

**IN THE CIRCUIT COURT OF THE STATE OF OREGON
FOR THE COUNTY OF MULTNOMAH**

DANE HADACHEK, an individual,
NATHANIEL HELLEWELL, an individual,
LONDON MOODY, an individual

Plaintiffs,

v.

THE STATE OF OREGON

Defendant.

No. 25CV18224

DECLARATION OF ROBERT S. VAN HOWE,
M.D., M.S., M.P. H. IN SUPPORT OF
PLAINTIFFS' OPPOSITION TO DEFENDANT'S
MOTION FOR SUMMARY JUDGMENT

I, Robert S. Van Howe, M.D., M.S., M.P.H., declare as follows:

1. I am a physician and pediatrician licensed in the states of Michigan and Wisconsin. I was the founding Chief and Professor of the Department of Pediatrics at the Central Michigan University College of Medicine, and I currently hold the position of Clinical Professor in the Department of Pediatrics and Human Development at the Michigan State University College of Human Medicine.

2. **Education:** I hold an M.D. degree from the Loyola University Stritch School of Medicine, completed a Pediatrics residency at Children's Hospital of Wisconsin, have a Master of Science degree in Clinical Research Design and Statistical Analysis from the University of Michigan School of Public Health, and have a Masters of

Public Health from Michigan State University College of Human Medicine. I am Board Certified in Pediatrics through the American Board of Pediatrics.

3. **Publications:** I have authored at least seventy scientific articles and letters on the topic of infant and child circumcision that have been published in peer-reviewed medicolegal journals including *Pediatrics*, *The Lancet*, the *Journal of Urology*, *BJU International*, the *Journal of Medical Ethics*, and the *Journal of Contemporary Health Law and Policy*. I have also authored several book chapters, a book to be released by an academic press in early 2027, and have lectured internationally about infant and child circumcision.

4. **Peer-Reviewer:** I have been a peer reviewer for the following medical journals and publishers: *American Journal of Public Health*, *Annals of Family Medicine*, *Archives of Disease in Children*, *Archives of Pediatrics & Adolescent Medicine*, *BMC Oral Health*, *BMC Public Health*, *BMC Urology*, *British Journal of Urology*, The Cochrane Renal Group, *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *International Journal of Cancer*, *International Journal of Gynecology & Obstetrics*, *International Journal of STD & AIDS*, *Journal of Pediatrics*, *Journal of Public Health in Africa*, *The Lancet*, *Lancet Infectious Diseases*, *Pediatric Dermatology*, *Pediatrics*, *Sexually Transmitted Infections*,

5. **Expert Opinion:** I have been invited to provide my expert opinion on the subject of infant and child circumcision by the American Academy of Pediatrics (AAP), the U.S. Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO).

6. **Awards:** I have won several awards for excellence in research and teaching. My contact information is available upon request through the attorneys in this matter.

7. I declare as follows, and I give my professional medical opinion here without any equivocation or hesitation. I have kept references to the medicolegal literature to the minimum to save space in this filing with the court, but I can provide a comprehensive list upon request.

8. Both the prepuce (clitoral hood) in females and the prepuce (foreskin) in males arise embryologically from the same tissue, although they emerge differently. Both have a high concentrations of neuroreceptors. Both contain a mucosal surface. Both play a role in sexual stimulation and pleasure and interact with simultaneous stimulation of the underlying anatomy: the clitoris in females and the glans penis in

males. The prepuce in the female covers the cephalic aspect of the clitoris, while prepuce in the male completely surrounds the glans penis and provides more protection. The prepuce in the male has a higher concentration of fine-touch neuroreceptors, is a larger structure, thus contains a greater number of fine-touch neuroreceptors. The most common form of genital cutting in males is to remove the prepuce from where it joins the glans of the penis at the sulcus. Genital cutting in females has many forms depending on how much tissue is removed. The most common form is the removal of clitoral hood. Other forms include only nicking or scraping genital tissue. All genital cutting irreversibly removes neuroreceptors that cannot be replaced and the loss of sensation these neuroreceptors provided. Any cutting carries the risk of complications and harms. The psychological and physical impact of genital cutting is only beginning to be explored, with genital cutting in both males and females resulting in negative consequences. Given that, when compared to the female prepuce, the male prepuce contains more tissue, has more fine-touch neuroreceptors, and provides more protection of underlying structures, these biological differences indicate that male children are more likely to be harmed by the most commonly performed form of non-medically necessary male genital cutting than female children undergoing the more commonly performed forms female genital cutting.

9. Elective, non-therapeutic male circumcision (ENTMC), usually performed at or near birth but sometimes later in childhood, is an unnecessary and irreversible invasive genital procedure.

10. Without the need for treatment, the physician's and surgeon's certificate, evidencing a license to practice medicine, does not authorize the holder to use drugs or to use devices to sever or penetrate the tissues of the genitals of normal newborn males. Physicians in the United States are outliers among physicians worldwide in circumcising healthy boys, and they fail to meet universal professionally recognized standards of health care. Non-therapeutic circumcision or genital cutting falls outside the scope of medical practice worldwide and in the United States.

11. Newborn male circumcision is not recommended by a single national medical organization in the world including the United States. Several national and international medical organizations recommend against the procedure, citing the lack of medical evidence to support the practice and ethical and human rights concerns.

12. Genital cutting in both males and females began as a sacrificial religious ritual, a painful rite of passage, and to suppress sexuality. Physicians introduced genital cutting of both males and females to the United States in the late 1800s to early 1900s to prevent masturbation, then considered a cause of illness. Physicians

claimed under medical theories circulating at the time that male circumcision cured or prevented more than 100 diseases. These theories were subsequently replaced with the germ theory of disease, but as a result male circumcision became a deeply embedded cultural norm in the United States, so the practice is self-perpetuating.

13. Parents in the United States who elect to have their son circumcised, after physicians or nurses under their direction solicit their permission, usually do so for cultural reasons, based on the parents' own religious, cultural, and personal aesthetic preferences — for example, the preference when the father is circumcised for the son's penis to “look like” the father's penis — rather than for medical reasons. In accordance with professional ethical standards, physicians are forbidden from acquiescing to parental requests to perform unnecessary medical procedures on their children.

14. Eighteen states in the United States ended Medicaid coverage of infant and child male circumcision, because it is not medically necessary and/or because they considered it a poor use of scarce Medicaid resources.

15. Physicians who circumcise healthy boys are engaging in a pattern of performing unnecessary surgery.

16. **Pain, Risks, and Harm.** Unnecessary surgery is painful; it risks many minor and serious complications, including death; it removes healthy tissue and a functional body part, leaves a scar as evidence of a wound; and it can cause psychological harm. The same is true of ENTMC.

17. ENTMC is one of the most painful procedures in neonatal medicine. Often no anesthesia is used, and anesthesia is not completely effective.

18. Newborn male circumcision carries many minor and serious risks. Procedures without a medical indication that carry any risk of a complication and that are undertaken without the valid consent of the patient, or in the case of ENTMC the healthy person, are not within the scope of medical practice.

19. Newborn male circumcision carries the risks (ranging from 2% to 35%) of: (a) interrupting infant feeding, especially breastfeeding; (b) disrupting the baby's sleep pattern for up to one week following the procedure; (c) invoking behavioral changes, including i. changes in initial maternal-infant bonding; ii. crying longer and louder when receiving vaccinations at 4 and 6 months of age, iii. autism, iv. attention deficit disorder, v. engaging in different sexual practices than males not circumcised, d. an overall increase in sexually transmitted diseases (gonorrhea, chlamydia, non-specific urethritis), e. bleeding (heavy bleeding in about 2% to 9%, resulting in shock, the

need for blood transfusions, or death); (f) infections (1% to 5% of infants) — localized or systemic infections including: i. bacteremia, ii. septicemia, iii. meningitis, iv. osteomyelitis, v. septic hip arthritis, vi. lung abscess, vii. staphylococcal scalded skin syndrome, viii. gangrene of the penis and scrotum, ix. scrotal abscess, x. impetigo, xi. erysipelas, xii. necrotizing fasciitis of the abdominal wall (gangrene), xiii. Tetanus, xiv. herpes simplex infection, xv. methicillin-resistant staphylococcus aureus (MRSA) infections (12 times more common in circumcised male infants); (g) necrosis (dead tissue) of the genital area, (h) meatitis and meatal ulceration (affecting 20% of infants following circumcision); (i) meatal stenosis (5% to 8% of circumcised boys, which can lead to kidney failure if untreated); (j) penile adhesions and skin bridges; (k) phimosis requiring surgical correction (following 1% to 2% of neonatal circumcisions); (l) retention of the Plastibell ring (if a Plastibell clamp is used, occurs in about 1-2%, resulting in painful swelling of the penis beyond the ring and possibly tissue death (necrosis) of the end of the penis) (m) buried or concealed penis; (n) unexpected cosmetic outcomes (approximately 1% to 2% of boys undergoing a surgical revision of the circumcision to address these cosmetic concerns): i, covering of the glans penis in 30% of boys, ii. crooked scars, iii. rotation of the penis, iv. scars darker or lighter than penile shaft skin, v. puffiness, vi. bumps or cysts, vii. skin tags, viii. excessive scar tissue (keloid), o. partial or complete amputation of the head of the penis; (p) loss of the penis; (q) excessive penile skin loss; (r) urinary retention and

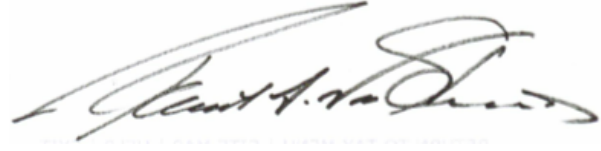
obstruction (which can lead to kidney failure and bladder distention to the point of bladder rupture); (s) lymphedema (t) urethral fistula; (u) scrotal trauma; (v) pneumothorax; (w) unilateral leg cyanosis; (x) breath holding (approximately 1% sometimes leading to seizures); (y) urine advancing in subcutaneous fascial planes; (z) subcutaneous granuloma (occur following 5% of circumcisions); (aa) pyogenic granuloma; (bb) penile tourniquet syndrome (reported almost exclusively in circumcised boys in which a human hair can get wrapped around the penis, shrink and cut into or cut off the penis) (cc) urethritis; (dd) gastric rupture; (ee) death (including increased risk of dying from sudden infant death syndrome (SIDS)); (ff) if local anesthesia is used it carries with it increased risks of, i. bleeding (usually small bruises at the injection sites in 1.2% to 43.5%), ii. loss of blood supply to the genitals, iii. methemoglobinemia (associated with use of prilocaine).

20. Even when properly performed, insofar as ENTMC is painful and removes the erogenous, functional foreskin, which adolescent boys and men value, it harms all boys and men.

I declare under penalty of perjury under the laws of the State of Oregon and the State of California that the foregoing is true and correct and that this Declaration was executed by me on this 4th day of August 2026, at Hazelhurst, Wisconsin.

Dated: August 4, 2026

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Robert S. Van Howe", is written over a horizontal line. Below the line, the text "DECLARATION OF ROBERT S. VAN HOWE, M.D., M.S., IN SUPPORT OF PLAINTIFFS' OPPOSITION TO" is printed in a small, light gray font.

Robert S. Van Howe, M.D., M.S.