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BRITH MILAH AND MEDICINE II



Transcript

AMERICAN JEWISH

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Symposium Conducted

at

Mount Sinai Medical School

New York City



BRITH MILAH AND MEDICINE II

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Rabbi Eugene J. Cohen, Ph.D.

Donald Gribetz, M.D.

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## PREFACE

Rabbi Gilbert S. Rosenthal  
Executive Vice President, New York Board of Rabbis  
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Circumcision, Brith Milah, is one of the first and foremost commandments given to the Jewish people. Indeed, before we became a people covenanted to the Torah, we were a people covenanted by circumcision for the mitzvah of milah dates to Abraham. It is the mark in the flesh that we are all Israel's sons; it is the first commandment a Jewish male observes (albeit unwittingly); it is a sign between the Creator and Israel that we are His covenanted people forever. It is no accident that the organ of procreation is singled out for the surgery. In doing so we say, "This covenant is for you and your descendants and for theirs after them -- forever."

It is noteworthy that circumcision assumed paramount importance in Jewish life precisely when Judaism was threatened with annihilation. The Hellenist party of assimilationist Jews in the time of the Maccabees are reported to have sought to undo their circumcision by painful plastic surgery in order to "pass" into the Greek world. Three centuries later in the days of the Roman Emperor Hadrian, circumcision was outlawed on penalty of death, no

doubt in order to stamp out Judaism once and for all. The tensions of the times are reflected in this Midrash (Mekhilta Yitro II, p. 247 ed. Lauterbach):

"To those who love Him and keep His commandments" (Deuteronomy 7:9). To whom does this refer? It refers to the Jews who gave their lives to observe the mitzvah. "Why are you being led out to execution?" "Because I circumcised my son to enter him into the covenant of Israel."

Clearly, Jews were prepared to lay down their lives in defense of this core mitzvah. I know of Jews in the Soviet Union who had their sons circumcised clandestinely, at night fully aware that exposure would have resulted in imprisonment. Instinctively, they felt that without milah what chance for Jewish survival is there? Doubtlessly, this is why the sages declared in obvious hyperbole that "the commandment of circumcision is so great that it equals all of the other mitzvot of the Torah" (Nedarim 32a).

Historically, theologically, religiously, and sociologically milah is a vitally important precept that deserves to be stressed and reevaluated constantly. There are, it seems, ever new and fresh overtones and nuances connected with circumcision. For example, it has been suggested that one of the reasons for the tragic rampage of AIDS in parts of Africa is the failure of males to practice circumcision. All the evidence is not in, but it seems as if the reasons for the Divine laws are constantly unfolding like some great tapestry.

Consequently, it is important to disseminate knowledge of the importance of milah especially in this age of sexual licentiousness and dangers. It is necessary and good that we convene periodic conferences of urologists, surgeons, epidemiologists, rabbis, and sages who share their accumulated wisdom and reveal new insights into the recondite glories of one of God's most remarkable imperatives. We are deeply grateful to Rabbi Eugene Cohen and the rabbis and physicians who participated in this symposium le-shem shamayim, "for the sake of Heaven."



Rabbi Eugene J. Cohen, Ph.D.:

I am very happy to introduce Dr. Donald Gribetz. He is a world renowned Professor of Pediatrics. He has many qualities: Chairman of the Physicians' Committee for UJA in this area; Chairman of the Medical Ethics Seminars in this Medical School; he spends a month each year in Israel teaching the pediatricians there how to be better pediatricians; he and his brother Dr. Irwin spend hours each day convincing parents to have a Brith Milah rather than a medical procedure. But above all his *אורח* *אורח* are exemplary. It is, therefore, a distinct honor to introduce a dear friend, a friend of everyone, Dr. Donald Gribetz.

Dr. Donald Gribetz:

After an introduction like that, if I say anything, I can ruin it.

Welcome to the Mount Sinai School of Medicine, and we hope that during this day, we will have a productive and informative session on the newest thinking on circumcision in general, and how this might apply to *אורח* *אורח*.

This Symposium is sponsored by: The Department of Urology, the Jack and Lucy Clark Department of Pediatrics, the Page and William Black Post-Graduate School of Medicine of the Mount Sinai School of Medicine (CUNY) and the

Brith Milah Board of New York and International Brith Milah Board.

None of the sponsors and nothing that we have done would have been possible without Rabbi Cohen. I continuously admire his tireless efforts for upgrading Brith Milah, and his uncanny way of getting people to work with him. Without him, there would be no Symposium.

The last time we met, it was to discuss the negative writings in the medical literature, which was subsequently mirrored in the media. I remarked then about our concern with this aspect and the growing indifference of Jewish couples to the fact that Brith Milah is an integral part of our tradition.

Two recent medical findings have conferred a more positive attitude to surgical circumcision. We are all familiar with the first, i.e., the decreased incidence of urinary tract infection in neonates who have been circumcised in contrast with those who were not circumcised; and the second the increased incidence of AIDS, certain venereal infections in non-circumcised males and perhaps even in their partners. These factors have provided a better outlook for circumcision than in the past.

It is to be hoped that our particular problem, Brith Milah, will be enhanced by the above new findings together with the fact that young couples may be further taught and

encouraged concerning the covenantal and the ritual aspects of circumcision. The incidence of Brith Milah may be increased. Symposiums such as these will be of benefit.

We have arranged a panel of my colleagues to discuss some of the newer findings.

I would like to introduce Dr. Elliot Leiter whom many of you know. He is a senior urologist at Beth Israel Hospital and professor of Urology at the Mount Sinai School of Medicine. He will discuss the newer technical aspects of circumcision.

Dr. Elliot Leiter:

I will discuss the technical aspects in the performance of circumcision and how to avoid complications as well as the new surgical techniques that we use to reconstruct the penis when circumcision is impossible because of the congenital anomalies.

Inspite of the optimism of Dr. Gribetz, namely that circumcision appears to be out of the Dark Ages, being decried by the Academy of Pediatrics, I think that we in medicine, and you as an extension of that, we are struggling with quite another problem that is at least as difficult to handle. The conviction on the part of the public that they truly understand the ramifications of the medical care and their unwillingness to abdicate the position of decision making to any other than themselves.

You may wonder why I am going off on this "social kick," but you must realize that you can not fall back on anything but a) your image; b) your convictions; and c) your knowledge. This is the importance of this type of meeting.

You will find that parents are suspicious of us, and probably more suspicious of you as mohelim practicing surgery. I think that you have to express your confidence, and your knowledge of the literature. Should you sense more suspicion, fall back on either a pediatrician or a urologist with whom you have established a relationship. It will be easier to tell a concerned parent: "Bring the child to a pediatrician or to a urologist." This will relieve you of your burden.

Many of you have seen hypospadias. The standard answer that we formerly gave was that such children should not be circumcised until the decision has been made as to whether they will need repair, which is done between the ages of six to twelve or eighteen months. That is no longer so. Most of the children with minor degrees of hypospadias can be circumcised at the correct time. This is important to satisfy the ritual. We are not out to fool God, we can not fool Him. You have to be aware of the fact that just because a child has hypospadias does not mean that the foreskin has to be saved. More important than whether the child has hypospadias is:

a) how severe is the hypospadias; and b) how curved is the penis. If it is curved, how severe is the chordee? The vast majority of children where the hypospadias originates close to the glans penis, and in whom there is no chordee, and that is critically important. Most children can be circumcised at eight days. But it is very important for you to be aware if there is curvature of significance. I would say to you: "Do not make the decision." You are much better off not making the decision. But do not decide that because there is hypospadias, circumcision can not be done. When you see a child who was born at New York Hospital, Presbyterian Hospital or any other place where there is no commitment to ritual circumcision, they will say: "Circumcision is not possible now, you will have to wait six or eight months." You do not have to accept that. You will find in New York, urologists who are committed to circumcision who can give you an opinion that is based on equal scientific merit, but with conviction that ritual circumcision should be done at the correct time, if at all possible.

The reason that you do not want to circumcise a child who has either chordee or hypospadias is because you will need the foreskin for rebuilding the penis. The foreskin is one of the two places where there is hairless skin. The other place is the eyelid which is not a very good place

from which to transplant skin. The foreskin is readily available and in place. It is perfectly correct to remove the foreskin when it will not be needed.

The reason it is needed is that when the opening is too far back and the tube has to be rebuilt, the skin is needed to construct a tube, or if it is so curved that when it is straightened-out there will be a defect and skin is needed to correct the defect.

The second reason is that much less skin is required than has been previously maintained. Even after a circumcision there is an abundant amount of skin on the penis to fill in for a degree of curvature. But you will need all the skin if there will be repair beyond a minimal amount of hypospadias.

Hypospadias is very easy to recognize. Generally a child will be seen by a pediatrician, but in the unlikely event that you are the first to see it, remember that you will rarely see a child whose foreskin is complete with hypospadias. On the other hand, you can see a child whose foreskin is incomplete; this does not mean that the child has hypospadias, but you have to be certain that he does not have hypospadias. Foreskin, embryologically, forms after the urethra has reached the tip of the penis. If the urethra has reached the tip of the penis, the foreskin may not yet close. If the foreskin has completed its circumference, you will not see hypospadias.

The repairs that we do now, we did not do ten or fifteen years ago. The minor degrees of hypospadias without chordee, we would ignore. We would tell the parents that the complications of repair are such that it is not worth taking the risk to fix it. Today, there is hardly a child with any degree of hypospadias that does not get a repair even if it is cosmetic in nature. It is done on ambulatory surgical basis with general anaesthesia. The minor degree can be fixed in thirty or forty minutes. The children are circumcised at the same time, if they haven't been circumcised before. They do not require catheters afterwards, with the minor degree of hypospadias. If the hypospadias is more, it is still generally done on an ambulatory basis, although the more severe case may require the child remaining in the hospital a day or two. They will go home with catheters.

I would say that from the point of view of the suspicion that we see in medical practice, that will be transmitted to you, as well. The most important thing that you can do is to have the children and the parents evaluated by you, before the circumcision is performed.

Think about it for a moment. I, as a surgeon, would never do surgery on a child without having a pediatrician seeing the child first, and say: "This child is O.K. for a surgical procedure." I would hope that you as mohelim

do the same. It is not wise in America at the end of the twentieth century to do circumcision on a child without a pediatrician, having his reputation on the line, as much as yours is. There is no reason why you should shoulder the responsibility. So, the first thing you do is to ascertain that some doctor has seen the child, and said: "It is O.K." The second thing you should do, is see the child and the parents. I get calls all the time, mostly from parents who have adopted a child. They want to have the child circumcised. I always say to them: "Bring the child to the office," not that I will find anything, but one should not have surgery without meeting your surgeon. And from the point of view of the parents, they should not be expected to let you operate on the baby without letting you see the baby first. This is important to enable the parents to ask questions to find out your feelings, and for you to meet the parents to ascertain whether these are parents that you can trust, as well. There are some parents that you will think: "There is something about them, perhaps I should send them for another opinion," if you will. And if you do not see the child two days or so before, you will not have time for the things you are concerned about. I do not think it is sufficient to see the child the morning of the circumcision, or the night before. You may not be able to have it checked out before the eighth day.



See to it that a pediatrician has examined the child, meet the parents before the circumcision, and then most of the problems will have been eliminated, because the idea is to avoid complications like a pro, not to get into complications like a shlemiel, and then get out of them like a pro. The best way to get out of complications is to avoid them, and not say: "I am pretty good, and I will get out of them."

Those of us who have been in surgical practice for years, realize that the best way to avoid complications is to be careful -- see the patient beforehand, then do the surgery appropriately.

A frequent question is: "What about hemostats?" As a mohel, the best thing is to avoid using hemostats. You will rarely have a situation of bleeding that you can not control by local pressure. When I get a hole in the aorta, which is larger than any artery in the penis, I put my finger on it, and 98% of the time, unless it is a very large hole, just my gloved finger on the aorta will stop most of the bleeding. You know that if you wrap the penis in a mild pressure dressing, the bleeding will stop. If the bleeding does not stop, then the likelihood is that you have a bleeding abnormality, you will not stop it with a hemostat. Avoid the use of hemostats.

I must caution you about chubby babies. If you are going to use the Magen Clamp, the complication that you are liable to see is, a relative catastrophe to the family, because it requires a complete redo of the circumcision, and this is what I call "hidden penis." In the chubby child, the penis sinks into the fat fold, and you push on the fat fold and the penis bounces out. It is a postoperative surgical complication, related to the use of the Magen Clamp or any clamp where you do not remove the foreskin to the base of corona. The reason it happens is because the scar is now part of the tip of the penis. You have done periah, but with the chubby child it can now fold over the penis. Circular scars contract into tighter and tighter circles, and if the scar is beyond the penis, it will continue to scar until there is no opening. The penis is hidden behind the scar.

The only way to solve this problem is to cut the scar, remove the inner aspect of the foreskin that was left, and redo the circumcision. The scar will be at the base of the corona. The reason that this does not occur in the non-chubby babies is that the scar contracts, hits the shaft of the penis, and since it can not contract anymore, it stops.

What you should do in the case of a chubby baby is to get the inner aspect of the foreskin back to the corona,

which you can not do with the Magen Clamp. You can do it, if you use a Magen Clamp free-hand, otherwise say to the parents that "should the penis sink back," deliver the penis once or twice a day, placing antibiotics on it, so that it pops out of the fold and avoid this complication.

I will conclude with several statements. Referring to what Dr. Gribetz said about the dramatic change of attitude on the part of physicians with regard to circumcision. Do not think that the change is as dramatic, as you may be led to believe.

It is true that the Academy of Pediatrics has modified its stand, from "no medical indication," they came out with a statement that is couched very carefully. It does not state that there are medical indications for circumcision. The jury is still out. We do not know if there are medical indications for circumcision. What they suggest is that there is increasing evidence that circumcision can prevent real problems. I think that in the future there will be more evidence to substantiate, but I do not think we will ever get back to the point where we were in America, that almost all boys were circumcised. It was probably a mistake -- by making something universal, you get a rabid minority up-in-arms. It would be a mistake to insist that all boys in America should be circumcised.

There are Jewish parents who are swayed by the rabid arguments. I see children who were not circumcised, and they are brought to me with complications.



Dr. Donald Gribetz:

Thank you, Dr. Leiter. I will now introduce Rabbi Charles A. Spirn, chaplain of The Mount Sinai Hospital.

Rabbi Charles A. Spirn, Ph.D.:

I know that you will be happy to learn that on Thursday, December 14th, we will formally dedicate our kosher kitchen. This represents a historic milestone in this prestigious hospital. In 1852, this hospital was founded as Jews' Hospital and was completely kosher. When it changed its name to The Mount Sinai Hospital in 1866, it became non-kosher. After a lapse of 124 years, we will again have a kosher kitchen for patients, staff, students and visitors when it opens on August 15, 1990. The kosher kitchen will be supervised by the Union of Orthodox Jewish Congregations. Mashgichim will be present whenever the kitchen is operational.

A second innovation is now in the making -- the construction of a synagogue on our premises. At present, services are conducted in a gymnasium in which we have a Torah Scroll and an Ark. The synagogue is to be completed in 1992, and will serve as a facility for ritual circumcision. These accomplishments were accomplished with great effort, and I am grateful to God that I was the shaliach for the creation of the kitchen and synagogue.

I am now working on my Mezuzah project. I want to affix 900 Mezuzahs on patient rooms. I need \$24,300 which amounts to \$27.00 for a strictly kosher Mezuzah. If you know a charitable person who may be willing to help us in this mitzvah, please let me know.

This being a conference on Brith Milah, you will surely be interested in figures which I have tabulated during the past nine years, from November 1980 to November 1989. I interviewed 3,747 maternity patients in our hospital. The statistics are the following: 3,327 in which both the husband and wife were Jewish, 89% had a Brith Milah on their sons. This is due to the large number of Orthodox women who come here, and are mostly the patients of Drs. Donald and Irwin Gribetz. When only the mother is Jewish, 225 maternity patients, 30% had a Brith for their sons. When only the father was Jewish, 195 maternity patients, 18% made a ritual circumcision as a prelude to conversion. When there is intermarriage, some have decided to raise the child as a Unitarian, Catholic or both the Jewish and non-Jewish religions. Six others had made no final decision at the time of the interview. When the mother is Jewish, I encourage the parents to rear the child as a Jew. We have an excellent mohel at this hospital: Rabbi Ephraim Rubin. I recommend him to many parents when they have no mohel of their own.

The Jewish community must have outstanding mohelim who know the halakhic and scientific requirements of a brith, and also know how to communicate well with the parents of the child. In addition, it seems to me, that perhaps, some religious surgeons and physicians ought to be encouraged to learn the laws of milah and practice as mohelim, or that mohelim acquire a medical certificate in addition to the halakhic qualifications. This will offer confidence to some hesitating mothers, knowing that a licensed surgeon or mohel is operating on their child.

I wish you success in your deliberations, and may we promote Yiddishkeit, mitzvoth, and add merit to the Jewish community.

Audience:

We were pleased to learn of the kosher kitchen, synagogue and the Mezuzah project. I think that any medical school that teaches doctors milah endangers milah because parents will think of this rite as surgery and not ritual.

Rabbi Spirn:

I said: "Perhaps." In a few cases, I salvaged milah by recommending an Orthodox physician from Teaneck who is also a mohel. Moreover, milah ought to be taught by rabbis and mohelim and not by a medical school.

Dr. Gribetz:

Your comments are well taken. My reaction is -- I do not know of any medical school that teaches mohelim. I think that this goes into Rabbi Cohen's lap. He is the head of the Brith Milah Board. If we need more mohelim, and we want people to learn by apprenticeship, you are right.

I want to take cognizance of one thing. The Conservative and Reform Movements began to teach and upgrade mohelim in their own organizations.

Audience:

I am from Massachusetts -- I am a urologist and a mohel for the past three years. What I do at a brith follows Halakhah and Yiddishkeit and not surgery.

Dr. Donald Gribetz:

What is your name?

Stuart Jaffe from Worcester, Massachusetts.

Dr. Donald Gribetz:

I think that this is what you had in mind. Here is a physician who is a mohel, not a mohel who is a physician.

Audience:

I think one is giving the wrong impression. When a person is looking for a religious person to perform a



religious function, he or she should be directed to a mohel, not a physician. Doctors have a tremendous advantage over the mohel, because the former can be reimbursed from insurance. Eventually, parents will only take the physician and the religious aspect will be lost.

Dr. Donald Gribetz:

We can discuss this further during the break. I think you are close to each other. Let me advise you -- do not bring money into the argument. Once you do, you will be in an untenable position.

Audience:

In Europe, a physician was not permitted to perform Brith Milah. Once a doctor becomes a mohel, the mohel becomes obsolete.

Dr. Donald Gribetz:

What you have just said is simply not true. This was not the practice in many communities. Across the Hudson River there is a wonderful doctor who performs Brith Milah.

Dr. Donald Gribetz:

I would like to introduce Dr. David Hodes, who is Associate Professor of Pediatrics at Mount Sinai and Chief of Infectious Disease of our Pediatric Department. He will discuss some of the newer thoughts on infection in terms of circumcision.

Dr. David Hodes:

It is an anomaly that we have allowed the publicity that surrounded circumcision during the last decade to have centered around questions of whether circumcision is medically indicated. When we discuss a religious ritual, of course, these are irrelevant considerations. They would be relevant, only if there were tremendous medical dangers in circumcision, which of course, there are not. Nonetheless, the events of the last decade, as Dr. Leiter told us, influenced many parents negatively, and it is unfortunate that a vocal rabid anti-circumcision group has gotten a lot of play in the press, and people's confidence has been undermined.

I think, however, as Donald has told you, that the worst is over. If the onslaught is not finished, it has to a degree been beaten back. There are medical reasons why circumcision is a good idea. Because of the Academy's recommendation, when a parent asks a pediatrician: "Is

circumcision a good idea?" he will say: "Yes." Things are headed in this direction.

What will this do for ritual circumcision? In the long run, it will be healthy for it. The general attitude of the public towards circumcision will improve, and pressures against it will diminish. The parents' anxiety will diminish. In the long run, this will be to the advantage of ritual circumcision.

To be more specific, there are three areas where the tide seems to be turning in favor of circumcision: 1) cancer of the penis; 2) venereal disease; and 3) urinary tract infection in the young male infant.

In one of these areas the evidence is not clear. In the other two areas there is not much doubt. Before discussing these, one should make a distinction when reading the medical literature. A medical question can only be satisfactorily and definitely answered when one does a randomized trial. If one wants to know, for example, in treating haemophilus meningitis, whether chloramphenicol or ampicillin is better, the proper way, and the only certain way, is a randomized trial. When you make the diagnosis -- flip a coin, and if it is heads, give chloramphenicol, if tails, give the child ampicillin, and see which does better. Then compare large groups of such children. If you want to do this properly, then the

physician caring for the patient does not know which medication the child is being given. One can then be totally objective.

In many situations, this type of study is not applicable, and circumcision is such a case. We do not randomly assign children to be circumcised or not circumcised. Rather parents make the decision about medical circumcision -- they decide for or against it. One can not be certain, under such circumstances that what are called confounding variables do not enter into the picture. When you find that circumcised individuals have less venereal diseases or less urinary tract infection -- it may be because parents who make the decision to circumcise are better parents, have cleaner homes, bring their children up better, etc. When you look at something after the fact, i.e., children with urinary tract infection, and then you ask, were they circumcised or not, rather than going prospectively, you can not be certain that you are rid of confounding variables. So too, with all retrospective data, there is an unavoidable amount of uncertainty. The amount of uncertainty may vary. Not all confounding variables are equally likely, and in not all situations are confounding variables likely to come into play.

The studies that have been done regarding venereal disease uniformly show that men who are uncircumcised tend to get more cases of herpes simplex. However, these studies are retrospective. It is possible that uncircumcised men have more permissive sexual behavior than circumcised men. This may be due to the fact that they are from a lower socioeconomic level or because they have a lower level of education. Unfortunately, the data on venereal disease is not clear. It is true that removing the foreskin would remove a large area of skin to which potential pathogens could adhere; so, there are good scientific reasons to presume that circumcision is protective; but because of the retrospective nature of the data, one can not be certain.

In the case of urinary tract infection, however, it strikes me that confounding data are rather unlikely to be the cause of the favorable results. What are these results? It was found in the U.S. Army's hospital systems, carried out mostly in this decade on infants under the age of one year, that the incidence of urinary tract infection in males who were not circumcised was fully ten times the incidence in males who were circumcised. This is a very large difference.

Is it possible that the process of circumcision weeded out the families who took better care of their

children? The answer is probably "no." This study being done in the army represents a fairly uniform level of housing, education, and pay scale. They live in a barracks situation. It is very unlikely that so great difference -- clinical difference -- could be accounted for modest differences. In these variables might be found.

Therefore, although the data, which covered several hundred thousand babies are retrospective, there is no counter hypothesis to counter the claim that circumcision caused the effect. It has subsequently been shown that a number of common urinary tract pathogens will adhere very readily to foreskin. Thus, I think it is fair to say -- urinary tract infection prevention is a valid one for circumcision.

I think that it is difficult to avoid the conclusion that cancer of the penis is prevented by circumcision. Many of the data are, admittedly, from countries where the incidence of cancer of the penis is high and the general level of hygiene is poor. Nonetheless, the data in the United States is striking -- no case of cancer of the penis has been noted in a circumcised man in the literature in any of the five major studies since the 1930s. This degree of disparity is striking, and, further, the demonstration that uncircumcised males tend to harbor papilloma viruses which appear to be associated with the causation of cancer is further support. In some developed

countries where circumcision is not common, the rate of the development of cancer of the penis in uncircumcised men is still ten-fold what it is in the United States. It thus seems that the prevention of penile cancer is another medical reason for recommending circumcision.

In sum, while the case of venereal disease prevention is not so clear, there is a clear-cut indication for the prevention of urinary tract infection in infants and in the prevention of cancer of the penis for circumcision.

It is likely, given the generally favorable review by the Academy of Pediatrics, that, while we may not see universal circumcision in the United States, it is very likely that doctors will recommend medical circumcision as a good idea. This, in the long run, will strengthen the hand of ritual circumcision, because it will remove some of the doubts that have been sown by the admittedly well-meaning, but unfortunately overenthusiastic opponents of medical circumcision.

Are there any other medical issues in circumcision? I think that there is one that everyone has in mind -- that is the question of AIDS, the question of safety. Is there a danger of contracting AIDS when performing a ritual circumcision? Surgeons in general are considered in danger of acquiring AIDS through accidental splashing of blood. Is this a potential danger in the performance of

ritual circumcision? We need to break the question down.

First, what is the incidence of AIDS in the population being served? Exact numbers are not possible, but, without doubt, it is extraordinarily low. In most cases the AIDS patients we take care of are from broken families. The children have mothers who are drug addicts, and fathers who are drug addicts. The incidence of children in an Orthodox Jewish population is negligible, perhaps no such children exist in the United States. There is a possible exception. Fathers who have hemophilia and AIDS may be asymptomatic. For some reason the incubation period of AIDS and hemophilia is prolonged. The father may be asymptomatic, but in such cases the mothers are sometimes infected. The efficiency of transfer from husband to wife, in the case of hemophilia, is in the neighborhood of 30% to 50%, not very efficient, but efficient enough to become a consideration. One-third to one-half of the babies will be carrying the virus. When children are born to such mothers, there would be a small but non-trivial risk. The child of a hemophiliac father would have blood capable of spreading AIDS virus. In such a situation, one would have to do a surgical procedure with care.

Have surgeons been infected in operations? Such cases are routinely reported to the Center of Disease Control in



Atlanta. At last count, fewer than 15 such cases were reported from needle sticks, scalpel cuts and splashes of the mucous membranes with infecting blood. The spreading of AIDS through the splashing of blood on the mucous membranes is very inefficient. It is not very efficient even when one gets stuck with a needle or a bloody scalpel. Nonetheless, the Center for Disease Control has recommended that in surgical procedures the operator take precautions, when the person to be operated is likely to be a carrier of AIDS. The precautions are: masks and a system of protecting the eyes, preferably by use of goggles which, unlike glasses, will not allow a drop of blood to enter at the side or over the top. This, in circumcision, is probably a reasonable precaution when there is parental hemophilia.

Are there other possibilities? Could the father be a bisexual man? The unfortunate thing is that you will not know this from the history by the time you perform the circumcision. One must presume that, in an Orthodox Jewish community, will be extremely rare.

Since the risks are low to begin with, and since the difficulty and delicacy of finding out the relevant information to ascertain the facts beforehand are probably impossible, it would be unnecessary to take surgical precautions such as masks and goggles in any other case

except parental hemophilia. On the whole, one can say that the AIDS epidemic should have a minimal effect on the performance of ritual circumcision, and we need not concern ourselves too heavily with it.

Dr. Donald Gribetz:

Drs. Leiter and Hodes will now answer questions.

Audience:

Should the mohel use gloves? Transfusions?

Dr. Hodes:

If there are no ritual objections to the use of gloves, they should be used, because they are part of the surgical procedure. Contact of blood in the mucous membrane should be avoided. If there is a risk, this adds to it. With modern screening programs the risk of AIDS from blood transfusions is minimal.

Dr. Leiter:

Is there anyone here who does circumcision without gloves? (No hands raised). You are all wrong both from the point of view of protecting yourselves and protecting the babies.

Dr. Donald Gribetz:

How many of you are still doing metzitzah b'phe?

Audience:

When requested.

Dr. Donald Gribetz:

Which is more important: wearing gloves or metzitzah without the phe?

Dr. Leiter:

I thought that doing metzitzah without the phe was dead thirty years ago.

Dr. Donald Gribetz:

It was not dead a month ago when I went to a bris.

Dr. Hodes:

We have never seen AIDS from a stable Jewish family.

Audience:

I have never done a bris without gloves. Can you shed light on the use of anaesthesia when performing a bris?

Dr. Leiter:

This was ignored up to a few years ago. It is obvious that you can not ask the child: "Did you feel that?" What we know is that there are physiologic changes when you do any type of stimulation. The heart rate goes up. The child breathes more quickly. A child may cry.

You get the same type of changes in a frog, for example, where the brain is separated from the lid. The question is whether or not the child feels the pain. The purpose of anaesthesia is to prevent pain stimuli from reaching the brain so that we do not appreciate the pain stimulus. The question is: whether the pain stimulus is reaching the conscious sensation of the child. Pain is saying: "I felt that." The question is: "Does the child feel pain?" This can not be answered.

When people say to you: "The child needs anaesthesia because he cried when he was circumcised, or because his blood rate went up." I do not accept that as evidence that the child had pain. However, you can not eradicate the secondary stimuli by giving local anaesthesia to the penis.

The next question is, is it necessary? We must consider the complications that may result from using local anaesthesia. There are a host of things that may result from the use of anaesthesia. The child may get convulsions. You can get infections at the sight of the local anaesthesia. You can get an allergic response to the local anaesthesia.

The question is -- was it worth it? What we do with older children, is to give them a general anaesthesia, and after the circumcision, they receive a long-lasting anaesthesia.

Audience:

At what age do you administer general anaesthesia?

Dr. Leiter:

This is done at any age. When we do a reconstruction, we can not do this under a local anaesthesia. We put the child to sleep, and then give the child a long-lasting anaesthetic which keeps them free of pain for twelve hours. The reason for the long-lasting anaesthetic is to keep the parents from feeling the pain. In ordinary situations, it is probably contraindicated. The best local anaesthetic is cocaine. You will not want to use it.

Dr. Donald Gribetz:

Anaesthesia or analgesia is a current topic in circumcision. There are physiologic studies that prove that babies suffer pain during a circumcision. There are a host of articles that recommend using a dorsal penile block. You have heard Rabbi Tendler say that there is nothing halakhic that a child must experience pain during a brith. If we could find a good way to eliminate pain, that would be nice. Many local things have been tried, but they do not work. Furthermore, they sometimes destroy the very landmarks that you have to use.

The dorsal penile block does work, but mohelim do not have the right to inject the base of the penis. The

American Academy of Pediatrics addresses the question and says that a small dosage of lidocaine can result in blood levels high enough to provide measurable systemic responses in neonates. Local anaesthesia adds an element of risk, and data regarding its use have not been reported in large numbers of cases. They conclude that it would be prudent to obtain more data from large controlled cases before advocating local anaesthesia as an integral part of newborn circumcision.

The advocates of using local anaesthesia emanate from the anti-circumcision people. They now have a new tactic -- that we are causing babies to suffer. We should find a way of using local anaesthesia.

Dr. Leiter:

When one cuts a finger with a sharp instrument, it is not felt until seconds later. In the case of circumcision, by the time it is felt, the circumcision is over. The important thing is to do the brith well. That is why a mohel should do it, because he has more experience.

Audience:

Why do you oppose using a hemostat?

Dr. Leiter:

If you put the hemostat on the artery, that would be fine. In the operating room, with good lighting, someone

holding it apart, you can not always get it the first time. This is the negative reason. A better reason is that one hardly ever needs it. In the newborn there is no vessel that requires it. Just apply pressure. It does more harm than good -- squeeze it a little bit.

Audience:

What is the best way to do p'riah?

Dr. Leiter:

The best way is the method of the old-fashioned mohel, pushing down with his fingers. The reason is that every once in a while, I see a child in the nursery where the resident put in a clamp or a probe that got into the urethral meatus, instead he will rupture the glandular urethra.

Audience:

Which topical anaesthesia do you recommend?

Dr. Leiter:

I think that there is no efficient, good topical anaesthesia.

Audience:

The method is to use the fingernail to achieve p'riah. When one uses gloves, this is not possible.

Dr. Leiter:

With a little friction, you will expose the nail. You are not only protecting yourself, you are selling the Jewish public on your doing circumcision. You will have difficulty if you do not use gloves.

Audience:

I would like to go back to the subject of topical anaesthesia.

Dr. Leiter:

You can use anything you want, and call it a topical anaesthesia. By the way, that is good medical practice.

Audience:

If a child was born prematurely, until what age do you advise going a brith without anaesthesia?

Dr. Leiter:

Three months, with a full-term normal size baby. I do not go beyond five weeks, and then they need general anaesthesia. The problem with these children is that the parents are more concerned with the anaesthesia than the circumcision. These are my practices. What do you think?

Dr. Donald Gribetz:

I agree with you. There are times when one does not have a choice. It is up to the parents.



Dr. Leiter:

It can be done with a penile block.

Audience:

I began using xylocaine, until I received calls that there was a long crying spell, beginning approximately five hours after the birth. I no longer use it. What I do now is pick up the baby. I tried using other types of topical anaesthesia, and the babies vomitted. I stopped using all of them.

Dr. Leiter:

For xylocaine to be effective, it should be injected and then you have a penile block. The State Health Department allows you to do circumcision, as a religious ritual, but this does not include administering anaesthesia. What will happen when you inject xylocaine into a baby and the baby has a convulsion and dies.

Audience:

There is a warning -- do not use it on an infant.

Dr. Leiter:

The best thing is salt water, and tell them it is an anesthesia.

Audience:

I had two cases where the children had a complete foreskin, and when I finished the birth, there was a

hypospadias in each infant.

Audience:

How can we protect ourselves from AIDS when doing a brith?

Dr. Hodes:

There have been several alleged cases of individuals contracting AIDS through the mucous membranes of the mouth. Most of the time, you will be unaware that the father of the baby has AIDS. The incidence of AIDS among hemophiliacs is substantial (70% to 80%). One must assume such a person contracted the AIDS virus if he had transfusions before 1985.

Dr. Donald Gribetz:

The father with the virus gives it to the mother, and she gives it to the child. David (Dr. Hodes), you said that it is very difficult to obtain information about the hemophiliac and/or homosexual, and/or bisexual. Knowing the population that we deal with, it would be virtually impossible to get that information in advance of a brith. No one will volunteer the information, even when aware of the hazards. It goes so far that they ask us to close the door when the child has swollen glands. So you will realize that they would never tell us about more serious things.

Audience:

I always ask about bleeding problems in the family and I do get the appropriate answers. When there is a question, I ask the doctor's opinion as to whether I may proceed with the birth. When it is a question of clotting, there is no difficulty in obtaining the information.

Dr. Donald Gribetz:

It is not only clotting, but clotting plus AIDS. Dr. Yudelman, would you care to comment from the hematologist's point of view?

Dr. Yudelman:

It is very important that you ask questions about clotting. Dr. Gribetz is making an important point. Since it appeared in the press that AIDS is transmitted by transfusions. This information is more readily available today than it was ten years ago. When it comes to a question of AIDS, people are extremely reticent about giving information.

Audience:

What is the percentage of contracting an illness in having a transfusion before 1985?

Dr. Hodes:

It depends where the blood came from. New York City was the worst affected city. In New York City, the

risk of AIDS from a unit of blood was one in ten thousand.  
Northern New Jersey was the same as New York City.  
Southern New Jersey was considerably less.

Rabbi Edwin Katzenstein:

We do not do metzitza b'phe and we do wear gloves.  
Should we be concerned whether it will get into the eyes?  
Can we become infected by being close to the child? There  
is a difference of opinion in the Orthodox Jewish community  
because we do not do metzitzah b'phe and we do wear gloves.

Dr. Donald Gribetz:

Please clarify what you mean by metzitzah b'phe.

Rabbi Edwin Katzenstein:

The mohel puts his mouth on the open wound.

Dr. Donald Gribetz?

What is the purpose of this procedure?

Rabbi Edwin Katzenstein:

The purpose is to cleanse the wound.

Dr. Donald Gribetz:

What is your position?

Rabbi Edwin Katzenstein:

It is dangerous to do this.

Dr. Donald Gribetz:

Can we get it on the record that the mohel should not suck the baby's penis?

Rabbi Edwin Katzenstein:

I go on record that the mohel should not do this.

Dr. Donald Gribetz:

I applaud what you are saying. I assume that most of the people in this room think similarly. There are those who do not agree. Can you think of any way that we can convince them?

Rabbi Edwin Katzenstein:

A Kol Korai appeared in the Jewish press with a list of prominent Roshai Yeshivoth that mohelim must continue doing it by mouth. I contacted a number of them and told them of the dangers involved. I asked one: "What about the tube?" He answered: "What do you do with the tube?"

Dr. L. Zobesman:

I am a physician and a mohel in Toronto. I also have Semicha. The problem that Rabbi Katzenstein intimated refers to the fact that in the 1830s when the problem of metzitzah b'p'he arose in the Orthodox community that babies contracted TB and syphilis from mohelim who did metzitzah b'p'he. The *אנדרשן* *מאמר* wrote that

the rabbis in Hungary ruled that we must do metzitzah b'phe not withstanding the fact that the vast majority of rabbis, including the Chatham Sofer, maintained that it was acceptable to do it with a tube. The Edah Charaidith came out with a cherem. In 1989 Rabbi Shach renewed the cherem of doing away with metzitzah b'phe. Last week, the Algemeiner Journal printed a list of prominent rabbis who insisted on metzitzah b'phe, and that any rabbi who allows this would not be considered to be a bona fide rabbi. This is a fact of life. I, as a doctor, do metzitzah only with a tube and wear gloves, because of the existing problems. However, we must realize that there is a large segment of religious Jews who are exposed to the dangers of the mohel coming down with undetected AIDS, and the children are at risk. The mohel is at risk.

Dr. Donald Gribetz:

I would like to sit down with these rabbis and let them hear our side of the argument. I do not think that they are aware of the problem. You just gave our side of the story beautifully. I do not think that I, as a pediatrician, who pushes milah should sit back and accept their opinion without informing them of the facts.

Are there any comments?

Dr. Hodes:

Urinary tract infection in the newborn infant is relatively rare and cancer of the penis is rare. Therefore, a pediatrician is not likely to urge that prophylactic steps against these conditions be taken. However, if asked: "What is the best medical practice?" He would likely recommend circumcision on purely medical grounds. You will gradually see the tide turn, now that the initial attack of the anti-circumcision forces seems to have waned. The Academy's latest statement was issued August 1989. Its full effect will come in time. There seem to be clear medical indications for circumcision. The atmosphere of terror which has been created by the anti-circumcision lobby is going to abate.

Audience:

We are exposed to danger because we have to suck the blood. It is a very emotional issue with many people. How can we protect ourselves?

Dr. Hodes:

If one does not use gloves, a good wash should help. In the mouth, it is more difficult, but I guess washing is possible. We always talk about AIDS because people fear it. There are two forms of hepatitis -- both more common than AIDS which are borne by blood. This should be a greater concern to those who do metzitzah b'p'he.

Rabbi Tendler:

There is a solution of borax which will kill AIDS virus quickly.

Audience:

I do metzitzah b'p'he based on g'dolim who rule on those who are strictly observant.





Dr. Donald Gribetz:

I would like to introduce Rabbi Paul Hait, Executive Director of The New York Board of Rabbis and Secretary of the Brith Milah Boards.

Rabbi Paul Hait:

I simply wish to express brief, though sincere, thanks to the participants of this year's Brith Milah Symposium. I am grateful to Rabbi Eugene Cohen for being the moving spirit behind the Annual Symposium and for arranging each time for the publication of the lectures and proceedings of these symposiums.

Kudos certainly go to the doctors, professors and rabbis who give their time and knowledge to advance the goals of the Brith Milah Boards, and who have impacted on our symposiums to the extent that Chief Rabbi Jacobovitz of Great Britain regards our publications as the best on Brith Milah in the English language.

The work of our Brith Milah Boards and the other departments of Mount Sinai Hospital remind me of a Midrash which reads as follows:

ב"ר אבא בר כהנא אמר רבי בושצ'א: "אם חקיבג דיין דמיא  
אפי' מה לא נמג לאקב"ר? אמר ר' זבדו: "לא מה שניקן דגמ  
י' דיושי' גריבין א"ג. אפלו אדקם גריק גקון."

"If the mitzvah of Brith Milah is so precious to God, why was not Adam created circumcised? The Sage' answered:

"Everything that God created requires perfecting. Even man himself is in need of acquiring a greater degree of perfection."

The Brith Milah Boards have made significant contributions in perfecting and perpetuating ritual circumcision. When mothers of newborn infants were being discharged from hospitals before eight days, the Brith Milah Boards circulated pamphlets and literature underscoring the need for Brith Milah on the eighth day, discouraging parents from proceeding with routine circumcision and emphasizing the importance of a proper Brith Milah. That was certainly a tikun.

Over the years there have been parents who were ambivalent about a bris performed by a non-medical practitioner, but when informed on the training of the Certified Mohel, fears were allayed and dispelled and many of these parents opted for Brith Milah. That is certainly a great tikun.

The Boards and all involved in its deliberations are to be commended for bringing greater perfection to the mitzvah of Brith Milah.

I also commend the mohelim who, by their presence here today, demonstrate their unending quest for knowledge and skill in the performance of Brith Milah, a mitzvah so basic and fundamental to the Jewish faith and to the perpetuation of our people.

Dr. Donald Gribetz:

Dr. Yudelman, Assistant Professor of Medicine at Downstate Medical School and hematologist at the V.A. Medical Center, Brooklyn, N.Y. He will discuss circumcision from the hematologist's viewpoint.

Dr. Ian Yudelman:

I would like to start with a historic perspective. In the Mishnah, Rabbi Judah recommended that if two consecutive male infants bled after circumcision, the third child of that union should not be circumcised. Subsequently, Maimonides determined that in these families the problems seemed to lie on the maternal side. The importance of these two rabbinical observations will become evident in a while.

After any surgical incision or cut we need three normal components in our body to act synchronously. In the circulating blood are two of these, the blood clotting factors, which are proteins and a small cell called a platelet. The third component does not concern us in this context, and that is the vessel wall. Of the many clotting factors known to exist, factor VIII, IX, XI and Von Willebrands factor are important. Although the baby may look well, any bleeding after circumcision is due to low levels of clotting factors. A low level of these factors in a healthy neonate is usually inherited from

the mother or father. So that now one can appreciate that bleeding after circumcision may be the initial evidence of an inherited bleeding disorder.

In principle, it is better to avoid problems or at least be prepared to deal with them. This is then the reason why it is so important for the mohel or the physician to ask the parents about bleeding disorders in their respective families before carrying out the procedure. In this regard one asks about any bleeding after surgery, dental extractions or excessive bruising relevant to the type of injury and naturally about how the other males tolerated their circumcisions.

While low levels of Factor VIII, IX and Von Willebrand factor occur in all groups of people, Factor XI only occurs in Ashkenasi Jews, and may be inherited from the mother or father.

So far only the inherited or congenital disorders have been mentioned. There are other situations where low levels of other clotting factors will be present in young infants and increase the chance of bleeding after circumcision. This will occur in a sick infant, who probably is already under the care of a pediatrician. The conditions would include liver disease, or the absence of an important vitamin, vitamin-K. The liver needs this to produce good clotting factors.

The second component, the blood platelet, may be the cause of bleeding if the level is too low or if the platelet is not functioning normally. In general these problems will be detected during the last stages of pregnancy and the pediatrician will have been consulted. However it pays to be safe and to ask the mother about any bleeding problems during pregnancy and what medications she has consumed within the previous 10 days.

In all instances, if you have concern about the risk of bleeding, call the pediatrician, he can arrange tests and obtain results within one day.

The last part of the talk will cover the issues of infection as a result of contaminated blood products and treatment. The worst part is that 800-900 hemophiliacs in the U.S. have AIDS as a result of transmission via blood products. Nobody knows how many are Jewish. Therefore, the concern that an infected mother will have an infected infant has to be kept in mind whenever the father or mother received blood prior to 1985. Since 1985 virtually all transfused blood is AIDS-free. The latest advances in testing for all the hepatitis viruses in donor blood and techniques for removing these contaminating viruses has produced a major benefit to patients who need these products.

It is important to appreciate that good quality blood products are available if needed. Most blood banks now allow directed donation where donors selected by patients can give the needed blood product. The last part of treatment is that Factor VIII can now be produced by recombinant DNA technology thus totally avoiding the transmission of viral disease such as hepatitis.



Dr. Donald Gribetz:

Thank you, Dr. Yudelman. I will now introduce Dr. Irwin Gribetz who is Professor of Pediatrics at the Medical School, and he will give important comments about jaundice.

Dr. Irwin Gribetz:

Jaundice in the newborn is generally harmless. The word "jaundice" comes from the French, meaning yellow and essentially describes the yellow appearance of the skin and the whites of the eyes. It reflects an imbalance between the rates of formation and the rate of elimination of the bile pigment. This bile pigment is measured as bilirubin and it is derived from the hemoglobin released when red blood cells are broken down or destroyed.

The problem is why is this condition so common in the newborn period? Fifty percent of newborn children have visualized jaundice. Understanding the metabolism of the bilirubin should clarify the state of affairs.

The newborn infant has a relative excess of red blood cells, the source of the bilirubin pigment. This is thought to be present because of the low fetal oxygen content. The extra blood cells are needed to more efficiently carry the lesser amount of oxygen to the vital organs developing in the fetus.

In addition to the extra amount of red blood cells, these red blood cells have a more rapid breakdown than adult red blood cells. The survival rate of newborn red cells is only 90 days, as compared to 120 days in the adult.

After birth, this condition changes and new blood cells are being created while old red blood cells are being broken down. The hemoglobin present within them is released and changed into bilirubin. The bilirubin is present in the blood stream in the unconjugated form and is measured as indirect bilirubin. It circulates in association with the plasma albumen through the blood stream, to the liver. There the liver enzymes act on the bilirubin and change the unconjugated bilirubin to the conjugated form, or directly acting bilirubin, which can be excreted through the bowel and kidney.

When we measure bilirubin in most newborn laboratories, the total bilirubin present in the blood is measured, that is both the conjugated and the unconjugated.

From the previous discussion, it should be obvious that an elevated bilirubin can occur either because of an increased bilirubin formation or load caused by greater than normal destruction of red blood cells or by the decreased excretion or elimination of this same bilirubin, due to the lack of liver enzymes at birth preventing



conjugation of the bilirubin which is necessary to allow excretion. A blockage in the liver preventing the conjugated bilirubin from reaching the intestines or kidneys for excretion also may cause an elevation of the bilirubin in the blood.

Because of the newborn's particular circumstances, i.e., excessive amounts and destruction of red blood cells relative to the maturity of the liver at birth, most newborn infants have elevated total bilirubin shortly after birth. This total bilirubin exceeds 2 miligrams percent, a value which would be considered as abnormal in the adult. About 50% of normal newborns have total bilirubin levels over 6 miligram percent. That is the amount that most observers find necessary to visualize the yellow color in the skin. This level is usually achieved in the third day of life.

In large studies, about 6% of newborns have bilirubin levels up to 12 miligrams percent, 1% of normal infants can have bilirubin levels up to 20 miligrams percent, all considered as physiologic jaundice.

It is obvious though, that the further we go from the average, the more likely we will encounter an abnormal child. This is the dilemma faced by the physician to determine if the jaundice is physiologic and normal or pathologic and abnormal. The physician views this as he

would any other medical problem. He first takes a history -- is there any problem in the family, hereditary spherocytosis, previous jaundiced babies, Rh or ABO incompatibility, genetic diseases? Was the mother on any drugs that can cause hemolysis, whether she has diabetes? He then checks the chart, calls the obstetrician to ascertain whether there was a difficult labor and delivery, whether there was trauma or bruising with a low Apgar score. He then goes to the nursery and asks the nurses concerning any abnormalities that they have noticed. This is all before examining the child. A physical exam is then performed. It can then be noted if the child is appropriate for the gestational age, appears infected, irritable, in respiratory distress, has a high or low temperature, is vomiting, or has diarrhea. A large spleen may be palpated, blood tests to determine the blood type of the mother and child, total bilirubin and direct bilirubin values are obtained. If the child looks sick, there would be a complete septic work-up. All pediatric and neonatal textbooks would contain the causes of pathologic jaundice in the first weeks of life.

This investigation is necessary to determine the cause and the appropriate measures to take if any abnormality is present. Within eight days before a religious circumcision, the physician should be able to determine the cause of the

jaundice. He should know if it is physiologic or pathologic. If it is pathologic, he should take the appropriate measures. The treatment of jaundice today is made easier because of the technique of phototherapy. I am ill at ease to mention this way to lower the bilirubin level of physiologic jaundice, because many people feel that it is unnecessary to alter the normal course of events regardless of the level of the bilirubin, although some authorities disagree. Nothing is really necessary with physiologic jaundice. It is harmless to the child regardless of the level.

If pathologic causes of jaundice are present then conservative measures may not control the situation, and other measures may be necessary to prevent harm to the baby. Circumcision must, in such an instance, be postponed until the baby is in good health.

The relationship between ritual circumcision and jaundice is very tenuous. The Talmud discusses a green baby, green like grass. The color of a baby is not of major importance. The health of a baby is. Jaundice does not harm the baby, it does not cause bleeding. The cause of the jaundice is the important factor.

When a physician assures the mohel that the baby is well, the circumcision should take place.

Dr. Donald Gribetz:

I want to introduce Rabbi Tendler, Professor of Talmud and Professor and Chief of the Department of Biology at Yeshiva University.

Rabbi Moshe D. Tendler, Ph.D.

Thank you, Dr. Gribetz. I must correct Dr. Irwin Gribetz on the term yarok. This word has several meanings. It can mean green, yellow, blue or green, depending on the context in which it is used. In reference to a neonate it means yellow, and is so understood by all reputable scholars.

One of the big dangers that has developed in milah is that mohelim put on white coats and they think they are doctors. Dressing like a doctor does not make you a doctor. It is audacious for mohelim to countermand the opinion of pediatricians, when all our greatest rabbis emphasize that a doctor is the arbiter in matters of health, even in the instance of capital punishment, when murder trials are involved. There is a constant evolution of medical knowledge to which physicians are privy, not we, and they must be accepted as the final arbiter. This is the Halakhah! When a mohel says: "I have a kabala (tradition) that we do not do milah after 12" (i.e., if a child has a bilirubin of 12 or higher). They do not have the slightest idea of what it is all about

and yet they take it on themselves to set standards which are in violation of biblical law. The Torah says that a child is to be circumcised on the eighth day, unless there is a reason to postpone it. There is no reason for postponing a bris, because of a self-declared "kabala," that is anti-halakhic. It is in violation of Torah Law. Such a mohel should not be allowed to practice. There is a study of bilirubin levels on day 6 involving 8,000 breast-fed neonates. The "mode" was 13.6. This means that more babies had 13.6 than any other value. This is indicative of the normalcy of this range. I would like to explain something that will help the mohel adjust psychologically to the current rigidity or authoritarianism of his colleagues. Some mohelim, claiming greater piety, go one better. Their kabala is 11 or even 8, in total disregard of the religious obligation to perform the bris on day 8. If they understood the reason for physiological jaundice they would give up their kabala.

In a scientific study, the rationale is pointed out. Why doesn't the liver "kick-in" until day 5? Free radicals are very harmful; they are toxic to all cells. When one breathes air, free radicals are formed. Our food contains protective elements -- vitamin E and vitamin C fight the free radicals. The most effective scavenger known today is bilirubin. It fights radicals

better than any other compound known to science. As the baby enters the aerobic respiratory phase, free radicals are formed in high volume. By keeping the physiologic jaundice high, the baby has a scavenger in his blood that inactivates free radicals and prevents damage to the cells (Science, January, 1987).

If the mohel is recalcitrant and will not do the bris, above 12 (which seems to be the magic number), he will suggest taking the baby off breast-feeding and give the baby sugar water, to lower the bilirubin. My father-in-law <sup>Fis</sup> was asked about this many times, and his answer was, as follows: "We will break a door down on the Sabbath to let the baby nurse from his mother. If the baby is at home and the mother is in the hospital, we are permitted to transport the baby on the Sabbath to the mother because breast-feeding for a baby is "life saving." ✓ It is forbidden to withdraw the baby from the breast in order to satisfy some unlearned mohel. To do so violates Biblical Law. Rav Feinstein <sup>Fis</sup> ruled that one should delay the bris, if the mohel refuses to do it, but never remove the baby from the breast.

On the hemophiliac issue, a definitive halakhic decision has not been made by rabbinic authorities. The question is -- can you perform milah on a hemophiliac? A hemophiliac is not a well child, and milah is never

done on a child who is ill. This simplistic analysis must be modified in light of the availability of blood elements to temporarily correct the clotting disorder.

When the pediatrician-hematologist prepares the baby for circumcision by giving the proper blood elements there is no danger. There is no need to delay the bris when the pediatrician says: "I have full confidence that the baby will behave normally even though two or three days later the hemophiliac condition returns. This is not like an antibiotic treatment for impetigo when the baby has an infection and the doctor suggests: "We will cover the baby with good antibiotics and, therefore, you can go ahead with the bris." We must follow the advice that the Gemorah gives: *"נשתדל עמו"ל* "It is better to wait." But with the hemophiliac, the child will never get better; waiting will not accomplish anything. The law of *החומר נשאר*, *"נשתדל עמו"ל"* applies in cases where delay will permit the bris to be done at a later time. With the hemophiliac there will never be a time, if you are waiting for a restoration of normalcy in the child. Consequently, the only question is whether there is danger or not. When there is no danger, when the baby is properly managed, the milah should be done as soon as the pediatrician allows it to

occur. There might be some halakhic rationale to wait thirty days. We know that during the perinatal period baby is unstable, or less stable. There might be some virtue because the language of the Gemorah is "עַד שֶׁיִּשְׁׁרְיֵהוּ זָרָה" "until he gets a little healthier." In these matters, the pediatrician should be the absolute arbiter as to when the milah should be performed.

A comment about aepsis. It is ludicrous for a mohel to put on gloves and then reach in and take instruments from a container which has never been sterilized. It is criminal to allow a mohel to function with nonsterile instruments as well as a biblical prohibition. There is no justification whatsoever to increase in the slightest the danger of infection. It is a violation of Torah Law, and I believe in violation of secular law, as well. The permission to do Ritual Circumcision is not a permission to violate good medical practice.

Too often the mohel does not wear gloves, but carries some alcohol in which he immerses his instruments for a minute or less, despite the fact that alcohol takes a minimum of eight minutes to kill staphylococcus. Then he runs his finger over the blade to wipe off the alcohol! His actions are disrespectful of God who ordained the laws of nature.



We come now to the use of different types of surgical instruments and the question of משיכה

There is an attitude expressed in the comment of the "אין ענין לשינוי כלל"  
"אין ענין לשינוי כלל"

Any innovation leads to conflict. There is an inherent resistance in Torah Judaism to change. Change must be justified on the basis of superior values to Torah life. If it does not meet this requirement, we do not want the change. We have adjusted in non-critical areas to social changes throughout our glorious history. On Shabbos, I wear "old-fashioned" dress. On weekdays, I wear modern dress. We educate our children at home and school to maintain the greatest degree the traditions of the past, but to live in the present.

I give this as a psychological background, a kind of construct when new instrumentation was presented. The initial reaction was negative. When, in addition, the Gomco Clamp or Magen Clamp causes pain to the child, then it is גויס. It is forbidden to cause unnecessary pain to the child -- it is a biblical transgression to add to the child's discomfiture. This applies to the mohel, who in his piety, grabs the foreskin and then closes his eyes and slowly recites the blessing -- when you recite the ברכה, it should be said as quickly as possible, lest you cause unnecessary pain.

Mohelim, wanting to show how quickly they perform their "surgery," go to a back room and probe the child to separate the mucosal layer, causing pain. They then put the diaper on, and twenty minutes later when edema has set in from the previous probing, they then "begin" the circumcision. The audience is impressed: "Look how fast he is." Regrettably the child cannot speak -- only cry.

If the clamp causes more pain by crushing nerve endings, then it is forbidden, for this reason alone. On this point there is unanimity -- no controversy.

All rabbinic authorities prohibited the use of both the Magen Clamp and Gomco Clamp. No one has questioned this ruling, which was based on three reasons: 1) there is no reason to change the procedure unless you prove that the new way is better; 2) it causes more pain to the child; and 3) if you follow the initial instructions for the Magen Clamp, it is possible to have a bloodless circumcision. With the Gomco Clamp, you have some bleeding because you have to do a dorsal slit. I advise mohelim who insist on using the Magen Clamp to cut a little "v" in the jaw of the clamp. There will be a little bleeding at that point so that the required minimal bleeding occurs.

The "metzitzah" issue has become a political, emotional subject. Mohel Romi Cohn mentioned the article

in the Jewish Press which listed *אוריאל' ער* who prohibited milah without *דבר מליצה*. In a perversion of the truth, my father-in-law *פ"ג* was amongst those listed. He never prohibited making *מליצה* with a glass tube or a 5cc barrel of a syringe. All *אבות* of previous generations agreed that if a mohel says: "I have a cold or a sore throat," that he must use a tube rather than direct mouth to wound contact. Today we are aware that there is a danger of hepatitis or AIDS. This is sufficient reason for avoiding contact.

Let us understand what it is all about. We can not sit in judgment. One of the sad facts about our Torah life today is the demand by some *קדו' קדו' ארז* do it my way, or else! A new phenomenon; Halakhah by terrorist action! *דבר דרוק* we do not succumb to terrorist action. The fact remains that the *אוריאל' ער* was a pious Jew. The *אוריאל' ער* was a frum Jew. And they said you do not have to do *דבר מליצה*. Other *אבות* insist that you do have to do *דבר מליצה*. But to claim that if you do not do *דבר מליצה*, you are a heretic, then the *אוריאל' ער* is a heretic. Whoever makes such an accusation against the "Chatam Sofer" or the "Tifereth Israel" is indeed an apikorus (an unbeliever). You can not succumb to this type of terrorist nonsense. They falsely

quoted my brother-in-law, Rabbi Reuven Feinstein as the source for their claim that Reb Moshe זצ"ל required metzitzah b'p'he exclusively. He never said such a thing.

It is against the הלכה to insist on קבה when there is a danger to the child, although the odds are slight that one will get infected, we must not assume needless risk.

The זכ"ר זצ"ל says in his opening comment to the אגודת ישראל:

אשר חידד המלצה, שמתפלל לנתן צדקה ואין זקוקים להינותן אלא בסכין, דהו' נולדו את צבאנו י"ג מקצתן אחר המלצה להצטרף ליאמו שני יקותי, שאולי אפשר לה לקחו אצלנו, ומה שישנו שם דה' י"ב ז"ל. ואי"כ שישנו הינותן בתורה, ואי"כ שישנו ככבודו, אי"כ נולדו את צבאנו. ואי"כ שישנו

The זכ"ר זצ"ל wrote: אין להצטרף לקבה דוקא וז"ל. אי"כ זכ"ר זצ"ל

If you want to do זכ"ר זצ"ל, you must receive permission from the family. You can not expose the child. The mohel should be aware that the child may have AIDS because the mother may have had a transfusion or because she or her husband are I.V. drug users or because he is bisexual. We have to be concerned with the exception. If the mohel wants to risk his life -- let him do so. The mohel may not put the child at risk.

My final point is that the mohel should present himself as one performing one of the greatest that God entrusted to the Jewish people. The grandstanding manner in which some mohelim act demeans the sanctity of this great mitzvah.

Audience:

If you use a shield, is that called free hand?

Rabbi Tendler:

That is correct. It is unfortunate that Rabbi Bronstein called his instrument Magen. This confuses it with the Magen or shield. The purpose of the shield is to prevent cutting the penis. Bronstein's is a modified Kantor Clamp with the potential for "bloodless" surgery.

Audience:

When are we to follow the doctor's advice?

Rabbi Tendler:

Doctors use two standards: one is normalcy, and the other is acceptability. A patient has a heart attack and they need to do open heart surgery on him. Doctors will not say he is "normal," but rather: "I think it is an acceptable risk." In milah, if he is not normal, it is not acceptable. Medically, there may not be any serious objection. But Halakha demands that we wait until the child is normal.

Audience:

There is much talk about bilirubin. Is there a rule about this?

Dr. Irwin Gribetz:

Yes! When it goes down (i.e., if it was 19 and went down to 18 and is now 17) go ahead and do the bris.

Dr. Donald Gribetz:

I want to thank the speakers in behalf of all of us.

