, especially when carried out in a non-clinical community setting? This includes infection control, emergency equipment and medicines.
How does the provider ensure the child is safely kept still or restrained during circumcision? Is any equipment used to do this?
What measures, including anaesthesia, does the provider use to minimise distress and discomfort during and after circumcision?
How would the provider respond to complications or an emergency during circumcision? What process and equipment do they have to handle this?
S2: How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?
If children have a pre-existing condition(s), how does the provider determine, assess and document potential increased risks in carrying out the procedure?

Effective

E2: How are people's care and treatment outcomes monitored and how do they compare with other similar services?

How does the provider record and monitor the clinical outcomes from circumcision procedures?

E6: Is consent to care and treatment always sought in line with legislation and guidance?

How does the provider:

- determine which people are required to provide consent for circumcision
- verify the identity of 'accompanying' adults and whether they have parental authority
- determine the need for consent from both parental guardians, if appropriate
- determine the competence of the child to consent?

How is this recorded and documented?

How does the provider ensure that parental guardians responsible for consent are informed about relevant issues, including the risks of the procedure?

If the provider has carried out circumcision without the consent of both parents, can they explain why and provide evidence to support their decision?

How would the provider manage situations where the child (even when determined as lacking capacity) and/or guardians disagree or refuse to give consent?

How does the provider determine the child's best interests? If the procedure is determined not to be in the child's best interest, what advice do they give to the parent(s) or person with parental responsibility? How does the provider justify and record the basis on which their decisions were made?

Caring

C1: How does the service ensure that people are treated with kindness, respect and compassion, and that they are given emotional support when needed?

Does the provider routinely have a parent or carer, or other healthcare professional in the room during the procedure? What determines this decision?

C2: How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support as far as possible?
Where possible, how does the provider engage and support children to express their views and involve them in the decision-making process?
Responsive
R1: How do people receive personalised care that is responsive to their needs?
What criteria does the provider use to determine whether to accept a request to perform circumcision at a home or other community setting? What potential additional risks do they consider?
Well-led
W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?
How does the provider manage its performance regarding circumcision procedures? What action is taken when issues are identified? Who oversees these?

Links to external guidance

British Medical Association: Non-therapeutic male circumcision of children ethics toolkit

World Health Organisation: Manual for early infant male circumcision under local anaesthesia

General Medical Council: Ethical guidance for all doctors: 0–18 years

Royal College of Nursing: Restrictive physical intervention and therapeutic holding for children and young people (currently under review).