and even if they agree to have sex, the other party will be guilty of sexual assault. If they cannot consent to sexual relations, they are certainly not competent to consent to having a part of their penis excised.

The practice with respect to genital surgeries should be no less strict than the rules governing sexual activity. If circumcision provides some protection against sexually transmitted infections (a contentious point[2,3]), the only logical age at which a male can legally consent to circumcision would be the same as that of consent for sexual purposes. If it is wrong to perform circumcision in infancy, it is equally wrong to perform it at any time before legal adulthood.

MacDonald's contention that circumcision at puberty provides "the opportunity for informed choice … the boy can give assent" is contradicted by experience. Many tribal societies perform initiation rites on peripubertal boys and girls, sometimes involving circumcision, but the children have no more opportunity to decline the operation than to fly to the moon. If they object, they are subject to violent coercion; if they run away, they are ostracized. Circumcision of boys at around 9 to 11 years of age is usual in South Korea and the Philippines, where social expectation, peer pressure and the fact that boys are still children subject to parental discipline means that they have little chance of saying, "No thanks."[4,5] Unless they can decline without prejudice to their future social status, there is no possibility of free choice.

The "medically important question" is not whether circumcision should be "routinely offered to young male adolescents rather than their baby brothers," but how we can find an effective way of giving boys some protection against genital cutting?

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Empathetic responses

I support what Buckman and colleagues have written about the teaching of empathy in medical schools.[1] I would add that it is the patient, not the doctor or faculty member, who evaluates whether a doctor shows empathy. Whereas we can always teach techniques to increase the awareness of doctors about the understandings, feelings and experiences of patients, the doctor does not determine whether he or she comes across as empathetic.

Mercer and Reynold's article included an "empathy scale," on which the patient grades the physician in 10 broad areas.[2] If the grade shows a lack of involvement, the physician may feel very vulnerable, especially with a difficult patient.

Few patients (and doctors) care about empathy if there is a speedy cure. The paradigmatic example is a surgeon: If you had to choose, would you want a good cutter or someone who understands you? Response by physicians to the patient's grading could provide additional scope for teaching empathy while acknowledging the need for empathetic interaction between physicians and teachers.

Empathy involves taking the time to know a patient as the patient understands him- or herself. And taking this time, as well as that required for understanding an often complex diagnosis, is in economic terms very inefficient and costly. Increasing the empathic communication of physicians is not independent of revising other system health care values.

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Some letters have been abbreviated for print. See www.cmaj.ca for full versions.