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# Commentary on American Academy of Pediatrics 2012 Circumcision Policy Statement

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Doctors Opposing Circumcision has reviewed the two-page American Academy of Pediatrics (AAP) 2012 *Circumcision Policy Statement*[1] and the accompanying thirty-page electronically-published "technical report" entitled *Male Circumcision.*[2]

The Circumcision Policy Statement was created by an internal "Task Force on Circumcision," appointed in 2007. No non-MD individuals were apparently invited to participate. The private deliberations of the Task Force have not been made public in any form.

Indeed, the American Academy of Pediatrics is a physicians' trade organization, whose focus is protecting the craft boundaries of pediatrics, and the income and continuing professional well-being of its members. The 2012 Task Force on Circumcision' included the following members:

- Susan Blank, MD, MPD, chair of the Task Force, an infectious disease specialist, who has a well-documented religio-cultural bias in favor of male circumcision.

- Andrew Freedman, MD, a pediatric urologist, who has reported that he circumcised his own son on a kitchen table, for religio-cultural reasons, and who derives twenty percent of his practice from treating boys for circumcision generated problems;

- Douglas Diekema, MD, an AAP bioethicist, who *twice* — first in 1996 and again in 2010, — on behalf of the AAP, proposed a billable "ritual nick" to the genitals of female children, despite the existence of international and U.S. federal law forbidding this practice;[3] and,

- Steven Wegner, MD, JD, a doctor-lawyer, who serves on the AAP Committee on Health Care Financing, whose presumed focus in this instance was on the circumcision income flow, over $1.25 billion, annually —$2.25 billion or more if circumcision could be made mandatory or universally subsidized by Medicaid.

It is abundantly clear that the members of the task force were chosen with a view to obtaining an outcome favorable for the continued practice of circumcision of American male children and to provide for third-party payment to physician and hospital providers.

The task force was augmented by representatives from the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians, representing the two other

trade associations — in addition to the AAP, itself — which profit most from performing medically unnecessary non-therapeutic circumcisions on children.

The task force, without irony, termed itself and these additional trade associations, "stakeholders"(p. 585, p. e756). Stakeholders are commonly understood to be institutions and individuals with a financial interest in an enterprise. And indeed, when all revenue sources are considered, medically unnecessary, non-therapeutic circumcision produces more than US $1.25 billion in income annually for these 'stakeholders.'[4]

It is a safe guess that no member of the task force had a foreskin or was partnered with anyone who did. No 'ombudsman' for children was invited to offer a devil's advocate defense of the advantages of healthy, highly evolved, intact male anatomy of the sort Europeans, Asians, and many others know well.

The task force asserts that current evidence shows that the health benefits of male circumcision outweigh the risks. The task force failed, however, to produce any sort of analysis to support that claim. Previously available cost-benefit studies do not support that conclusion.[5-8] Moreover, even the task force freely admitted that, "The true incidence of complications after newborn circumcision is unknown…"[9]

It is difficult to countenance how the task force could blithely tout the 'health benefits' vs. risks and harms of circumcision while admitting the incidence of morbidity is 'unknown.' Complications, short-term and long, are the very important numerator of that equation.

**No information on nature and function of the foreskin**

Male circumcision is an extensive and intrusive operation that irreversibly excises and amputates a healthy, functional, male body part. The foreskin or prepuce of the penis constitutes more than fifty percent of the skin and mucosa of the penis, and in the intact adult, measures approximately 15 square inches, or 90 square centimeters of surface area.[10] The foreskin is a complex structure containing smooth muscle, extensive vascular structures and specialized nerve endings. It has numerous protective, immunological, mechanical, sensory, and sexual physiological functions.[11,12] The Task Force, however, makes absolutely no mention of the nature or function of the foreskin, although this information is of great relevance to making a decision regarding its loss to circumcision, and detailed information on the basic anatomy is readily available in the medical literature.

**Rights of the child**

It is well established in both domestic law and international human rights law that a child is a distinct and singular person with rights of his own from the moment of birth. The task force, however, treated the child-patient as a non-person with no legal rights of his own. There was no discussion of the child's *right to bodily integrity*[13] or the child's right to *security of his person* and *special protection during childhood*,[14] which rights nontherapeutic circumcision clearly violates. There was no mention of what the child might be presumed to prefer. The task force, instead, treated the child as a chattel possession of the parents, one with which they can do

whatever they please in this regard. The AAP has failed to understand that domestic and international laws for the protection of individuals are written for the protection of the *best interests* of those individuals and that the violation of those laws *cannot* be in the child's best interest.

**Medical Ethics**

Although the section on medical ethics is much expanded from the previous statement of 1999,[15] it still suffers the same faults. Infants and children cannot consent, so surrogate consent for child circumcision must be adduced from parents or guardians. Although the task force statement quotes from the statement on consent, it omits the section that limits the consent power of the surrogate:

> Only ***patients*** who have appropriate decisional capacity and legal empowerment can give their ***informed consent*** to medical care. In all other situations, parents or other surrogates provide ***informed permission*** for diagnosis and treatment of children with the ***assent*** of the child whenever appropriate.[16] [Emphasis added]

Since the typical infant circumcision is non-therapeutic, and constitutes neither diagnosis nor necessary treatment, this section would prohibit parental consent on its face. The task force ignored this caution. It appears that no one has the power to consent to nontherapeutic excision of healthy body tissue from a child. This has also been the conclusion of appellate courts in Canada,[17] Australia,[18] and Germany.[19]

This task force relied, as did the previous task force, on a paper by Fleischman *et al.* (1994) on caring for gravely ill children.[20] This paper is totally inappropriate and inapplicable to the care of healthy children who do not need treatment.

The Task Force consistently defends and asserts parental cosmetic whims and cultural preferences, while ignoring the more fundamental rights of the child. It is clear from reading the task force's distortion of medical ethics that the protection and preservation of ritual circumcision –as an unfettered parental option– is a continuing preoccupation of the AAP.

**Use and misuse of medical literature**

Due to the emotional issues created by involuntary amputation of part of the male phallus,[21,22] the medical literature has been described as "voluminous, argumentative, polemical, confusing, chaotic, and contradictory."[23] For this reason, references can be found to support either side of any argument, and even lengthy documents on the subject can appear highly authoritative by the mere quantity of footnotes, while remaining highly selective.

The AAP task force examined medical literature published from 1995 to 2010. By doing this they excluded important articles unfavorable to male circumcision that were published before 1995 or after 2010. The task force then selectively cherry-picked the medical literature to support its predetermined position that male circumcision has health benefits. Much of the chosen medical literature was produced by a team from the pro-circumcision Bloomberg School of

Public Health, which is funded by Michael Bloomberg, the well-known billionaire and mayor of New York City in 2012.

**Sexually transmitted disease**

The task force claims that male circumcision reduces STD infection by forty to sixty percent. The task force frequently used unreliable studies from Africa that may not be applicable to the United States, many of which were produced by the pro-circumcision Bloomberg group.[24,25]

American studies that do not confirm to the task force hypothesis (that the foreskin contributes to STD infection) were ignored. Van Howe (1999) wrote in his systematic review, "In summary, the medical literature does not support the theory that circumcision prevents STDs."[26]

A longitudinal study of a birth cohort in Dunedin, New Zealand found little difference in STDs in circumcised and intact males.[27]

**Human immunodeficiency virus**

The decision to create a new AAP task force to update their circumcision policy position of 1999, was based on the publication in 2005 and 2007 of three randomized clinical trials (RCTs) carried out in Africa. The three studies purported to conclude that male circumcision provided a 60 percent reduction in female-to-male heterosexual transmission of HIV.

Since 2007 a substantial number of papers have been published that debunk, delimit, or narrow the claims of the three RCTs.[28-33] The task force totally ignored these important papers.

Recent evidence shows higher rates of HIV infection among circumcised men as compared to non-circumcised men in numerous populations. However, the task force did not choose to report this information.

The three RCTs, even if they are correct, studied HIV transmission among *adults* in *Africa*. Any conclusions to be drawn about African adult sexual behavior and inappropriate or inadequate sexual hygiene are not readily applicable to infants and children in North America, who will have access to clean water and proper hygiene at their sexual debut.

**Urinary tract infection (UTI)**

The 2012 task force, in its zeal to promote male circumcision, has resurrected the myth that 1% of boys who are not circumcised are subject to a UTI in the first year of life. This claim was even partially debunked by their own predecessor, the 1999 task force.[34]

Furthermore, Chessare (1992) showed that even if the claims about UTI were correct, the complications from circumcision exceed the benefits from prevention of UTI.[35] (The task force chose to arbitrarily exclude this significant paper because it was written in 1992.)

At the annual AAP convention in New Orleans in October, 2012, a urologist presenter, when questioned on the record, freely admitted that the thirty-year-old claimed 1% absolute rate of UTI in intact boys could easily be ascribed to "unnecessary, intrusive, and septic genital tampering."

The best way to prevent UTI is breastfeeding, a fact well known to the AAP,[36] but the task force chose not to divulge this information to the public, apparently preferring to promote male circumcision rather than easier methods of UTI prophylaxis.

**Bacterial vaginosis (BV)**

The task force on circumcision proposes that male infants should be circumcised to protect adult women from BV. This is a ludicrous suggestion at best.

Studies that suggest male circumcision prevents BV were carried out in Africa and may not be relevant to North America. One study was authored by known pro-circumcision doctors associated with the Bloomberg School of Public Health,[37] so it is likely to suffer from researcher bias. The other study found that racial differences, cigarette smoking, lack of vaginal $H_2O_2$-producing lactobacilli, and anal intercourse before vaginal intercourse were confounding factors.[38] The science that supports the BV claim is extremely dubious at best.

Even if the science were indisputable, it is not clear that amputation of a body part from a child to protect an unrelated and unknown adult is in the child's best long-term interest or even ethical. Bioethicists condemn the cutting of one healthy body without consent to prevent future disease – maybe – in an unidentified and unknowable other. The task force on circumcision has not provided any evidence that a surgical excision operation of a healthy functional body part from a child to help an unknown adult is in any child's best interest, or meets modern epidemiological or bioethical standards.

In a few cases, organ removal has been found to be in the best interest of the child, if the organ removal is to save the life an immediate family member; however, that is not the case here. Parents may not grant surrogate consent to surgery unless it is the best interest of the incompetent child-patient himself, and no other, and such motivation does not include humoring the felt-needs and whims of the child's birth family and relatives.[39]

**Sexual function and sensation**

The task force relied upon dubious sexual sensation studies carried out in Africa by pro-circumcision researchers,[40,41] studies that did not study the foreskin,[42,43] and an unreliable telephone survey from Australia.[44]

The task force ignored significant findings that did not meet their objective. Solinis and Yiannaki (2007) studied couples and reported:

> There was a decrease in couple's sexual life after circumcision indicating that adult circumcision adversely affects sexual function in many men or/and their

> partners, possibly because of complications of surgery and loss of nerve endings.[45]

Frisch *et al.* (2011) reported:

> Circumcision was associated with frequent orgasm difficulties in Danish men and with a range of frequent sexual difficulties in women, notably orgasm difficulties, dyspareunia and a sense of incomplete sexual needs fulfillment. Thorough examination of these matters in areas where male circumcision is more common is warranted.[46]

Taylor (2007) speculated that the ridged band of the foreskin regulated the bulbo-cavernosus reflex.[47] Podnar (2012) found that it is difficult to elicit the bulbo-cavernosus reflex (now called the penilo-cavernosus reflex) in circumcised men.[48]

The task force, inadvertently or intentionally, declined to elaborate upon, and withheld from the American public, significant information on the effect of circumcision on sexual function.

**Lack of knowledge of the foreskin**

The task force has displayed an appalling lack of knowledge of the human foreskin. This may not be surprising because it appears that not one of the task force members possessed or had intimate knowledge of this normal and natural body part. The task force falsely claimed (citing Camille *et al*. 2002) that "adhesions (actually a normal protective membrane of childhood) present at birth, spontaneously dissolve by age 2 to 4 months" (p.e763). However Camille *et al.* actually said no such thing.[49]

Øster (1968) proved that the common connective epithelium of glans and foreskin breaks down slowly over a widely variable period of years and might endure, harmlessly, to age 17 years.[50] The mean age of full and non-traumatic foreskin retraction, by study of a large cohort, has been set at 10.4 ***years***,[51] and a similar timeline has been observed by numerous confirming studies.

For the AAP task force to suggest otherwise is an atrocious misstatement of fundamental gross anatomy which has been understood for centuries. It does more than cast doubt on the medical competency of the AAP task force. It provides unfortunate fodder for clinicians to claim a birth defect when millions of healthy boys each year present with fully normal, still developing, penile anatomy.

The task force says, in addition, that penile wetness (subpreputial moisture) is "considered a marker for poor hygiene and is more prevalent in uncircumcised men than in circumcised men." In actuality, sub-preputial moisture is completely normal in the intact male,[52] and contains lyzozyme and other immune-active and protective substances.[53] This 'moisture' is similar in function and protection in both genders.

As one medical malpractice lawyer has exclaimed, "[i]f they are wrong about this, what else are they wrong about?"

## It's all about the money

The AAP has been concerned about state Medicaid agencies denying payment for unnecessary circumcision because its doctors receive less money. The protection of the source of funding is so important to the AAP that a section on financing newborn circumcision by third-party payers has been included in this medical position statement.

A careful reading of this 2012 Circumcision Policy Statement shows that the task force was created five years ago with the transparent intention of using fear of HIV infection to make infant circumcision nearly universal in the United States. If this happened, the medical industry's income from circumcision of an additional one million boys would jump from about $1.25 billion to about $2.25 billion. The AAP, ACOG, and AAFP apparently saw HIV infection prevention as the way to make this happen. Unfortunately for their scheme, the three African RCTs have been debunked in the five years that have elapsed since the formation of the task force.

One apparent purpose for this statement is to re-energize taxpayer-funded Medicaid to allow payment to doctors who perform non-therapeutic, unnecessary circumcisions once again, although it has been argued persuasively that it is unlawful to use Medicaid to pay for unnecessary, elective cosmetic surgery like circumcision.[54]

To increase the income of their members (whom the AAP call 'fellows'), these medical associations are willing to put healthy American boys under the circumcision knife and expose them all to the risks of any surgery, and the unique risks, harms, and losses of circumcision itself.

## Conclusion

The 2012 Circumcision Policy Statement was created by a team put together for the specific purpose of protecting the goose that lays golden eggs for the American medical industry. None of the members had any specific expertise in circumcision and their document suggests they knew little or nothing about the anatomy and utility of the human foreskin. They claimed to have studied voluminous literature, but ignored older and more useful studies, and cherry-picked the medical *oeuvre*.

The advice given by this Circumcision Policy Statement is designed to support the continuation of an income stream for its stakeholders and also to protect ritual circumcision, by misapplication of ethical and legal rules for therapeutic operations to a non-therapeutic procedure, and distortion and misstatement of acknowledged clinical findings.

The American Academy of Pediatrics – and more importantly the vulnerable children they claim to protect – would have been better served had the task force been fully neutral.

Rather than choosing individuals with ethnic, religious, financial, professional, and even psychological motives to continue the practice of circumcision, a better choice would have been an unpaid group of volunteers, with no financial or cultural stake in the procedure.

A task force composed of Europeans, some medically trained and some not, from historically non-circumcising cultures, would have been much more scientifically honest and ultimately more credible.

This the AAP failed to do.

The Canadian Paediatric Society,[55] the British Medical Association,[56] the Royal Dutch Medical Association,[57] and the Royal Australasian College of Physicians8[6] have issued statements that stand in stark opposition to this new position of the AAP. It cannot be claimed that American male infant genitals are in unique need of urgent surgical reduction, while the children of other nations, where circumcision is uncommon, was never adopted, or has been fully abandoned, are doing just fine.

Parents should be aware that the so-called medical information in the AAP Circumcision Policy Statement is fully tainted by easily identified conflicts-of-interest and financial motives.

Government and insurance company officials should be aware that the claims of this statement are designed to protect third-party payment and should not be considered genuine – or even honest – medical advice.

The American public should have none of this. They should reject the 2012 AAP Circumcision Policy Statement outright, and avoid any medical professional who advises them by quoting the tainted task force claims.

The American Academy of Pediatrics has transparently overplayed its hand and should repudiate this travesty of a medical pronouncement immediately, before the Academy loses any more of its lingering – and endangered – bioethical credibility.

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