Delineating the role of penile transplantation when traditional male circumcisions go wrong in South Africa

Stuart Rennie,[1,3] Keymanthri Moodley[2]

Back in 2017, Moodley and Rennie published a paper in the *Journal of Medical Ethics* entitled 'Penile transplantation as an appropriate response to botched traditional circumcisions in South Africa: an argument against.'[1] As the title suggests, we took a critical view towards penile transplantation as a way of responding to the problem of young men in South Africa experiencing genital mutilation and amputation as a result of traditional circumcision practices. Our main conclusion was that prevention is key: social, cultural and political strategies to prevent mutilations and amputations should be prioritised, rather than surgical solutions, particularly in low-resource communities. Van der Merwe, who led the surgical team for the first successful penile transplantation in Stellenbosch, South Africa, has responded to our views, and in what follows, we will distill and evaluate his main arguments.

Cost and access to services: Van der Merwe states that our position is mostly based on costs, that is, that penile transplantation is expensive and it is unrealistic to think that young men in traditional communities will be able to avail themselves of such services. Against this, Van Der Merwe argues that the actual cost of penile transplantation can be favourably compared with another, more established medical intervention, that is, renal transplantation. Of course, cost comparisons are difficult with a new intervention when it is unsure whether and to what extent the government will help cover expenses. But even assuming that government would step in, and make the cost (to the client?) of penile transplantation as affordable as renal transplantation, where does this leave us? In South Africa, public hospitals are already struggling to provide standard health services.[2] Access to renal transplantation services to those who need them is very limited. This is partly due to financial constraints in the healthcare sector, partly due to scarcity of donor organs. In any case, many different studies have shown that access to renal transplantation in South Africa is very limited (less than 10 transplantations per million),[3] and those who are sick but with financial means seek renal transplantation from private clinics. If this is the analogy Van der Merwe wants to draw, the resulting picture is disturbingly familiar: the majority of young men damaged by traditional circumcision practices will not benefit from this new surgical innovation, though perhaps a (lucky) few will.

The benefits for a 'lucky few' : Van Der Merwe argues that due to cultural taboos about seeking Western medicine, very few young men from traditional communities will even enter the waiting lists for penile transplantation. In addition, given that donor scarcity might be even more of problem here than in the renal case, only a handful (a lucky few) of the hundreds of young men mutilated each year would actually receive a transplant. Van Der Merwe seems to see this as a way of responding to concerns about cost, but it actually shows something else: this innovative surgery will do very little to repair the damage caused by botched tradition circumcisions in South Africa. Those most in need of such surgery seem the least likely to get it.

False hope: We argued that the development of penile transplantation surgery and its dissemination in the media was likely to give rise to false hope among those who have experienced genital mutilation and their loved ones. Van Der Merwe responds by stating that such hope is not false, because (like the hope of winning the lottery) there is a small chance they might be able to obtain a penile transplant. On reflection, 'false hope' may have been a wrong choice of words on our part, for two reasons. First, the situation for some boys may be even worse than we had imagined. If Van Der Merwe is right, and there are taboos against seeking help from Western medicine, then many young men will simply suffer without even hoping of gaining a transplant. Second, young men who overcome the taboo and get on a waiting list could have a better-than-lottery chance of a successful transplant, so if hope is involved, it is not false for them. They could get lucky. However, this does not detract from the larger point that we wanted to make: the impact of penile transplantation is likely to be negligible in South African communities where the greatest damage to young men's genitalia is regularly happening.

Standard of care: Van der Merwe argues that penile transplantation cannot be regarded as standard of care for penile injuries. Here, we agree: reconstruction surgery should be the first port of call for those who have experienced penile injuries, and transplantation should only be contemplated when reconstructive surgery is unable to restore function. It would be interesting to know the extent to which young men injured in circumcision rituals have undergone reconstruction surgery in South Africa. Has this standard of care also made few inroads in traditional communities?

Prevention and treatment: Van der Merwe argues that penile transplantation is not a high tech and expensive intervention likely to be of benefit largely to first world nations and the wealthy elsewhere; the option was created for poor patients in South Africa. However, as we have seen, only exceedingly few of the poor are likely to benefit, for reasons that go beyond cost. This does not at all mean such services should not be funded or offered, but (in our view) it does put penile transplantation into perspective. As we argued in our original paper, when hundreds of young men are damaged each year, prevention of injuries caused by traditional circumcision rites has to be a priority, particularly as treatment approaches are likely only to benefit a (lucky) few of the injured. The importance of prevention is sometimes lost in the shuffle when an exciting new medical treatment is introduced.

The 'yuk' factor: Finally, Van der Merwe seems to suggest that our argument is influenced by a 'yuk' factor, that is, an emotional response to the idea of a penis being transplanted from one man to another. This is not the case. Again, we were not saying that penile transplants in South Africa are 'taboo' and should be prohibited altogether. It surely will have some role to play.

[1]Social Medicine, University of North Carolina, Chapel Hill, North Carolina, USA
[2]Centre for Medical Ethics and Law, University of Stellenbosch, Stellenbosch, Western Cape, South Africa
[3]Center for Bioethics, University of North Carolina, Chapel Hill, North Carolina, USA

Correspondence to Dr Stuart Rennie, Social Medicine, University of North Carolina, Chapel Hill, NC 27599, USA; stuart_rennie@med.unc.edu

J Med Ethics: first published as 10.1136/medethics-2019-105414 on 27 April 2019. Downloaded from http://jme.bmj.com/ on 29 April 2019 by guest. Protected by copyright.

What we were questioning was the extent to which resources should be invested in this intervention in resource-constrained settings, particularly if very few in traditionally circumcising communities are likely to benefit from it. Nothing in Van Der Merwe's argument has alleviated that basic concern.

Competing interests None delcared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

© Author(s) (or their employer(s)) 2019. No commercial re-use. See rights and permissions. Published by BMJ.

To cite Rennie S, Moodley K. *J Med Ethics* Epub ahead of print: [please include Day Month Year]. doi:10.1136/medethics-2019-105414
Accepted 21 February 2019

J Med Ethics 2019;**0**:1–2.

doi:10.1136/medethics-2019-105414

REFERENCES

1 Moodley K, Rennie S. Penile transplantation as an appropriate response to botched traditional circumcisions in South Africa: an argument against. *J Med Ethics* 2018;44:86–90.
2 Hudson M. Tygerberg soos 'n oorloghospitaal. *Die Burger* 2018;1.
3 Garcia GG, Harden P, Chapman J. The global role of kidney transplantation. *Curr Opin Nephrol Hypertens* 2012;21:229–34.

J Med Ethics: first published as 10.1136/medethics-2019-105414 on 27 April 2019. Downloaded from http://jme.bmj.com/ on 29 April 2019 by guest. Protected by copyright.