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# Circumcision and the American Academy of Pediatrics: Should Scientific Misconduct Result in Trade Association Liability?

*Matthew R. Giannetti\**

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\* Law student, University of Iowa College of Law Class of 2000. I would like to thank my parents for their support and encouragement during the writing of this Note.

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## INTRODUCTION

On October 16, 1998, three-week-old Dustin Evans, Jr. died in Cleveland, Ohio during anaesthetized surgery necessary to repair his urethra, which had become blocked when his circumcision failed to heal.<sup>1</sup> The boy's father is quoted as having said, "you think, 'what could go wrong with a circumcision?'"<sup>2</sup> It appears that no physician fully informed Dustin's parents that serious complications can occur with circumcision, and that such complications can lead to further surgical procedures. However, the entire medical establishment, as well as individual physicians and hospitals, must share part of the blame for needless tragedies that occur, such as that which befell Dustin Evans. Circumcision, while being a widespread and long-standing surgery in American medical practice, has never been the subject of a comprehensive, prospective investigation into its complication rates.<sup>3</sup>

Modern American medicine's reputation and esteem depend upon its adherence to scientific methodology and reasoning in making causal inferences. However, the initial practice of American medicine predated the ascendancy of microbial theories for certain diseases. Consequently, a procedure may have come into use prior to a thorough examination of its scientific validity and may remain an inadequately proven procedure today. Routine infant male circumcision is one example.

Nineteenth century physicians used circumcision as a "medical" cure

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1. See The Associated Press, *Anesthesia Complications Killed Baby: Three-Week-Old Boy Dies At Local Hospital* (visited Nov. 2, 1998) <<http://www.newsnet5.com/news/stories/news-981020-051123.html>> (relating the story of Dustin Evans, Jr.'s death, but omitting from the headline any reference to the circumcision complications that necessitated the corrective surgery and, thus, anesthesia); James F. McCarty, *Reaction to Anesthesia Killed Baby Boy, Report Says* (visited Nov. 2, 1998) <<http://www.cleveland.com/news/pdnews/metro/crainbow.phtml>> (relating the story of Dustin Evans, Jr.'s death, with a similar omission from the headline). Both articles reflect the interviewed physicians' decision to assert that a rare reaction to anesthesia was at fault and to discount any possibility that circumcision as a medical practice had any role in the patient's death.

Routine circumcision of infant boys usually takes place during the first two days of life, before the infant is returned home with his mother. The child is immobilized, by being strapped down on a formed plastic board, and a physician proceeds to tear the foreskin from the glans with a thin flat metal probe inserted between the two attached structures. See ANNE BRIGGS, CIRCUMCISION: WHAT EVERY PARENT SHOULD KNOW 24-31 (1985) (displaying the Gomco clamp procedure and its effects on an infant in a series of photographs); ROSEMARY ROMBERG, CIRCUMCISION: THE PAINFUL DILEMMA 162-69 (1985) (diagramming both procedures and including a series of photographs showing the Gomco clamp method); EDWARD WALLERSTEIN, CIRCUMCISION: AN AMERICAN HEALTH FALLACY 198-210 (1980) (describing both procedures with diagrams). Then either a Plastibell device or a Gomco clamp is used to guide the amputation of the foreskin. *Id.* For many decades, and sometimes still today, no pain control was used. *Id.*

2. Associated Press, *supra* note 1.

3. See American Academy of Pediatrics Task Force on Circumcision, *Report of the Task Force on Circumcision*, 84 PEDIATRICS 388, 390 (1989) [hereinafter AAP 1989] ("The exact incidence of postoperative complications is unknown . . .").

for masturbation, which was thought to cause disease.<sup>4</sup> Amazingly, as medicine became more scientific, circumcision was never thoroughly reevaluated. Instead, the medical community developed alternate causal hypotheses of disease related to the presence of the foreskin of the penis to clinically justify its removal by circumcision.<sup>5</sup>

The medical necessity of circumcision was successfully questioned in 1949. That year, an influential article published in the *British Medical Journal* reviewed the rationales regarding the benefits of circumcision and failed to attribute medical utility to any of them.<sup>6</sup> The article examined the development of the foreskin and its physiological importance and also exposed the varieties and approximate rates of complications attendant to circumcision.<sup>7</sup> When the British National Health Service discontinued coverage for circumcision in response to these findings, the surgery essentially disappeared from that country.<sup>8</sup>

Contrary to the events in the United Kingdom, the United States experienced an increase in circumcision rates after World War II.<sup>9</sup> It was not until 1975 that the American Academy of Pediatrics Report of the Ad Hoc Task Force on Circumcision (1975 AAP report), in a review of available research, reached a conclusion similar to that in Britain, stating that "[t]here is no absolute medical indication for routine circumcision of the newborn."<sup>10</sup> The 1975 AAP report, published in the AAP's journal *Pediatrics*, also concluded that good personal hygiene could replace this surgery

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4. See ANNE BRIGGS, *supra* note 1, at 7-10 (1985) (discussing historical aspects of circumcision); ROSEMARY ROMBERG, *supra* note 1, at 97-99 (1985) (same); EDWARD WALLERSTEIN, *supra* note 1, at 32-40 (1980) (tracing the development of circumcision in order to control masturbation and "sexual excess," which were thought to cause many diseases, including syphilis and other sexually transmitted diseases, as well as various abnormal mental and physical conditions).

5. See BRIGGS, *supra* note 1, at 10-11 (citing the beginnings of theories based on a scientific understanding of the origins of disease); ROMBERG, *supra* note 1, at 108, 114, 235 (same); WALLERSTEIN, *supra* note 1, at 20, 27, 93 (same).

6. See Douglas Gairdner, *Fate of the Foreskin*, BRIT. MED. J. 1433, 1437 (Dec. 24, 1949) (concluding the scientific evidence in support of circumcision was "not convincing," and that even if it might someday become convincing, proper hygiene could accomplish the same level of protection without the surgical risks).

7. *Id.*

8. See WALLERSTEIN, *supra* note 1, at 28, 214-17 (citing M.P.M. Richards et al., *Early Behavioral Differences: Gender or Circumcision*, 9 DEVELOPMENTAL PSYCHOBIOLOGY 90 (1976)). As Wallerstein notes, although the British National Health Service has kept very accurate census records for what is now a rare surgery there, Richards et al. had to "quer[y] 18 American teaching hospitals," out of an approximate total of 7000 American hospitals, and construct a "not very reliable" estimate of the overall circumcision rate. *Id.* at 28.

9. See WALLERSTEIN, *supra* note 1, at 214-17 (estimating U.S. rates based on various samples of various size, over the course of the last century).

10. American Academy of Pediatrics, Committee on Fetus and Newborn, *Report of the Ad Hoc Task Force on Circumcision*, 56 PEDIATRICS 610, 611 (1975) [hereinafter AAP 1975] (concluding that there are no clear medical benefits from neonatal circumcision).

in maintaining the health of the male genital organs.<sup>11</sup> However, because the 1975 AAP report deemed the surgery unnecessary, but not harmful when balanced against surgical complications, physicians continued to circumcise.<sup>12</sup>

Fourteen years later, a new AAP Task Force on Circumcision (1989 AAP report) revised the organization's position, stating that "new evidence has suggested possible medical benefits from newborn circumcision."<sup>13</sup> While retaining the now quite old—but still unproven—justifications of reducing sexually transmitted diseases (STDs) and cancer, the "new evidence" for a benefit from circumcision primarily consisted of studies asserting lower rates of urinary tract infections (UTIs) among circumcised infants.<sup>14</sup> Unlike the 1975 AAP report, the 1989 version cited medical literature to support its conclusions.

However, upon closer analysis, the 1989 AAP report's medical authority provides stronger support for the findings of the 1975 report. The 1989 AAP task force deemed almost all of the cited articles showing STD and UTI benefits from circumcision to be flawed, but found none of the cited articles with findings adverse to circumcision flawed.<sup>15</sup> If the 1989 AAP task force chose to credit STD and UTI research that it knew to be methodologically flawed, as it appears to have done, it would have breached scientific protocol. Methodological soundness is the preeminent consideration for those engaged in scientific investigation.<sup>16</sup> It would be a failure to act in a scientifically responsible manner to give more credit to a larger number of flawed studies supporting the medical utility of circumcision than a smaller

11. See *id.* at 611 (noting that good hygiene "would offer all the advantages of routine circumcision without the attendant surgical risk").

12. Cf. Hugh C. Thompson, *The Value of Neonatal Circumcision: An Unanswered and Perhaps Unanswerable Question*, 137 AM. J. OF DISEASES OF CHILDREN 939, 940 (1983) [hereinafter Hugh C. Thompson] (relating his experience chairing the 1975 task force and explaining how the ambiguous language was purposely designed to allow individual physicians to continue to perform circumcisions while it admitted that the value of the surgery was debatable and unknown).

13. AAP 1989, *supra* note 3, at 388.

14. See *id.* (introducing these rationales in the second paragraph of the report).

15. See *infra* Parts I(C)-(D) (noting the findings of of the 1989 AAP report on circumcision, STD's, and UTI's).

16. See DAVID L. FAIGMAN, DAVID H. KAYE, MICHAEL J. SAKS & JOSEPH SANDERS, MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY, *Scientific Method: The Logic of Drawing Inferences from Empirical Evidence* § 2-1.1 (1997):

To real scientists a finding of fact is only as good as the methods used to find it. . . . Well designed methods permit observations that lead to valid, useful, informative answers to the questions that had been framed by the researcher. . . . Methodology—the logic of research design, measures and procedures—is the engine that generates knowledge that is scientific. . . . While for lawyers and judges credibility is the key to figuring out which witnesses are speaking truth and which are not, for scientists the way to figure out which one of several contradictory studies is most likely correct is to scrutinize the methodology.

(emphasis added).

number of sound studies finding no medical utility from circumcision.

The AAP also drew questionable conclusions concerning infant pain during and after circumcision. The 1989 AAP report described the now acknowledged, but for many decades disputed, physiological pain responses and behavioral changes as “transient and disappear[ing] within 24 hours after surgery.”<sup>17</sup> This statement ignored the increasing knowledge of infant perceptive abilities and warnings concerning the unknown long-term effects of perinatal pain.<sup>18</sup>

After a decade of continuing debate about circumcision, both inside and outside the medical field, the AAP established another task force to review the controversial practice of routine neonatal circumcision. The new AAP task force issued a report in March of 1999 (1999 AAP report) that ultimately concluded, “[e]xisting scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision.”<sup>19</sup> Though this statement was an improvement over the 1989 position, many of the research failings of the 1989 report recurred in the 1999 report.<sup>20</sup> More im-

17. AAP 1989, *supra* note 3, at 389.

18. See generally K.J.S. Anand & P.R. Hickey, *Pain and Its Effects in the Human Neonate and Fetus*, 317 NEW ENG. J. MED. 1321, 1326 (1987) (reviewing over 200 published research papers concerning the effects of pain on neonates). The authors explained:

Apart from excellent studies in animals demonstrating the long-term effects of sensory experiences in the neonatal period, evidence for memories of pain in human infants must, by necessity, be anecdotal. . . . [C]urrent knowledge suggests that humane considerations should apply as forcefully to the care of neonates and young, nonverbal infants as they do to children and adults in similar painful and stressful situations.

*Id.* at 1326. See also Anthony DeCasper & Melanie J. Spence, *Prenatal Maternal Speech Influences Newborns' Perception of Speech Sounds*, 9 INFANT BEHAV. & DEV. 133 (1986) (“[P]renatal auditory experience can influence postnatal auditory preferences.”); Bertil Jacobson et al., *Perinatal Origin of Adult Self-destructive Behavior*, 76 ACTA PSYCHIATRICA SCANDINAVICA 364, 370 (1987) (finding that among 412 deaths due to suicide, alcoholism, and drug abuse, the chosen mechanism of self-destructive behavior was statistically correlated to a similar type of trauma at birth). The authors explained:

The striking resemblance between conditions at birth and eventual adult behavioral disorders makes it necessary to consider the former as possible causative factors. . . . [Salk et al.] suggest that the increasing rates of suicides in the United States are due to a decline in infant mortality rates . . . [because] infants who survived adverse perinatal conditions would be more vulnerable to environmental conditions eliciting suicide. Our results may suggest a somewhat different interpretation. . . . [I]t seems more likely that varying obstetric procedures caused iatrogenic [i.e., medically caused] injuries leading to eventual self-destructive tendencies.

*Id.* at 370; Lee Salk et al., *Relationship of Maternal and Perinatal Conditions to Eventual Adolescent Suicide*, LANCET, March 16, 1985, at 624, 627 (“The findings of this study provide evidence that perinatal experience influences the risk of suicide in adolescence.”).

19. American Academy of Pediatrics Task Force on Circumcision, *Circumcision Policy Statement*, 103 PEDIATRICS 686, 691 (1999) [hereinafter AAP 1999].

20. See generally *infra* Parts II(A)–II(H) (delineating the AAP’s failures to evaluate and weight evidence according to methodological soundness and its failures to investigate pertinent concerns raised in research findings).

portantly, the AAP equivocated in its duty to decide whether this surgery should be considered valid preventive medicine; instead, it left the decision to the "cultural" desires of parents.<sup>21</sup> In doing so, the AAP failed to realize that decades of asserted medical utility had created these prevailing cultural "norms."

Another oddity of the medical practice of circumcision is that it is usually obstetricians, not pediatricians, who perform circumcisions.<sup>22</sup> This practice results in the anomalous situation of having physicians with expertise in female reproductive anatomy performing unanesthetized surgery on a male reproductive organ. The American College of Obstetricians and Gynecologists (ACOG) historically has deferred to the latest AAP circumcision task force position statements on the medical utility of circumcision.<sup>23</sup> Although much of the negligence asserted against the AAP may also attach to ACOG for its deference to the AAP's position, a discussion of whether any such liability is appropriate lies beyond the scope of this Note. In any case, ACOG's deference to the AAP's analysis and recommendations concerning circumcision is evidence of professional reliance, suggesting that the AAP should be subject to a duty of care.

This Note examines the possibility of bringing a claim against a medical professional society or trade association, such as the AAP, for negligent promulgation of recommendations. Trade association liability may be predicated on section 324A of the Restatement (Second) of Torts.<sup>24</sup> Section 324A allows for the imposition of liability upon a trade association for gratuitous services, such as professional standard setting, if the association renders those services negligently.<sup>25</sup>

Trade association liability for issuing faulty guidelines was also addressed in 1996 by the New Jersey Supreme Court in the case of *Snyder v.*

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21. See AAP 1999, *supra* note 19, at 691 ("In the case of circumcision, in which there are potential benefits and risks, yet the procedure is not essential . . . [i]t is legitimate for parents to take into account cultural, religious and ethnic traditions.").

22. See THOMAS J. RITTER & GEORGE C. DENNISTON, SAY NO TO CIRCUMCISION § 36-1 (2d ed. 1996) (noting that most circumcisions are performed by obstetricians and general practitioners, but it is generally pediatricians who engage in follow-up care of male infants and children).

23. See AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 103 (3d ed. 1992) (basing the recommendation on the 1989 AAP task force report); AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 93-94 (2d ed. 1988) (adopting the recommendation of the 1975 AAP task force report); AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 87 (1st ed. 1983) (same); see also Edward Wallerstein, *Circumcision: The Uniquely American Medical Enigma*, 12 Urologic Clinics of N. Am. 123, 124 (1985) (citing to the jointly authored AAP and ACOG Guidelines for Perinatal Care, which abbreviate the most recent AAP task force position statements).

24. RESTATEMENT (SECOND) OF TORTS § 324A (1965); see also *infra* Part III(D) (laying out the text of section 324A of the Restatement).

25. *Id.*

*American Ass'n of Blood Banks*.<sup>26</sup> The plaintiff, a recipient of blood platelet transfusions performed in 1984, contracted AIDS.<sup>27</sup> In order to address the liability of the American Association of Blood Banks (AABB), the court examined the role that the AABB played in the blood banking industry. The court found that "[b]y words and conduct, the AABB invited blood banks, hospitals, and patients to rely on the AABB's recommended procedures."<sup>28</sup> The court held that the AABB owed a duty of care to individuals, like Snyder, because it was foreseeable that blood banks would follow the AABB's recommended procedures.<sup>29</sup> The court also found that at the time of Snyder's transfusions, ample evidence existed that blood products could transmit AIDS, and, therefore, the AABB was negligent.<sup>30</sup>

This Note will delineate how the *Snyder* decision and section 324A of the Restatement can be used to extend tort liability to the AAP. However, much of the case against the AAP depends upon a thorough understanding of the research findings available to the AAP and its choices in interpreting them. Therefore, Parts I and II of this Note will address at length the medical rationales and issues surrounding circumcision at the time of the 1989 and 1999 AAP reports. Part III examines a number of legal theories by which the AAP could be held liable for its role in promoting circumcision as a viable medical practice. This Note concludes by recommending that the AAP face liability in order to force it to act in a scientifically responsible manner when investigating scientific evidence and issuing guidelines concerning the possible benefits and known harms of circumcision.

## I. CIRCUMCISION AS MEDICAL PRACTICE UNDER THE 1989 AAP REPORT

Following more than a decade of argument in the wake of an equivocal 1975 AAP task force statement, the 1989 AAP Report re-examined the medical justifications for infant circumcision. Most of the utility claimed for circumcision was of a preventive nature. The maladies supposedly reduced or prevented by circumcision consisted of various STDs, cancers, UTIs, and abnormal conditions of the foreskin. Preventive surgery is not troubling if proven benefits of the procedure outweigh the costs and risks, as reflected through reliable complication rates. However, in the case of circumcision, the American medical profession has failed for half a century to institute a sufficiently comprehensive prospective research and evaluation program.

### A. PHIMOSIS

In adulthood, the foreskin is able to retract back from the glans down onto the shaft of the penis. Phimosis is the abnormal condition of a non-

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26. 676 A.2d 1036 (N.J. 1996).

27. *Id.* at 1038.

28. *Id.* at 1048.

29. *See id.* at 1048-49 (stating that foreseeability of harm implies a duty of care).

30. *Id.* at 1049, 1055.

retractable foreskin, diagnosed from the occurrence of the hardening of the opening of the foreskin or from prolonged adherence of the foreskin to the glans.<sup>31</sup> Circumcision has long been recommended to parents as a preventive measure for phimosis.<sup>32</sup>

Edward Wallerstein, a former Communications Coordinator in the Department of Community Medicine at the Mount Sinai School of Medicine, in his book *Circumcision: An American Health Fallacy*, forcefully argued that circumcision as both a curative and preventive therapy for phimosis is unwarranted.<sup>33</sup> He cited the groundbreaking 1949 study by the British researcher Douglas Gairdner, which demonstrated that foreskin retraction is a gradual process of development that can take years.<sup>34</sup> Gairdner concluded that a diagnosis of phimosis "cannot properly be applied to the infant."<sup>35</sup> Additionally, Wallerstein cited an eight-year study of 1,968 intact<sup>36</sup> Danish boys that found 63% of the six to seven year-old boys did not have fully retractable foreskins.<sup>37</sup> The study also found that by sixteen to seventeen years of age only 3% of these boys could not fully retract their foreskins.<sup>38</sup> Out of the total of 1,968 boys, only three (.15%) eventually were circumcised to correct phimosis.<sup>39</sup> In retrospect, the author of the study, Dr. Jakob Oster, was not convinced that circumcision was necessary even in the three cases where it had been performed.<sup>40</sup>

The 1975 AAP report stated neonatal phimosis "is not a valid medical indication for a circumcision."<sup>41</sup> The 1989 AAP report, without presenting any new information that clearly called for circumcision to prevent phimosis, simply warned that circumcision later in life "may be a more compli-

31. See WALLERSTEIN, *supra* note 1, at 62, 65 (offering definitions of the term); AAP 1989, *supra* note 3, at 388 (same).

32. AAP 1989, *supra* note 3, at 388. If a foreskin is removed, possible conditions of the foreskin will not occur. However, this justification holds for any body organ or part. It would be more prudent to inquire into the incidence of foreskin conditions, their severity, alternative therapies, and the complication rates of each therapy, in order to render judgment as to the utility of any one therapy.

33. See WALLERSTEIN, *supra* note 1, at 62-66 (arguing that phimosis is over-diagnosed in American infants and children).

34. See *id.* at 63-64; Gairdner, *supra* note 6, at 1433-34 (presenting analysis of then-existing research).

35. Gairdner, *supra* note 6, at 1435.

36. The term, "intact," will be used throughout this Note to refer to "uncircumcised" individuals, because it more accurately reflects the fact that having a foreskin is the natural and, therefore, truly "normal" condition for men. The term "uncircumcised" carries with it an implication that to be circumcised is natural and normal.

37. See WALLERSTEIN, *supra* note 1, at 64 (citing Jakob Oster, *Further Fate of the Foreskin*, 43 ARCHIVES OF DISEASES OF CHILDHOOD 200 (April 1968)).

38. See WALLERSTEIN, *supra* note 1, at 64 (citing Oster).

39. See WALLERSTEIN, *supra* note 1, at 64 (citing Oster's study). As will be demonstrated in Part I(E), this percentage is less than the likely percentage of complications attendant to circumcision.

40. *Id.*

41. AAP 1975, *supra* note 10, at 610.

cated procedure."<sup>42</sup> The 1989 AAP task force was aware of Gairdner's article and findings because it cited him for his information concerning the progressive development of foreskin retractability.<sup>43</sup> However, the 1989 AAP report does not mention Dr. Oster's findings or conclusions regarding phimosis.<sup>44</sup> The logical inference from the AAP's omissions is that it is better to perform painful, unanaesthetized surgery within the first several days of every infant boy's life than to circumcise a rare few later in life. The 1989 task force did not weigh the incidence of foreskin conditions, such as phimosis, against the complication rates for neonatal circumcision. Likewise, the task force failed to examine any alternative therapies for phimosis. As a result, the 1989 AAP task force could not justifiably use the prevention of phimosis to support its alteration of the 1975 AAP statement.

### B. CANCER

Although the threat of phimosis might not be enough to convince parents to circumcise, the threat of cancer obviously might be more influential. The rationale of using circumcision to prevent cancer had been around since the 1930s, but the 1975 AAP report found no solid support for using circumcision to prevent cervical or prostate cancer and found that good hygiene was a preferable method for preventing penile cancer.<sup>45</sup> However, the 1989 AAP report resurrected the rationales of using circumcision to prevent both penile and cervical cancer.

#### 1. Cervical Cancer

The 1989 AAP report omitted two well-designed studies that found no statistical effect between a husband's circumcision status and the incidence of cervical cancer in his wife.<sup>46</sup> In addition, the 1989 AAP report did not review the international epidemiological evidence contained in Edward Wallerstein's book on circumcision, which essentially renders any link be-

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42. See AAP 1989, *supra* note 3, at 388 (implying that circumcision should be done as a preventative on infants instead of as a curative for the few cases of phimosis which can only be diagnosed later in life).

43. *Id.* at 388, 391 (citing Gairdner, *supra* note 6).

44. The 1989 AAP task force cites Wallerstein's article, *Circumcision: The Uniquely American Medical Enigma*, *supra* note 23, in which Wallerstein cites at least three times to Oster. See *supra* note 37. The task force was also most likely aware of Wallerstein's book, *CIRCUMCISION: AN AMERICAN HEALTH FALLACY*, *supra* note 1, wherein Oster is cited repeatedly.

45. See AAP 1975, *supra* note 10, at 610-11 (declining to recommend circumcision for the prevention of cancer).

46. See Jean Aitken-Swan & D. Baird, *Circumcision and Cancer of the Cervix*, 19 BRIT. J. OF CANCER 217, 226-27 (1965) (finding no correlation between the circumcision status of husbands and the cervical cancer rate of their wives); see also Milton Terris et al., *Relation of Circumcision to Cancer of the Cervix*, 117 AM. J. OF OBSTETRICS AND GYNECOLOGY 1056 (1973) ("No significant differences were found in the circumcision status of marital partners of cases and controls.").

tween male circumcision status and cervical cancer unsupported.<sup>47</sup> The 1989 AAP task force did observe that cervical cancer appears to be related to the age that a woman begins sexual relations and the number of sexual partners she has throughout life.<sup>48</sup> The 1989 AAP task force, in making this observation, did not give any citation. Thus, readers of the 1989 AAP report were not alerted to sources of evidence unfavorable to theories linking a male partner's circumcision status to cervical cancer.

Aside from its omissions of pertinent evidence, the 1989 AAP report used language that appears to have been chosen to induce readers to make faulty inferences. Were it not for the misleading sentence construction in the summary section of the 1989 AAP report which stated, "[a]n increased incidence of cancer of the cervix has been found in sexual partners of uncircumcised men *infected with the human papillomavirus*,"<sup>49</sup> the report would have clearly acknowledged a stronger linkage of cervical cancer to viral STDs. The sentence appears to have been constructed to draw attention to "uncircumcised men" and to rhetorically conceal "infected with the human papillomavirus." Thus, the summary section fails to reiterate better supported hypotheses that human papillomavirus and other viral STDs are causal agents of cervical cancer in women, irrespective of the circumcision status of their partners.<sup>50</sup>

The section of the 1989 report addressing cervical cancer contained further misleading language. The 1989 AAP report stated:

Human papillomavirus types 16 and 18 are the viruses most commonly associated with cancer of the cervix; Herpes simplex virus type 2 has also been linked with cervical cancer. *Although human papillomavirus types 16 and 18 are also associated with cancer of the penis, evidence linking uncircumcised men to cervical cancer is inconclusive.*<sup>51</sup>

The second sentence leads with a clause addressing the linkage between human papillomavirus infection and cancer of the penis, but the second part of this sentence substituted "uncircumcised men" for men infected with human papillomavirus, without supporting an equivalence for the two

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47. See generally WALLERSTEIN, *supra* note 1, at 95, 96, 99 (citing international epidemiological data that do not support the hypothesis that an intact penis is more likely to cause cervical cancer in female sexual partners).

48. Compare AAP 1989, *supra* note 3, at 389 (stating without attribution that "[t]he strongest predisposing factors in cervical cancer are a history of intercourse at an early age and multiple sexual partners. The disease is virtually unknown in nuns and virgins."), with WALLERSTEIN, *supra* note 1, at 99 (stating with attribution to sources critical of a circumcision correlation to cervical cancer, that "[n]uns rarely develop the disease, while prostitutes usually have a very high incidence rate").

49. See AAP 1989, *supra* note 3, at 390 (emphasis added) (leaving it to the reader to note that circumcision status may be irrelevant due to the presence of the virus, while implying that circumcision status is the root cause of cervical cancer).

50. *Id.* at 389 (admitting growing evidence linking viral STD infection to cervical cancer).

51. *Id.* (emphasis added).

groups. Reliable evidence for a higher rate of viral infection due to lack of circumcision was not presented anywhere in the report's section on STDs.<sup>52</sup> The section of the 1989 AAP report devoted to penile cancer did cite a Brazilian study that reported finding human papillomavirus in 31 of 53 cases of penile cancer.<sup>53</sup> However, the penile cancer section of the report did not cite this study to support the proposition that viral STD infections are higher in intact men.<sup>54</sup> The word "although," which begins the sentence, further concealed the rhetorical substitution. These rhetorical maneuvers appear to have been designed to divert attention from the "inconclusive"<sup>55</sup> linkage between cervical cancer and circumcision status, while subtly reinforcing a suspicion of linkage between foreskins and human papillomavirus, and, consequently, a male with a foreskin and cervical cancer in his partner.

## 2. Penile Cancer

Although the prevention of *cervical* cancer through the circumcision of male infants has always been questionable, the prevention of *penile* cancer has always been circumcision advocates' strongest cancer argument. The 1989 AAP report stated that penile cancer "occurs almost exclusively in uncircumcised men," and continued by stating that "in five major reported series since 1932, not one man had been circumcised neonatally."<sup>56</sup> The report cites a 1975 article by researchers Elliot Leiter and Albert Lefkovits to support the contention that circumcision provides virtual immunity from penile cancer.<sup>57</sup> However, the main purpose of the Leiter and Lefkovits article, which was labeled a "case report," was to report penile cancer in a man circumcised neonatally and to cite other reported cases.<sup>58</sup> It appears that the 1989 AAP task force, in failing to enumerate the nine "reported" cases that occurred in men circumcised neonatally, was uncritically parroting an industry opinion. Additionally, the task force appears not to have considered the possibility that there were only nine reported cases due to an industry-wide reporting bias. This failure to consider reporting bias as a

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52. See *infra* Part I(D) (delineating how all of the studies cited by the 1989 AAP task force finding higher STD rates among intact males were also found by the task force to be methodologically unsound).

53. See AAP 1989, *supra* note 3, at 389 (citing D.J. McCance et al., *Human Papillomavirus Types 16 and 18 in Carcinomas of the Penis from Brazil*, 37 INT'L J. CANCER 55, 57 (1986)).

54. See AAP 1989, *supra* note 3, at 389 (beginning the paragraph which cites the McCance article with, "[f]actors other than circumcision are important in the etiology of penile cancer").

55. See AAP 1989, *supra* note 3, at 389 (characterizing any linkage as inconclusive).

56. *Id.* at 388.

57. See *id.* (citing Elliot Leiter & Albert M. Lefkovits, *Circumcision and Penile Carcinoma*, 75 N.Y. ST. J. MED. 1520 (1975)). Leiter and Lefkovits stated, "[t]hat circumcision in infancy virtually guarantees immunity from penile carcinoma is a well known fact." *Id.* at 1520.

58. See Leiter & Lefkovits, *Circumcision and Penile Carcinoma*, 75 N.Y. ST. J. MED. 1520, 1520 (1975) ("We should like to report a sixth case of carcinoma of the penis in a Jewish male circumcised eight days after birth.").

possible confounding variable could result in readers erroneously concluding that circumcised men are immune to penile cancer.

The 1989 report, citing a 1980 estimate derived in a study by Mosze Kochen and Stephan McCurdy, then stated that one in six hundred intact men will develop penile cancer in their lifetime.<sup>59</sup> Kochen and McCurdy based their estimate on the assumption that all cases of penile cancer would occur in intact men.<sup>60</sup> The 1989 AAP task force reported the estimate even though it was based on this assumption. In the very next paragraph, however, the task force, citing an article by Edward Wallerstein, admitted that countries which do not routinely circumcise have rates less than, equal to, and greater than the rate in the U.S.—where the majority of males are circumcised.<sup>61</sup> It was thus not valid for the 1989 task force to report a one in six hundred lifetime risk for penile cancer among intact males when a major premise for the estimate, that only intact males get penile cancer, was clearly erroneous.

Additionally, Edward Wallerstein identified multiple incidences of faulty research design and wild hypothesizing in the search for a link between the retention of an intact foreskin, the presence of smegma, and the occurrence of penile cancer.<sup>62</sup> It was irresponsible for the 1989 AAP task force, as reviewers of medical research, to have uncritically parroted a conclusion that neonatal circumcision provides virtual immunity from penile cancer in light of the pattern of researcher bias that Wallerstein exposed. The task force's underreporting of penile cancer cases in neonatally circumcised males, unfortunately, fit well into this historical pattern of bias on the part of the American medical profession.<sup>63</sup>

### 3. Prostate Cancer

Whereas penile cancer made it onto the first page of the 1989 AAP re-

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59. See AAP 1989, *supra* note 3, at 388 (citing Mosze Kochen & Stephen McCurdy, *Circumcision and the Risk of Cancer of the Penis*, 134 AM. J. DISEASES CHILDREN 484 (1980)).

60. See Kochen & McCurdy, *supra* note 59, at 484 ("We assumed that virtually all of the reported cancers occurred in uncircumcised males. We therefore adjusted the rates for the estimated fraction of the population that was uncircumcised in each age group.")

61. See AAP 1989, *supra* note 3, at 388-89 (citing Wallerstein, *supra* note 23, at 126-27, for his international epidemiological evidence).

62. See WALLERSTEIN, *supra* note 1, at 111-12 (demonstrating outright misstatements of numerical figures as well as unsupported assertions by circumcision advocates); see also *id.* at 96-97 (discussing studies concerning smegma); Wallerstein, *supra* note 23, at 127 (citing a horribly flawed study in the medical literature which purported to prove that smegma was carcinogenic).

63. See generally WALLERSTEIN, *supra* note 1, at 108-09 (relating the successive reporting in medical literature of no penile cancer among neonatally circumcised men). Cf. AAP 1989, *supra* note 3, at 388 (citing Abraham L. Wolbarst, *Circumcision and Penile Cancer*, LANCET, Jan. 16, 1932, at 150, for the conclusion that "[c]ancer of the penis does not occur in Jews circumcised in infancy. There is no case on record."); Leiter & Lefkovits, *supra* note 57, at 1520-21 (1975) (same). Both the 1989 AAP report and Leiter and Lefkovits cite to Wolbarst's statement, even after Leiter and Lefkovits reported six such cases.

port, cancer of the prostate was not even mentioned. The 1975 report mentioned it, but solely for the purpose of debunking any theory that prostate cancer occurs more frequently among intact men.<sup>64</sup> As with theories linking circumcision to other cancers, Wallerstein demonstrated that findings connecting circumcision to prostate cancer were the result of badly designed and conducted research.<sup>65</sup> By failing to present the fact of the discredited link between circumcision status and prostate cancer, the 1989 AAP task force, unlike its 1975 counterpart, did not alert the medical community to the full magnitude of the panacean claims for circumcision. Thus, a physician relying on the AAP's analysis was not put on guard in reviewing the claims for circumcision in the fight against cancer.

### C. URINARY TRACT INFECTIONS

For many decades, circumcision advocates tried to use the prevention of cancer to justify circumcision. A new justification emerged in the 1980s—the prevention of urinary tract infections (UTIs). The 1989 AAP Task Force on Circumcision modified the 1975 position statement, primarily using the reduction of urinary tract infections as its rationale, by stating in the introductory section, “[n]ew evidence has suggested possible medical benefits from newborn circumcision. Preliminary data suggest the incidence of urinary tract infection in male infants may be reduced.”<sup>66</sup> However, the section of the report devoted to UTIs ended with the admission that the UTI studies suggesting the utility of circumcision “are retrospective in design and may have methodologic [sic] flaws,” and “the study population may have been influenced by selection bias.”<sup>67</sup> A 1990 article by Robert Thompson more thoroughly explained the methodological flaws in these UTI studies.<sup>68</sup> He noted that these studies neither controlled for population variables among the boys’ families nor accounted for “differences in the health-care-providing behavior of physicians.”<sup>69</sup>

Notwithstanding the AAP's own worry over methodological flaws, the

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64. See AAP 1975, *supra* note 10, at 610 (“There is presently no convincing scientific evidence to substantiate the assertion that circumcision reduces the eventual incidence of cancer of the prostate.”).

65. See generally WALLERSTEIN, *supra* note 1, at 100-04 (tracing the development of the theory and the scientific flaws in the research done on prostate cancer).

66. AAP 1989, *supra* note 3, at 388.

67. *Id.* at 389.

68. See generally Robert S. Thompson, *Routine Circumcision in the Newborn: An Opposing View*, 31 J. FAM. PRAC. 189, 189-92 (1990) (delineating flaws in studies by Thomas E. Wiswell et al., *Decreased Incidence of Urinary Tract Infections in Circumcised Male Infants*, 75 PEDIATRICS 901 (1985); Thomas E. Wiswell & John D. Roscelli, *Corroborative Evidence for the Decreased Incidence of Urinary Tract Infections in Circumcised Male Infants*, 78 PEDIATRICS 96 (1986); Thomas E. Wiswell et al., *Declining Frequency of Circumcision: Implications for Changes in the Absolute Incidence and Male to Female Sex Ratio of Urinary Tract Infections in Early Infancy*, 79 PEDIATRICS 338 (1987)).

69. Robert S. Thompson, *supra* note 68, at 191.

results of these UTI studies formed the impetus for the 1989 AAP review of circumcision.<sup>70</sup> Once again, it appears that when the benefit of circumcision was the topic of investigation, the AAP task force was willing to overlook methodological flaws in research. The task force used the UTI findings to support their change in the position statement, even when such flaws consisted of failure to control subject variables, failure to control for physician biases, and the elimination of data that presented problems for the hypotheses.<sup>71</sup>

Additionally, the 1989 AAP task force readily adopted a theory championed by Thomas Wiswell—the main author of these problematic studies asserting UTI benefits from circumcision—that the presence of a foreskin provides a site for bacterial colonization leading to UTIs.<sup>72</sup> A hypothetical alternate explanation could be that some UTIs result from a lack of proper information on the care of the foreskin. Well meaning, but misinformed parents might have attempted to forcefully retract the foreskin for cleaning underneath due to a lack of understanding of the foreskin's natural structural development. Forced retraction might have resulted in tissue irritation and avenues of entry for the germs that caused the UTIs. Neither Dr. Wiswell nor the AAP appear to have considered this possibility as an intervening causal variable in the results.

The AAP was aware of the forced retraction problem in 1989. In 1984 it had published a brochure called *Care of the Uncircumcised Penis*, largely to address the shocking lack of knowledge physicians displayed in surveys conducted in the early 1980s.<sup>73</sup> The AAP brochure may have begun to educate physicians and parents to stop forcibly retracting children's foreskins and to stop unnecessarily cleaning under the foreskin with cotton swabs and antiseptics. However, the problem has not disappeared,<sup>74</sup> and the AAP still

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70. See AAP 1989, *supra* note 3, at 388 (stating that “[s]ince the 1975 report . . . [p]reliminary data suggest the incidence of urinary tract infection in male infants may be reduced [by neonatal circumcision]”); see also Robert S. Thompson, *supra* note 68, at 189 (claiming that “[l]argely because of these [UTI studies] data, the [AAP] convened a task force on circumcision” to revise the statement of the 1975 task force).

71. See Robert S. Thompson, *supra* note 68, at 189-92 (delineating problems involving failures “to control for age, race, education, or income,” to control for “differences in the health-care-providing behavior of physicians,” and the dropping of data which did not fit the researchers' hypotheses).

72. See AAP 1989, *supra* note 3, at 389 nn.5, 25, 26 (citing three separate studies conducted by Wiswell and co-authors, *supra* note 68, resulting in a hypothesis that the foreskin provides a site for bacterial colonization leading to UTI).

73. See Wallerstein, *supra* note 23, at 128 (citing studies showing only 3-49% of physicians in the early 1980s were aware that the foreskins of infants should not be forcibly retracted). Additionally, over 50% of physicians were unaware that the newborn's non-retractable foreskin is normal. *Id.*

74. Unfortunately, a significant percentage of pediatricians still attempt to forcibly retract the foreskin. See National Organization of Circumcision Information Resource Centers, *Survey Reveals Need for Pediatrician Education*, NOCIRC ANNUAL REPORT 1, 8 (Spring 1999). According to NOCIRC, an informal survey of pediatricians at the 1999 AAP national convention revealed that 22% did not know the proper care of the foreskin. *Id.* See also David J. Llewellyn, *Legal*

suggests the daily use of soap under the foreskin once retraction has occurred.<sup>75</sup> Anne Briggs, in *Circumcision: What Every Parent Should Know*, relates the story of Dr. William Mitchell, who was warned that smegma was a carcinogen, while attending medical school during the late 1940s, and subsequently started washing under his foreskin with soap daily.<sup>76</sup> It was only after changing from a daily rinse with water to this cleansing method that he developed his first foreskin infection.<sup>77</sup> The ensuing series of infections and constant irritation unfortunately led him to choose circumcision as a cure.<sup>78</sup> Dr. Paul M. Fleiss, in a 1997 article published in the magazine *Mothering*, recommends simply rinsing underneath the foreskin with water once it is retractable<sup>79</sup>—the method that kept Dr. Mitchell free of problems for 29 years.<sup>80</sup> In view of its knowledge of the forced retraction problem, and the possibility that some cleaning behaviors themselves may be at fault, the AAP should have remained skeptical of Wiswell's causal hypothesis for UTIs.

#### D. SEXUALLY TRANSMITTED DISEASES

Another non-cancer rationale for circumcision, but one which has been proposed since the nineteenth century, is the prevention of sexually transmitted diseases (STDs). Even though the 1989 AAP report retained a section addressing circumcision as a possible preventive measure for STDs, the task force admitted that the “[e]vidence regarding the relationship of cir-

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*Remedies for Penile Torts*, THE COMPLEAT MOTHER, Winter 1995, at 13 (relating how that author's wife had to pull her son away from a pediatrician who was attempting to forcibly retract the boy's foreskin); Amanda Schneider, *My Son Clayton* (visited March 4, 1999) <<http://weber.u.washington.edu/~gcd/DOC/clayton.html>> (relating the forcible retraction attempt by a nurse practitioner and a subsequent \$100 small claims default judgment against the nurse). One instance of a medical practitioner's ignorance is well known to the author of this Note. While his nephew was at the office of a pediatrician in Texas, the pediatrician attempted to forcibly retract the nephew's foreskin. Thanks to the swift action of the boy's mother, the pediatrician was not successful and no harm was done.

75. See AMERICAN ACADEMY OF PEDIATRICS, BROCHURE NO. HE 0023R, NEWBORNS: CARE OF THE UNCIRCUMCISED PENIS (1992) (stating that “external cleansing with soap and water is all that is required . . . retracting the foreskin and cleaning beneath it during his bath or shower”).

76. See BRIGGS, *supra* note 1, at 46 (quoting personal correspondence with Dr. William Mitchell, M.D.).

77. See *id.* (quoting personal correspondence with Dr. William Mitchell, M.D.).

78. See *id.* (relating how Dr. Mitchell retrospectively concluded that daily soaping of the inner foreskin irritated it and allowed infections to occur).

79. See Paul M. Fleiss, *The Case Against Circumcision*, MOTHERING, Winter 1997, at 41 (“The best way to care for a child's intact penis is to leave it alone. After puberty, males can gently rinse their glans and foreskin with warm water.”). This information mirrors the common knowledge among many women that a daily scrubbing with soap in the recesses of the female genitalia can be counter-productive.

80. See BRIGGS, *supra* note 1, at 46 (relating the conclusions of Dr. William Mitchell concerning his foreskin problems and proper hygiene).

cumcision to sexually transmitted diseases is conflicting."<sup>81</sup> Two studies that the report cited indicated that both gonorrhea and nonspecific urethritis occurred with greater frequency in intact men.<sup>82</sup> However, the next sentence of the report described both these studies as inconclusive due to methodological problems.<sup>83</sup> Other studies cited in the 1989 report, purporting to link intact penises to higher rates of viral STDs, such as human papillomaviruses and genital herpes, are also listed as likely to have methodological flaws.<sup>84</sup> In fact, every study that the task force cited for the proposition that circumcision lessens the risk of contracting STDs was also cited as methodologically troubled.<sup>85</sup>

The 1989 task force report was also void of an analysis of the availability and cost effectiveness of alternate means of treatment and prevention for STDs. The analysis further lacked any comparison of medical utility between neonatal circumcision and alternative therapies. These two omissions served to undermine any implication that circumcision should be considered as prophylactic therapy for STDs. In view of the uncertainty in the data that purported to link circumcision status and numerous STDs, a responsible health organization should have reiterated the fact that avoiding sexual promiscuity and using condoms are the best methods of protection against STDs. The 1989 AAP report failed to do this.

The only methodologically non-problematic study cited in the STD section of the report found no difference in the incidence of gonorrhea between circumcised and intact groups and, in fact, found "a higher incidence of nonspecific urethritis in circumcised men."<sup>86</sup> Based on its own cited material, the 1989 task force could have scientifically concluded that avoiding circumcision confers a benefit against the risk of contracting STDs. In any case, similar to the situation for UTIs, the flawed studies, claiming circumcision reduced the risk of contracting an STD, failed to justify the 1989 task force's change of policy on circumcision.

#### E. PHYSICAL COMPLICATIONS OF CIRCUMCISION

Turning from a benefit examination of circumcision to a risk examination of circumcision, the 1989 AAP report continued the practice of ignoring sound evidence against circumcision while crediting flawed evidence

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81. AAP 1989, *supra* note 3, at 389.

82. *See id.* at 389 (citing S.W. Parker et al., *Circumcision and Sexually Transmitted Disease*, 2 MED. J. AUSTL. 288 (1983); R.A. Wilson, *Circumcision and Venereal Disease*, 56 CAN. MED. ASS'N J. 54 (1947)).

83. *See* AAP 1989, *supra* note 3, at 389 (citing the studies of Parker, *supra* note 82, and Wilson, *supra* note 82, as methodologically flawed).

84. AAP 1989, *supra* note 3, at 389.

85. *See id.* (listing every study with a finding of a benefit from circumcision as also having methodological flaws).

86. *See id.* (citing G.L. Smith et al., *Circumcision as a Risk Factor for Urethritis in Racial Groups*, 77 AM. J. PUB. HEALTH 452 (1987), and not citing it for methodological flaws, unlike every other source cited in the STD section of the report).

supporting the procedure. The report stated that “[t]he most common complications are local infection and bleeding.”<sup>87</sup> Though severe complications following circumcision are rare, they should have been mentioned in the AAP’s report when it mentioned three deaths which were openly attributed to circumcision complications in the last forty years.<sup>88</sup> The report failed to warn that infections resulting from a circumcision can become quite serious and can have impacts on other parts of the body. This has been documented in a four-year case study report of four infants who were admitted to one Australian hospital for meningitis following their circumcisions and in a press release concerning the Alaskan lawsuit of Jacob Sweet.<sup>89</sup> The AAP should have warned parents that infections from this surgery do not always remain local.

Aside from “local infection and bleeding,” there is a striking range of complications that can result from circumcision. Rosemary Romberg, in her 1985 book, *Circumcision: The Painful Dilemma*, devoted over thirty pages to reviewing reports of various clinical conditions and surgical mishaps that can occur as a result of circumcision and can result in the loss of part or all of the penis.<sup>90</sup> The 1989 report did not cite Romberg’s book and failed to

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87. AAP 1989, *supra* note 3, at 390.

88. *Id.*

89. See Jacqueline M. Scurlock & Patrick J. Pemberton, *Neonatal Meningitis and Circumcision*, 64 MED. J. AUSTL. 332, 332-34 (1977) (describing the events and indications surrounding four circumcised boys admitted to the hospital for meningitis over a four-year period); see also Johnson Flora, *Johnson Flora: Alaska Law Firm Settles Lawsuit With Family of Brain-Damaged Boy: Betrayed by Doctors and Lawyers in Alaska, Sweets Find Justice Through Seattle Malpractice Attorney* (visited Mar. 9, 2000) <[http://biz.yahoo.com/prnews/000308/wa\\_johnson\\_1.html](http://biz.yahoo.com/prnews/000308/wa_johnson_1.html)> (publicizing the settlement of the case of Jacob Sweet who suffered seizures and brain damage following an infected circumcision). This press release notes that the parents fought a 13-year legal battle starting on January 25, 1986, the day their nine-day old son suffered seizures while under hospital care. *Id.* The parents lost the original medical malpractice suit when their attorney improperly handled the presentation of the evidence that the hospital had *lost* the medical records. *Id.* They finally received some compensation in their legal malpractice case. *Id.*

90. See ROMBERG, *supra* note 1, at 198-234 (1985) (detailing the range of complications that can result from circumcision); *id.* at 200 (“Meatal Ulceration”—urine burns that occur around the meatus because the foreskin is no longer there to protect it); *id.* at 204 (“Meatal Stricture”—the narrowing of the meatus resulting from recurrent meatal ulceration); *id.* at 206 (“Hemorrhage”—bleeding that can be minor or severe); *id.* at 208 (“Infection”—which can be minor or severe); *id.* at 211 (“Concealed Penis”—a rare occurrence where the penile shaft retreats into the body requiring further surgery to correct); *id.* at 214 (“Urethral Fistula”—an abnormal hole on the urethra which is not the meatus); *id.* at 217 (“Urinary Retention”—blockage of urine flow usually the result of an overtight bandage); *id.* at 219 (“Injury or Loss of the Glans”—usually due to mistakes in cutting); *id.* at 219 (“Excessive Skin Loss”—resulting from the excision of too much foreskin); *id.* at 221 (“Skin Bridge”—a condition which results from the circumcision wound healing and adhering onto the glans); *id.* at 222 (“Vomiting and Apnea”—trouble breathing); *id.* at 223 (“Laceration of Penile or Scrotal Skin”); *id.* at 223 (“Preputial Cysts”—a fluid-filled sack on what remains of the foreskin); *id.* at 226 (“Keloid Formation”—thick red scar tissue); *id.* at 226 (“Lymphedema”—swelling of lymph vessels); *id.* at 228 (“Loss of Penis”—in two cases the remedy chosen was penile reconstruction, in two other cases *gender reassignment* was chosen) (emphasis added).

address the lengthy list of complications that she compiled from the medical literature.

At the very least, the 1989 report should have included what was mentioned in the "Surgical Risks and Aftermaths" section of the 1975 report, which informed parents and physicians that "[t]he immediate hazards of circumcision of the newborn include local infection *which may progress to septicemia, significant hemorrhage, and mutilation.*"<sup>91</sup> The 1989 AAP report skipped directly from, "the most common complications are local infection and bleeding," to mentioning three reported deaths in the last forty years.<sup>92</sup> Thus, the AAP appeared to imply that there was no range of harmful effects between the two extremes.

Even though it postdated the 1989 AAP report on circumcision, the 1995 AAP Committee on Bioethics statement, entitled *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, recommended that all known potential risks should be presented to parental decision makers:

[P]atients should have explanations, in understandable language, of the nature of the ailment or condition; the nature of the proposed diagnostic steps and/or treatment(s) and the probability of their success; the existence and nature of the risks involved; and the existence, potential benefits, and risks of recommended alternative treatments (including the choice of no treatment) . . . [and] assurance . . . that the patient has the freedom to choose among the medical alternatives without coercion or manipulation.<sup>93</sup>

This policy statement appeared to underscore the duty to avoid "manipulation" by omission, which was probably not different in 1989, just six years before. The 1975 AAP report explicitly stated that possible adverse outcomes should be discussed with parents "well in advance of delivery, when the capacity for clear response is more likely."<sup>94</sup> The 1989 AAP task force should have been urging physicians to present parents with information concerning all possible adverse outcomes of the surgery, the uncertain nature of circumcision's benefits, and the benefits of remaining intact.

In addition to failing to include a discussion of the full variety of complications that can result from circumcision, the 1989 AAP report also understated the statistical rate of complications. The report stated: "The exact

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91. AAP 1975, *supra* note 10, at 611 (emphasis added).

92. See AAP 1989, *supra* note 3, at 390 (failing to note that *reported* complications and deaths do not equal the real incidence of these adverse outcomes).

93. See American Academy of Pediatrics Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 315 (1995) (discussing a statement of principles). This statement of principles would imply that parents should be told of all the adverse outcomes—such as those listed by ROMBERG, *supra* note 90—and also should be informed of the protective functions the foreskin would continue to provide with the option of no treatment.

94. AAP 1975, *supra* note 10, at 610.

incidence of postoperative complications is unknown, but large series indicate that the rate is low, approximately 0.2% to 0.6%. The most common complications are local infection and bleeding.<sup>95</sup> The AAP task force was able to provide this low estimate of complications by screening the research with the requirement of a "large series" study. It thereby avoided citation of an immediate complication rate of 4% on a smaller subject pool of 361 infants in Utah, published by researchers Thomas Metcalf et al. in 1983.<sup>96</sup> The task force also neglected to report the phenomena of "late" complications circumcision—those that manifest farther into the first year of the infant's life—which Metcalf et al. reported at an astonishing rate of 13%.<sup>97</sup>

Aside from omitting Metcalf's findings from its survey of published complication rates, the 1989 AAP report also misstated the results obtained by researchers William Gee and Julian Ansell in a 1976 retrospective study. The AAP apparently quoted a figure of 0.2% for "really significant" complications from the article's discussion section and abstract, without examining the information provided in the main body of the article, which gave an overall immediate complication rate of 2.0% for the subject pool of 5882 infants.<sup>98</sup> Ignoring the 2.0% figure, the 1989 AAP report then implied that the 0.2% complication figure can be discounted further because it included the "most common complications [which] are local infection and bleeding."<sup>99</sup> However, the task force failed to acknowledge that Gee and Ansell had already removed what they considered minor infections and

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95. AAP 1989, *supra* note 3, at 390.

96. See Thomas J. Metcalf et al., *Circumcision: A Study of Current Practices*, 22 CLINICAL PEDIATRICS 575, 577 (1983) (listing 14 complications for 361 neonates, a 4% complication rate).

97. See *id.* at 577 (listing delayed complications of neonatal circumcisions such as "[f]loreskin adhesions," "[p]oor hygiene," "[m]eatitis," and "[s]urgical revision," for a total of 13% of a subject pool of 230). The complication category of "poor hygiene" is problematic. It appears to be simply parental dissatisfaction with the eventual appearance and the irrational fear of smegma. *Id.* at 578. Even subtracting this category from the complications list would leave a late complication rate of 10%. See *id.* at 577 tbl.3 (subtracting the 3% for "poor hygiene" from the table yields 10%).

98. See AAP 1989, *supra* note 3, at 390 (citing William F. Gee & Julian S. Ansell, *Neonatal Circumcision: A Ten-Year Overview: With Comparison of the Gomco Clamp and the Plastibell Device*, 58 PEDIATRICS 824 (1976)). Gee and Ansell state that out of 5882 infants, "[o]nly 14 complications (0.2%) are considered really significant—one life-threatening hemorrhage, four systemic infections, eight circumcisions of infants with hypospadias, and one complete denudation of the penile shaft." Gee & Ansell at 827. Complications included in the results which totaled 1.8%, but which were not accounted for in this "really significant" list, included: hemorrhage at four to seventy-two hours after surgery requiring medical intervention; infection requiring care, and in four cases antibiotics; dehiscence, "[c]omplete separation of the penile skin from the mucous membrane" which had to be "repaired with fine chromic gut"; partial denudation (excessive loss) of penile skin in two cases which were left to heal up on their own; edema (swelling) and cyanosis (bluing from lack of oxygenated blood), resulting from incorrectly performed *Plastibell* circumcisions; urinary retention; and "superficial" laceration of the glans. Gee & Ansell at 825-26.

99. See AAP 1989, *supra* note 3, at 390 (characterizing complications as local infection and bleeding, after stating the complication rate at 0.2-0.6%).

bleeding from their total complication rate of 2.0%, to arrive at the 0.2% figure.<sup>100</sup> In compiling their data, Gee and Ansell noted that they had encountered recording bias on the part of medical staff, stating that “most complications were *not* indexed, and only by careful perusal of the nurses’ notes were they ferreted out.”<sup>101</sup> Amazingly, Gee and Ansell’s decision to focus on what they characterized as “really significant” complications subsequently enabled the 1989 AAP task force to pare away many of the complications—complications which these two researchers had carefully ferreted out.

Aside from citing Gee and Ansell, in providing a complication range of 0.2-0.6%, the 1989 AAP report also cited two 1987 letters to the editor of *Pediatrics*.<sup>102</sup> Thomas Wiswell, who had conducted the methodologically problematic UTI studies which had led to the task force’s change of policy, estimated a complication rate of 0.3% from a review of 175,000 male births in Army hospitals over ten years.<sup>103</sup> His findings were later reported, after the 1989 AAP report was published, to be a complication rate of 0.19% of over 100,000 male infants from a six-year period.<sup>104</sup> Similar to Gee and Ansell’s discounting of an overall rate of 2.0% to arrive at a reported rate of 0.2%, Wiswell’s low rate, reviewer Thompson noted, may have also been due to a restrictive filtering and defining of complications as only those “complications specifically recorded as such” by medical personnel.<sup>105</sup> The upper end of the 1989 AAP report’s complication range, 0.6%, came from another letter to the editor in a 1987 issue of *Pediatrics*, submitted by a physician who reviewed the records of 4000 births in his hospital over a two year period.<sup>106</sup>

The 1989 AAP task force displayed an unscientific selection bias in giving more weight to two letters to the editor—those of Wiswell and Harkavy—over the scientifically designed and published research of Metcalf et al. and Gee & Ansell. Presumably, the raw data and operational definitions for complications of the Metcalf et al. and Gee & Ansell research was available for peer review by the AAP task force, whereas the data that

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100. See *supra* note 98 and accompanying text (enumerating the complications that Gee and Ansell chose not to include in arriving at the figure of 0.2%).

101. Gee & Ansell, *supra*, note 98, at 826 (emphasis in original).

102. See AAP 1989, *supra* note 3, at 390 (listing citations for complication rates).

103. See *id.* at 390 (citing Thomas E. Wiswell, 79 PEDIATRICS 649, 650 (1987) (letter to the editor) (estimating a complication rate of 0.3% for 175,000 births)).

104. See Robert S. Thompson, *supra* note 68, at 194 (citing Thomas E. Wiswell & D.W. Geschke, *Risks from Circumcision During the First Month of Life Compared with Those for Uncircumcised Boys*, 83 PEDIATRICS 1011 (1989) (reporting a complication rate of 0.19% for 100,000 infants)).

105. Robert S. Thompson, *supra* note 68, at 194 (noting that Wiswell’s low overall complication rate of 0.19% reflected “the stringency of the criteria and recording practices of physicians involved”).

106. See AAP 1989, *supra* note 3, at 390 (citing Kenneth L. Harkavy, 79 PEDIATRICS 649 (1987) (letter to the editor) (relating a 0.6% rate of “notifiable complications”)).

Wiswell and Harkavy provided in their letters to the editor was not. Additionally, unlike George Kaplan's 1983 review of published literature on circumcision, the 1989 AAP report completely ignored complication rates gathered from other countries such as Canada, the United Kingdom, and Australia.<sup>107</sup> The standard of medical care in these countries has to be comparable to that in the United States. To avoid an appearance of selection bias, researchers' findings from these countries should have also been included in the task force's investigation of physical complication rates.

#### F. BEHAVIORAL EFFECTS OF CIRCUMCISION

In addition to the possibility of potentially devastating physical complications, circumcision has negative effects upon behavior. Until the last couple of decades, the widespread belief was that an infant was either incapable of perceiving pain, or that, because such pain would not be remembered, it had no effect on his behavior.<sup>108</sup> The 1989 AAP task force, unable to avoid addressing this misconception concerning infant cognition, devoted a section of its report to infant pain.<sup>109</sup> The 1989 report authoritatively stated that infants can feel pain; it supported this conclusion with citation to the thorough 1987 review on infant pain authored by researchers Anand and Hickey in the *New England Journal of Medicine*.<sup>110</sup>

However, the 1989 AAP report went on to state that while behavioral changes occurred, such as crying from surgical trauma, irritability, altered sleep and feeding patterns, and altered maternal-child social interaction, "[t]hese behavioral changes [were] transient and disappear[ed] within 24 hours after surgery."<sup>111</sup> There is a great difference between the statement that experimentally measured behaviors return to pre-operative levels and the report's summary section conclusion that "[i]nfants respond[ed] to the procedure with transient behavioral and physiologic changes."<sup>112</sup> In addressing the question of neonatal memory, the 1989 task force missed or

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107. Compare AAP 1989, *supra* note 3, at 390 (citing only to information obtained in the U.S.), with George W. Kaplan, *Complications of Circumcision*, 10 UROLOGIC CLINICS OF N. AM. 543, 545 (1983) (citing to articles from Australia, Canada, and the U.K.).

108. See WALLERSTEIN, *supra* note 1, at 135-44 (tracing the attitudes of many medical practitioners and medical sources, who downplayed or even denied that infants felt pain or that the pain had significance); Anand & Hickey, *supra* note 18, at 1321 (stating the fact that for many years there existed "a widespread belief in the medical community that the human neonate or fetus may not be capable of perceiving pain").

109. Compare AAP 1989, *supra* note 3, at 389 (stating authoritatively that infants experience pain and that circumcision does cause pain), with AAP 1975, *supra* note 10, at 610-11 (recommending that the surgery not be routinely performed, but failing to mention anywhere that pain is a consideration in the equation).

110. See AAP 1989, *supra* note 3, at 389 (citing Anand & Hickey, *supra* note 18).

111. AAP 1989, *supra* note 3, at 389. The 1989 report cited Richard E. Marshall et al., *Circumcision: II. Effects upon Mother-Infant Interaction*, 7 EARLY HUM. DEV. 367, 373 (1982), for the proposition that experimentally measured feeding intervals and infant availability scores reverted to pre-circumcision levels by 24 hours after surgery.

112. AAP 1989, *supra* note 3, at 390.

ignored Anand and Hickey's warning:

In the long term, painful experiences in neonates could possibly lead to psychological sequelae, since several workers have shown that newborns may have a much greater capacity for memory than was previously thought. . . . Long-term memory requires the functional integrity of the limbic system and diencephalon . . . these structures are well developed and functioning during the newborn period . . . [M]emory and learning depend on brain plasticity, which is known to be highest during the late prenatal and neonatal periods. Apart from excellent studies in animals demonstrating the long-term effects of sensory experiences in the neonatal period, evidence for memories of pain in human infants must, by necessity, be anecdotal. Early painful experiences may be stored in the phylogenically old "procedural memory," which is not accessible to conscious recall.<sup>113</sup>

This warning should have discouraged the task force from making any affirmative statement that circumcision has no enduring behavioral effects.

Indeed, during the 1980s, researchers had accumulated evidence of the remarkable abilities of infants to retain memory. In 1986, researchers Anthony DeCasper and Melanie Spence published the results of an experiment designed to measure fetal and neonatal memory for speech sounds.<sup>114</sup> They found that in utero subjects, who were read a target story twice daily by their mothers, would later as neonates respond preferentially to their target story as opposed to similar sounding stories, regardless of who recited it to them.<sup>115</sup> By 1987 researchers had begun to see that the view that infants were incapable of experiencing memory or pain had more to do with the failings of researchers' study designs than it had to do with the failings of infants.<sup>116</sup> The 1989 AAP task force should have at least investigated these studies and mentioned them in their report.

Additionally, at the time of the 1989 AAP report, information was available that neonatal pain experiences might have a deleterious effect on future behavior. For example, a 1985 issue of the *Lancet* contained an article that found a significantly higher percentage of adolescent suicide among subjects that had experienced respiratory distress at birth, compared to adolescents who experienced no problems at birth.<sup>117</sup> A pattern of distressed behaviors, similar to those "of infants born at risk," occurs during

113. Anand & Hickey, *supra* note 18, at 1325-26.

114. See DeCasper & Spence, *supra* note 18, at 142-48 (relating their results).

115. See *id.* at 143, 148 (concluding that the subjects amazingly had learned the acoustical characteristics of their target stories, not just the voice of the storyteller).

116. See Nancy Angrist Myers et al., *When They Were Very Young: Almost-Threes Remember Two Years Ago*, 10 *INFANT BEHAV. & DEV.* 123, 123 (1987) ("The pursuit of such questions requires versatility and ingenuity in methodology, to say nothing of fortuity in opportunity.").

117. See Salk et al., *supra* note 18, at 625, 627 (detailing the results of a study on the relationship between perinatal factors and suicide).

the trauma of circumcision.<sup>118</sup> In another retrospective epidemiological study conducted in Sweden, researchers also found a significant correlation between the type of suicide method chosen by suicide victims and the type of complications they experienced at birth.<sup>119</sup> Researchers in both studies dealing with adolescent suicide carefully pointed out the correlational, rather than causal, certainty of their findings.<sup>120</sup>

The lesson the 1989 AAP task force should have gleaned from these findings was that psychologists were only beginning to devise ways to measure infants' amazing ability for memory and its effects on later behavior. In view of these research findings, the 1989 AAP task force either failed in its duty to investigate the state of knowledge on infant memory and perception or failed to report on its investigation. It also breached its duty of care to provide scientific guidance to physicians and parents, because it simply dismissed neonatal circumcision's behavioral effects as "transient" and "disappearing."

### G. FUNCTIONS AND BENEFITS OF THE FORESKIN

Returning to the physical issues surrounding the foreskin and circumcision, a logical scientific investigation should start with an inquiry into why nature created the foreskin. A short-lived paragraph in the 1984 AAP brochure *Care of the Uncircumcised Penis* described the protective functions of the foreskin and the adverse consequences of its loss after circumcision.<sup>121</sup> That paragraph was deleted in subsequent printings of the brochure.<sup>122</sup>

118. See Fran Lang Porter et al., *Newborn Pain Cries and Vagal Tone: Parallel Changes in Response to Circumcision*, 59 CHILD DEV. 495, 495, 502 (1988) (discussing alterations in "vagal tone," as measured by comparing heart period with breaths per minute (*see id.* at 498-99 n.2) during circumcision and finding the patterns comparable to those exhibited by "medically compromised infants").

119. See Jacobson et al., *supra* note 18, at 367-68, 370 (tying the type of birth complication to later methods of suicide).

120. See *id.* at 369 (admitting that "self-destructive behavior has many roots. Here perinatal factors only are considered."); Salk et al., *supra* note 18, at 627 (noting "[m]any babies survive adverse perinatal conditions, and therefore we do not suggest a direct relationship between perinatal adversity and eventual suicide").

121. See BRIGGS, *supra* note 1, at 102 (quoting AMERICAN ACADEMY OF PEDIATRICS, CARE OF THE UNCIRCUMCISED PENIS (Newborn Series, 1984)):

The glans at birth is delicate and easily irritated by urine and feces. The foreskin shields the glans; with circumcision, this protection is lost. In such cases [i.e., when circumcision is performed], the glans and especially the urinary opening (meatus) can become irritated or infected, causing ulcers, meatitis, (inflammation of the meatus) and meatal stenosis (a narrowing of the urinary opening). Such problems virtually never occur in uncircumcised penises. The foreskin protects the glans throughout life.

*Id.*

122. See AMERICAN ACADEMY OF PEDIATRICS, BROCHURE NO. HE0023R, NEWBORNS: CARE OF THE UNCIRCUMCISED PENIS, GUIDELINES FOR PARENTS (1992) (omitting the paragraph from the 1984 AAP pamphlet quoted *supra* note 121). This revised pamphlet was published after the 1989 AAP report on circumcision.

The 1989 AAP report acknowledged, in its sections on local infections and STDs, that certain clinical conditions are found more frequently in circumcised boys and men.<sup>123</sup> It gave examples of meatitis, an inflammation of the urinary opening, and nonspecific urethritis.<sup>124</sup> However, the AAP displayed a bias in favor of circumcision by altering its brochure for parents. The AAP also displayed bias in omitting the higher prevalence of meatitis and nonspecific urethritis in circumcised men from the introductory and summary sections of the 1989 report, while including supposed lesser rates of UTI and cancer.

The AAP task force did not inquire into nature's reasons for the foreskin, but some medical researchers are seeking to understand why the foreskin is more than just skin, continuing the efforts pioneered by the British researcher Douglas Gairdner in the late 1940s.<sup>125</sup> In a 1997 article published in *Mothering* magazine, physician Paul M. Fleiss reviewed the accumulated knowledge about the specialized tissue of which the foreskin is made, and the functions it serves.<sup>126</sup> A study in the *British Journal of Urology* noted that the presence of "Meissner's corpuscles firmly separate prepuccial [meaning of the foreskin] epithelium from true skin," and that these specialized receptors are comparable "with similar nerve-endings in the fingertips and lips."<sup>127</sup>

Medical practitioners should have at least some knowledge of what it is they are surgically removing. However, for many years the AAP and the profession as a whole have viewed the foreskin as merely extra skin.<sup>128</sup> To view the foreskin as a mistake of nature is analogous to attitudes formerly held concerning tonsils and adenoids.<sup>129</sup> However, whereas the AAP has

123. See AAP 1989, *supra* note 3, at 388-89 (admitting, in the section of the report devoted to local infections, that "[m]eatitis is more common in circumcised boys," and in the section devoted to STDs, admitting "a higher incidence of nonspecific urethritis in circumcised men").

124. See *id.* at 389 (providing these two examples).

125. Dr. Gairdner observed that:

[I]t is often stated that the prepuce is a vestigial structure devoid of function. However, it seems to be no accident that during the years when the child is incontinent the glans is completely clothed by the prepuce, for, deprived of this protection, the glans becomes susceptible to injury. . . . Meatal ulcer is almost confined to circumcised male infants.

Gairdner, *supra* note 6, at 1434.

126. See Fleiss, *supra* note 79, at 40-41 (noting the immunologically significant presence of lysozyme and immunoglobulins, the scientifically interesting presence of estrogen receptors and apocrine glands for the production of pheromones, the protective functions served through coverage and lubrication of the glans, and the lubricant preserving function of having the shaft of the penis move more within its own skin than having the penile skin move in and out of the female exposing her lubricant to drying in the air).

127. J.R. Taylor et al., *The Prepuce: Specialized Mucosa of the Penis and its Loss to Circumcision*, 77 *BRIT. J. OF UROLOGY* 291, 295 (1996).

128. See AAP 1989, *supra* note 3, at 388 (stating simply that the foreskin "is the fold of skin covering the glans").

129. See AMERICAN ACADEMY OF PEDIATRICS, BROCHURE NO. HE0154, TONSILS AND ADENOIDS: GUIDELINES FOR PARENTS (1994) (observing first that "having tonsils and adenoids

corrected the rush among physicians to surgically remove the tonsils,<sup>130</sup> the AAP has failed to correct this same clinical mistake for the foreskin. The AAP should have inquired for what purpose nature created the foreskin before classifying it as a perilous mistake.

#### H. COST-BENEFIT ANALYSIS OF CIRCUMCISION AS MEDICINE

Any examination of the medical efficacy of circumcision should also have included some reference to cost-benefit analyses. The 1989 AAP report did not refer to, engage in, or call for any cost-benefit analysis. In response to the 1989 AAP report, physician Robert S. Thompson applied risk-benefit analysis to Thomas Wiswell's assertion that circumcision lessens the occurrence of UTIs.<sup>131</sup> Thompson found that when accounting for Metcalf's 1% figure for late complications requiring surgical revision—which the AAP task force had failed to consider—Wiswell's UTI benefit would not outweigh the surgical risks, even accepting Wiswell's immediate complication rate at 0.2%.<sup>132</sup> Two other economic cost-benefit analyses were published in 1991, but neither could find utility for routine circumcision in assessing essentially the same data that would have been before the 1989 task force.<sup>133</sup>

Prior to the issuance of the report from the 1989 task force, the AAP appears to have been aware of the necessity to justify circumcision, like any other preventive therapy, on a cost-benefit basis. This is demonstrated in the AAP's own publications. The AAP authored, in conjunction with ACOG, three book editions of *Guidelines for Perinatal Care*, in 1983, 1988, and 1992.<sup>134</sup> Both the 1983 and the 1988 editions maintained that "there is no

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removed was quite popular," but later observing that now physicians know "[b]oth the tonsils and adenoids make antibodies to help fight infections").

130. See *id.* ("Nowadays, doctors know more about when this surgery is really needed and when it should not be done. . . . These days, the American Academy of Pediatrics considers surgery absolutely necessary only under the following conditions [of abnormal breathing, swallowing, and speech]."). The AAP's challenge to the old established practice on this other "non-essential" but functional, normal, and healthy tissue should likewise have influenced the 1989 circumcision task force approach.

131. See Robert S. Thompson, *supra* note 68, at 189-92 (describing the change in the AAP policy in response to Wiswell's findings on UTIs as the motivation for his risk-benefit review).

132. See *id.* at 194 tbl.3 (comparing the possible nine per one thousand spared a UTI, according to Wiswell's conclusions, against an immediate complication rate of two per one thousand and late complication rate of ten per one thousand, using the data of Metcalf). For Metcalf's data, see *supra* notes 96-97 and accompanying text.

133. See Theodore G. Ganiats et al., *Routine Neonatal Circumcision: A Cost-Utility Analysis*, 11 MED. DECISION MAKING 282, 288 (1991) ("For routine neonatal circumcision, however, these advantages and disadvantages cancel each other."); see also Frank H. Lawler et al., *Circumcision: A Decision Analysis of Its Medical Value*, 23 FAM. MED. 587, 590 (1991) ("In none of the analyses did circumcision yield a shorter theoretical life span than the noncircumcision strategy. In most of the analyses, cost considerations favored the noncircumcision strategy.").

134. AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *GUIDELINES FOR PERINATAL CARE* (3d ed. 1992) [hereinafter AAP GUIDELINES 1992]; AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF

absolute medical indication for circumcision in the neonatal period”—thereby reflecting the findings of the 1975 AAP task force.<sup>135</sup> However, the 1988 edition mentioned the pending report from the 1989 Task Force on Circumcision to be published in the following year: “the present policy . . . will be modified only if data conclusively demonstrates the value of the procedure.”<sup>136</sup> Wiswell’s methodologically problematic studies hardly qualified as data “conclusively demonstrat[ing] the value of the procedure.” Nevertheless, the AAP, in the 1992 edition of *Guidelines for Perinatal Care*, adopted the view of circumcision’s value reflected in the 1989 task force’s report.<sup>137</sup> Thus, the AAP as a whole, with respect to cost-benefit analysis, failed to scrutinize the 1989 task force report as it professed it would, and instead proceeded directly to disseminate its findings.

## II. THE 1999 AAP REPORT

In the wake of the 1989 task force report and a decade of increasing controversy surrounding the medical practice of circumcision, the AAP issued the findings of the third Task Force on Circumcision on March 1, 1999.<sup>138</sup> On the surface, the 1999 task force appeared to take a step toward opposing circumcision. It reported that the data was insufficient to endorse circumcision, and that “the procedure is not essential to the child’s current well-being.”<sup>139</sup> The 1999 AAP report made no mention of cervical cancer.

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OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE (2d ed. 1988) [hereinafter AAP GUIDELINES 1988]; AMERICAN ACADEMY OF PEDIATRICS & AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE (1st ed. 1983) [hereinafter AAP GUIDELINES 1983].

135. Compare AAP GUIDELINES 1988, *supra* note 134, at 94 (stating that “there is no absolute medical indication for circumcision in the neonatal period”), with AAP GUIDELINES 1983, *supra* note 134, at 87 (“There is no absolute medical indication for the routine circumcision of the newborn.”), with AAP 1975, *supra* note 10, at 611 (“There is no absolute medical indication for routine circumcision of the newborn.”).

136. AAP GUIDELINES 1988, *supra* note 134, at 93-94. One can only assume that the drafters of the 1988 guidelines were aware of continued debate regarding the efficacy of circumcision. In view of the demonstrated risks attendant to any surgery, as well as occasional severe complications reported in the medical literature, the drafters must have determined that the responsible course of action in lending advice to practitioners, and subsequently parents, would be to claim medical benefits for this elective surgery only if the 1989 AAP circumcision task force found research data that clearly supported such a claim. Until then, the guideline drafters decided to adhere to the established policy that the uncertainty of the data supported.

137. See AAP GUIDELINES 1992, *supra* note 134, at 103 (“Circumcision may also result in a reduced incidence of urinary tract infection, although prospectively collected data in this regard are lacking.”). The AAP 1992 guidelines classify circumcision as an elective procedure. *Id.* UTI prevention is the only benefit mentioned in the paragraph on circumcision contained in the guidelines. Yet, this uncertain benefit, reported by the 1989 task force, *supra* notes 66-72 and accompanying text, somehow qualified as the “conclusively” demonstrated value that the 1988 guidelines professed to require of the 1989 task force report in order to change the AAP and ACOG’s policy.

138. See AAP 1999, *supra* note 19, at 686, 691 (stating findings).

139. *Id.* at 691.

Thus, the AAP appears to have finally exonerated the foreskin for cervical cancer. Notwithstanding these improvements, the AAP devoted the overwhelming majority of the report, once again, to asserting that “[e]xisting scientific evidence demonstrates potential medical benefits of newborn male circumcision.”<sup>140</sup>

#### A. PENILE CANCER

Unlike the silence concerning cervical cancer, the 1999 AAP report, like its predecessor, links the risk of penile cancer to an intact foreskin. While evidence had accumulated since 1989 that clearly demonstrated that neonatally circumcised men were not immune to penile cancer, the 1999 report presented the “strong association” and “threefold risk” for developing penile cancer from foregoing neonatal circumcision as authoritative.<sup>141</sup> The task force reported this elevated risk, notwithstanding its own admission that “there have been few rigorous hypothesis-testing investigations,” and “it is difficult to estimate accurately the magnitude of this risk based on existing studies.”<sup>142</sup>

The 1989 presumption that neonatal circumcision provided virtual immunity from penile cancer was thoroughly refuted when a single 1993 study on subjects from the state of Washington and British Columbia found twenty-two cases of penile cancer among men circumcised at birth.<sup>143</sup> This study, while surmising that circumcision status may play some role in the etiology of penile cancer, concluded, “at least some cases of cancer at this site are associated with the presence of other conditions that occur in circumcised men as well.”<sup>144</sup> Some of those “other conditions,” which all produced a higher risk for penile cancer than did lack of circumcision, included a history of genital warts, penile tear, penile rash, smoking, and more than thirty sexual partners.<sup>145</sup> Interestingly, in reporting the statistical effect of circumcision status, the authors only adjusted the results for the variable of circumcision with the variables of age and penile tear, but not with the other concurrent variables.<sup>146</sup> A statistical adjustment of the variable of circumcision status with the variables of the number of lifetime partners and a history of viral STDs was a necessity in order to assess fully the role of circumcision status, because these other variables were more strongly correlated with penile cancer. Still, due largely to these findings, the 1999 task force had to acknowledge that circumcised men get penile

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140. *Id.*

141. *Id.* at 690-91.

142. *Id.*

143. See Christopher Maden et al., *History of Circumcision, Medical Conditions, and Sexual Activity and Risk of Penile Cancer*, 85 J. NAT'L CANCER INST. 19, 20-22, tbl.6 (1993) (surveying 110 penile cancer cases in the Pacific Northwest).

144. *Id.* at 24.

145. *Id.* at 21-22.

146. *Id.* at 22 tbl.6.

cancer, that the overall incidence of penile cancer is extremely low, and that other factors such as cigarette smoking, viral STDs, and sexual promiscuity are risk factors.<sup>147</sup>

Although the AAP report contained a sentence addressing the wide differences in incidences of penile cancer among countries where circumcision is not performed,<sup>148</sup> the 1999 task force, like its counterpart in 1989, did not cite statistics gathered by the International Agency for Research on Cancer for the World Health Organization. The World Health Organization's publication, *Cancer Incidence in Five Continents, vol. IV*, from 1982, listed the non-circumcising Scandinavian countries reporting incidences of penile cancer equal to or less than the incidence in the United States.<sup>149</sup> In *volume VI*, from 1992, this same publication listed the incidence of penile cancer in Israel and Japan—where Israel circumcises at birth while Japan does not—both with lower penile cancer rates than the United States.<sup>150</sup> Because of this wide variation between nations, and the fact that the figures do not clearly group according to whether a country does or does not practice neonatal circumcision, it was untenable for the AAP to assert or imply that circumcision status was a causal variable for penile cancer. Genetic predispositions, exposure to causative agents, and cultural practices other than circumcision must account for susceptibility to penile cancer.

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147. See AAP 1999, *supra* note 19, at 690-91 (addressing the possible link between penile cancer and circumcision status and citing Maden et al., *supra* note 143).

Additionally, the 1999 task force received a letter from two Vice Presidents of the American Cancer Society. See Fathermag.com, *Letter from the American Cancer Society* (visited Mar. 9, 2000) <<http://www.fathermag.com/health/circ/acs/>> (relating a public letter from Hugh Shingleton, M.D., National Vice President Detection & Treatment, American Cancer Society, and Clark W. Heath, Jr., M.D., Vice President Epidemiology & Surveillance Research, American Cancer Society, to Dr. Peter Rappo, Committee on Practice & Ambulatory Medicine, American Academy of Pediatrics (Feb. 16, 1996)). The letter stated:

Portraying routine circumcision as an effective means of prevention distracts the public from the task of avoiding the behaviors proven to contribute to penile and cervical cancer: especially cigarette smoking, and unprotected sexual relations with multiple partners. Perpetuating the mistaken belief that circumcision prevents cancer is inappropriate.

*Id.*

148. See AAP 1999, *supra* note 19, at 690 (mentioning penile cancer rates obtained from Denmark, Brazil, and India).

149. Compare 4 INTERNATIONAL AGENCY FOR RESEARCH ON CANCER AND INTERNATIONAL ASSOCIATION OF CANCER REGISTRIES, *CANCER INCIDENCE IN FIVE CONTINENTS* 751 (1982) (listing available incidences of penile cancer in Finland at 0.5 to 0.6 per 100,000 men, in Norway at 0.6 to 0.7 per 100,000 men, and in Sweden at 0.9 per 100,000 men), with AAP 1989, *supra* note 3, at 388 (providing a incidence of penile cancer in the United States at 0.7 to 0.9 per 100,000 men).

150. Compare 6 INTERNATIONAL AGENCY FOR RESEARCH ON CANCER AND INTERNATIONAL ASSOCIATION OF CANCER REGISTRIES, *CANCER INCIDENCE IN FIVE CONTINENTS* 974 (1992) (listing Israel's incidence of penile cancer at 0.2 to 0.9 per 100,000 men and Japan's at 0.4 to 0.7 per 100,000 men), with AAP 1999, *supra* note 19, at 690 (listing the U.S. incidence of penile cancer at 0.9 to 1.0 per 100,000 men).

### B. SEXUALLY TRANSMITTED DISEASES

As with the long-standing suspected link between circumcision status and penile cancer, the possibility of a link between circumcision status and STDs was once again addressed in the 1999 AAP task force's report. The 1999 AAP report's section on STDs admitted that evidence for a possible relationship between STDs and circumcision "is complex and conflicting."<sup>151</sup> This complexity has increased since the 1989 report, because the 1999 task force had to address HIV, in addition to the other STDs.

Since 1989, circumcision advocates had added HIV to the list of STDs from which circumcision supposedly offered some protection. The 1999 AAP report focused on studies that asserted a prophylactic effect for circumcision against HIV, while ignoring evidence of methodological flaws in such studies.<sup>152</sup> The report did not cite a thorough 1994 editorial review, authored by researchers Isabelle de Vincenzi and Thiery Mertens, in the journal *AIDS*.<sup>153</sup> This article noted that articles published on the geographical distribution of AIDS in Africa had used outdated data on circumcision from "anthropological studies of rural areas written between 1930 and 1950."<sup>154</sup> This article detailed other methodological flaws in AIDS and circumcision studies such as a "lack of distinction between susceptibility and infectivity, inadequate control for confounding variables, potential selection bias and misclassification of exposure, inappropriate choice of a comparison group, and publication bias."<sup>155</sup> De Vincenzi and Mertens further noted that "the magnitude of the association, when present, varie[d] strongly between studies, and its crude measure [wa]s overestimated in some reports by the use of OR [odds ratio] instead of RR [relative risk]."<sup>156</sup> They found that this problem in the statistical measuring may have been "misleading toward causality."<sup>157</sup> De Vincenzi and Mertens ultimately concluded that circumcision was not warranted as a measure to combat the spread of HIV.<sup>158</sup>

Returning to other STDs, the 1999 AAP report selectively reported

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151. AAP 1999, *supra* note 19, at 691.

152. *See id.* ("In addition, there is a substantial body of evidence that links noncircumcision in men with risk for HIV infection.") (citations omitted).

153. *See* Isabelle de Vincenzi & Thierry Mertens, *Male Circumcision: A Role in HIV Prevention?*, 8 *AIDS* 153 (1994) (analyzing studies asserting a linkage between circumcision status and HIV transmission in Africa).

154. *Id.* at 156.

155. *Id.* at 157.

156. *Id.*

157. *Id.*

158. *See* de Vincenzi & Mertens, *supra* note 153, at 159 (stating that "[a]s the safety, expected benefits, feasibility and acceptability of mass circumcision are all questionable . . . [neither circumcision nor controlled studies would] be defensible options before there is stronger evidence from observational studies in different settings that show lack of male circumcision may be a genuinely independent risk factor for the transmission of HIV").

only those findings suggesting circumcision's prophylactic effect. One example was the report's omission of the results reported in an article by researchers Laumann et al., which found a higher rate of chlamydia among circumcised men, while no higher STD rates occurred in intact men.<sup>159</sup> Even though the 1999 AAP task force cited this article, it was only mentioned to support the general statement that "the relationship of circumcision to STD in general is complex and conflicting."<sup>160</sup> Thus, a reader of the report would be unaware that the Laumann article found that circumcision conferred no benefit against any STD, and may, in fact, have been a risk factor for contracting chlamydia. This was STD information that the 1999 task force should have included in its report.

### C. URINARY TRACT INFECTIONS

While circumcision provides no clear benefits in protecting against the contraction of STD's, like the 1989 AAP report, the 1999 report found UTI prevention as the best reason to defend circumcision. However, by 1999, Wiswell's poorly designed studies were superceded by the less spectacular, but more reliable, results of a 1998 article by a Canadian research team, which used a large prospective three-year research design.<sup>161</sup> These Canadian researchers found that foregoing a neonatal circumcision produced a 3.7 relative risk of hospital intake for UTI over the first three years of a boy's life, which was much less than the 10.1 to 19.8 risk factor Wiswell had obtained in methodologically problematic retrospective studies.<sup>162</sup>

Moreover, unlike previous studies on circumcision and UTI, which addressed inpatient care, the Canadian researchers also examined physician billing records to estimate outpatient UTI treatment rates. Here, the heightened risk from not circumcising resulted in only a 1.73 relative risk for a UTI.<sup>163</sup> The finding was that, "for every circumcised infant admitted for UTI, there were 11 outpatient billings for UTI compared with five for the uncircumcised infants."<sup>164</sup> The article noted the lack of any information

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159. See Edward O. Laumann et al., *Circumcision in the United States: Prevalence, Prophylactic Effects, and Sexual Practice*, 277 JAMA 1052, 1054-55 (1997) (finding statistical significance that 26 cases of chlamydia occurred in 1033 circumcised men, but none occurred in 353 intact men).

160. See AAP 1999, *supra* note 19, at 691 (citing only generally to Laumann et al., *supra* note 159).

161. See AAP 1999, *supra* note 19, at 689 (citing the results of Teresa To et al., *Cohort Study on Circumcision of Newborn Boys and Subsequent Risk of Urinary-Tract Infection*, 352 LANCET 1813 (1998)); see also *supra* notes 67-71 and accompanying text (delineating the flaws of the Wiswell research).

162. See To et al., *supra* note 161, at 1813 (delineating the findings and methodology of this study); see also *id.* at 1815 tbl.2 (comparing the relative risk figures of their own research to figures obtained by other researchers, including Wiswell).

163. See *id.* at 1815 (analyzing the data on outpatient UTIs of boys from physician-billing records).

164. *Id.*

that UTI severity differed between circumcised and intact boys.<sup>165</sup>

The almost negligible relative risk observed in outpatient records may indicate that physicians were biased toward hospitalizing intact baby boys, instead of circumcised boys, for UTIs. Further research on physician treatment decisions for UTIs in boys might reveal that the treatment recommendations for intact boys include circumcision. This surgery would probably involve general anesthesia,<sup>166</sup> due to the boy's age, and possibly also due to the awakened physician sensitivity for reducing behavioral disturbance to the attachment between the now communicative child and his parents. In contrast, the option of circumcision was already performed on the neonatally circumcised boys, so physicians might have required a more serious UTI before recommending hospitalization. The possible confounding effect of physician bias was left out of the 1999 AAP report. Likewise, neither the Canadian article nor the 1999 AAP report considered inappropriate physician, or parental, forced retraction of the foreskin as a possible causal variable for UTIs in intact boys.

Potential confounding variables that might have intervened in measuring circumcision's effect on UTI rates, recognized in the 1999 AAP report, were prematurity, lack of breastfeeding, and method of urine collection.<sup>167</sup> The report conceded that one Italian case-control study demonstrated that breastfeeding had "a threefold protective effect on the incidence of UTI in a sample of uncircumcised infants."<sup>168</sup> In the next sentence, the 1999 AAP report appeared to hide the significance of the protective effect of breastfeeding by stating that "breastfeeding status has not been evaluated systematically in studies assessing UTI and circumcision status."<sup>169</sup> Assuming the 3.7 relative risk for UTI in foregoing neonatal circumcision, as Dr. David Alwin observed, a circumcision is an unfavorable preventive strategy since "the protective effect of breastfeeding is roughly equivalent to that of circumcision but poses no risk."<sup>170</sup>

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165. See *id.* (noting that no study has addressed any possible difference in severity between the UTIs in the two groups).

166. See AAP 1999, *supra* note 19, at 688 (noting that general anesthesia becomes a normal procedure when performing a circumcision beyond the neonatal period).

167. See *id.* at 689-90 (noting possible methodological problems).

168. *Id.* at 689 (citing Alfredo Pisacane et al., *Breastfeeding and Urinary Tract Infection*, 120 J. PEDIATRICS 87 (1992)).

169. See AAP 1999, *supra* note 19, at 689 (downplaying the results of Piscane et al. unnecessarily). Italy does not engage in routine infant circumcision. Pisacane et al.'s entire subject pool was then presumably intact. One could compare the effect of breastfeeding intact boys against the effect of circumcising intact boys. One would not have to compare the effect of breastfeeding or not breastfeeding on intact and circumcised boys, as the 1999 task force was apparently suggesting.

170. See David Alwin, *The Urinary Tract Infection Myth Revealed* (visited Apr. 30, 1999) <<http://infocirc.org/top.htm?uti2.htm>> (assuming the 3.7 relative risk factor established by To et al., *supra* note 161).

## D. COMPLICATIONS

Contrary to the relatively large amount of new material regarding the supposed benefits of neonatal circumcision between 1989 and 1999, there was little new material published concerning circumcision's complications. Unfortunately, twenty-four years after the first AAP task force report on circumcision and a decade after the 1989 report, the AAP still could not authoritatively cite a complication rate for circumcision. The task force once again provided an estimated complication rate of 0.2% to 0.6%, citing the figures obtained by Harkavy and Gee & Ansell.<sup>171</sup> First, the AAP again avoided or missed the fact that the Gee and Ansell study had already discounted the occurrence of what were considered minor (but significant enough beyond the normal tissue trauma to warrant intervention and recording) complications.<sup>172</sup> Second, following the 1989 AAP report's lead, the 1999 AAP report ignored the 4% immediate complication rate, and 13% late complication rate, published in the 1983 Metcalf article.<sup>173</sup> The task force failed to take seriously the phenomena of surgical corrections of circumcision, such as that which led to Dustin Evans, Jr.'s death in October of 1998, terming them "isolated case reports" and failing to list death as a possible outcome.<sup>174</sup> Finally, the 1999 task force completely ignored a comprehensive 1993 review of estimates for circumcision's complication rates authored by British researchers N. Williams and L. Kapila.<sup>175</sup> If the AAP task force had found the study's conclusion that "a realistic figure [for the complication rate] is 2-10 per cent"<sup>176</sup> was flawed, it should have at least cited the study and provided reasons for not crediting it.

Interestingly, in stating that the "data are not sufficient to recommend" circumcision as routine care, the 1999 report essentially concluded

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171. See AAP 1999, *supra* note 19, at 688 (admitting that the complication rate can only be roughly estimated and citing complication rates obtained by Harkavy, *supra* note 106, and Gee & Ansell, *supra* note 98).

172. See *supra* note 98 and accompanying text (relating the discounted complications); Gee & Ansell, *supra* note 98 at 825-27 (reporting the full range of complications at 2% within their graph and reporting the 0.2% figure as reflecting what the authors termed "really significant" complications).

173. See Metcalf et al., *supra* note 96, at 577 (obtaining an immediate complication rate of 4% for a sample of 361 circumcised neonates, but also noting a 13% rate for later complications).

174. Compare Metcalf et al., *supra* note 96, at 577, 578 tbl.3 (finding an immediate complication rate of 4%, including surgical problems at 1%, and a late complication rate of 13%, including foreskin adhesions (*skin bridges*) at 8%, meatitis at 1%, and surgical revision at 1%), with AAP 1999, *supra* note 19, at 688 (listing skin bridges, meatitis, urinary retention, and major surgical problems, etc., as "isolated case reports"). Dustin Evans, Jr.'s problem surely would have to be classified as a complication: at least urinary retention or a major surgical problem, not to mention his death. See *supra* notes 1-2 and accompanying text (relating Dustin Evans, Jr.'s story).

175. See N. Williams & L. Kapila, *Complications of Circumcision*, 80 BRIT. J. SURGERY 1231 (1993) (finding "a realistic figure [for circumcision's complication rate] is 2-10 percent").

176. *Id.*

that the risks of circumcision outweigh the benefits.<sup>177</sup> The report, therefore, essentially admitted that leaving a boy intact could not be proven to be a sufficient risk factor for UTIs, STDs, and penile cancer warranting the intervention of circumcision. However, the task force provided no cost-benefit studies or figures to support this ultimate conclusion. The 1999 AAP report did not cite Robert S. Thompson's 1990 UTI/circumcision risk-benefit analysis,<sup>178</sup> yet Thompson's article would appear to support the report's conclusion that the data on the benefits of circumcision were "not sufficient to recommend routine neonatal circumcision."<sup>179</sup>

After expounding for almost the entire length of the report on the alleged benefits of circumcision, the AAP incongruously concluded that the data was insufficient to recommend the procedure. The AAP appeared to be inviting physicians to credit a lengthy and heavily cited recitation of alleged benefits and to find the task force's brief and final recommendation insufficient. Due to the lack of cited support for the report's ultimate conclusion, it seemingly encouraged physicians to continue the amputation of normal, healthy, functional foreskins. One possible motive that could explain this approach was a disingenuous attempt to shield the AAP from liability while still listing medical sources supporting circumcision. The 1999 AAP report will likely result in the perpetuation of the "cultural" preference for circumcision among medical practitioners and parents.

#### E. BEHAVIORAL EFFECTS AND PAIN

Unlike the paucity of new material coming from the medical profession concerning circumcision's true physical complication rates, in the decade following the 1989 AAP task force report, psychological investigators conducted numerous studies and published a great deal on infant abilities in memory, including memory of pain. For example, in 1998, researcher Charles Nelson electronically recorded brain activity in infants during memory experiments.<sup>180</sup> He discussed his results and reviewed various studies conducted in the 1990s, most notably those of psychologist Carolyn Rovee-Collier, which demonstrated that three-month-old infants can remember a picture for weeks after a brief exposure.<sup>181</sup> Nelson came to the

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177. AAP 1999, *supra* note 19, at 691.

178. See Robert S. Thompson, *supra* note 68, at 194 (demonstrating that even accepting the faulty 0.2% circumcision immediate complication rate and Wiswell's faulty ten-fold relative risk of UTIs for remaining intact, medical utility is lacking for circumcision). With the more correct assumption of a 2-4% immediate complication rate and only a four-fold relative risk from being intact (this still ignores the 1.7 relative risk obtained by To et al., *supra* note 163 and accompanying text, in examining outpatient billings), the deficit of using routine circumcision as a treatment for UTIs is even more pronounced.

179. AAP 1999, *supra* note 19, at 691.

180. See generally Charles A. Nelson, *The Nature of Early Memory*, 27 PREVENTIVE MED. 172 (1998) (detailing the method of his research).

181. See *id.* at 172 (relating the experimental results of Carolyn Rovee-Collier, *Development of Memory in Infancy*, in THE DEVELOPMENT OF MEMORY IN CHILDHOOD (N. Cowan ed., 1996)).

conclusion that infants have “covert” long-term memory, “even if there is no overt evidence of such memory.”<sup>182</sup> Proposing that more work should be performed measuring brain activity in infants, he expressed the hope that “we may be able to examine how early life experiences come to shape our brain and, ultimately, our behavior.”<sup>183</sup> However, the 1999 AAP task force, like its predecessors, neglected to devote any meaningful effort toward examining the research on long-term behavioral effects of painful experiences in infancy.

The 1999 task force’s omission of psychological research was all the more shocking in light of the findings of a 1997 article, which it did cite.<sup>184</sup> Researchers Anna Taddio et al., demonstrated that neonatal circumcision increased the pain response of infants to vaccinations at four and six months.<sup>185</sup> This result held even for those boys given Emla cream as a pain prevention measure during their neonatal circumcisions.<sup>186</sup> This article soundly proved that neonatal circumcision does have long-term behavioral effects. Despite the results of this study and the task force’s admission that even the most effective pain measure, the subcutaneous ring block, also failed to fully eliminate operative pain, the report concluded, “analgesia is safe and effective in reducing the procedural pain.”<sup>187</sup> Although the 1999 task force no longer claimed, like the 1989 task force, that behavioral effects are short-term and transitory, the 1999 task force’s dismissive treatment of Taddio’s findings was irresponsible.<sup>188</sup> In light of these results, the 1999 task force should have instigated a literature search into long-term psychological effects of infant pain. This should have led them to the findings of Jacobson et al.,<sup>189</sup> concerning choice of suicide method and its relation to perinatal pain.

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182. Nelson, *supra* note 180, at 179 (emphasis in original).

183. *Id.*

184. See AAP 1999, *supra* note 19, at 688 (citing Anna Taddio et al., *Effect of Neonatal Circumcision on Pain Response During Subsequent Routine Vaccination*, 349 LANCET 599 (1997)).

185. See Taddio et al., *supra* note 184, at 601-02 (finding that during vaccinations at four and six months of age, neonatally circumcised infants had a significantly stronger pain response than intact infants).

186. See *id.* at 599, 602 (noting that lidocaine-prilocaine 5%—Emla—cream only partially diminished the heightened pain response during later vaccinations and theorizing that aside from the fact that the Emla cream did not eliminate circumcision pain, it could not reduce post-operative pain while the wound healed in the following week).

187. See AAP 1999, *supra* note 19, at 688-89 (discussing the effectiveness of various pain measures but progressing to a conclusion that does not address the problem of long-term behavioral effects implicated in the results of Taddio et al., *supra* note 184).

188. See AAP 1999, *supra* note 19, at 688-89 (citing the findings of Taddio et al., *supra* note 184, and following the citation with a lengthy description of the available pain measures, but failing to examine the significance of infant memory for pain and its behavioral effects, known and unknown).

189. See generally Jacobson et al., *supra* note 18 (demonstrating that later suicide cases chose methods similar to the type of distress experienced perinatally).

#### F. PHIMOSIS AND FORESKIN MISCHARACTERIZATION

Another moderation of the 1989 AAP position, but one that also failed to fully relate the evidence, was the 1999 task force's abandonment of circumcision as the treatment of choice for phimosis. The report stated, "[m]edical therapy [i.e. medication] has been successful in resolving both secondary phimosis and paraphimosis, but surgical intervention is sometimes indicated."<sup>190</sup> An article, electronically published by the AAP itself, compared the phimosis treatments of topical steroids, prepuccial plasty [surgery which does not amputate the foreskin], and circumcision for cost effectiveness.<sup>191</sup> This article found topical steroid treatment to be the most cost effective and circumcision to be the least cost effective.<sup>192</sup> However, this article was not cited in the 1999 AAP report, nor did the report mention the non-circumcision surgical alternatives examined in the article.

The 1999 task force also unprofessionally dismissed the growing body of evidence that foreskin tissue has characteristics beyond that of regular skin. The report presented the research of J.R. Taylor et al. as merely suggesting the presence of specialized sensory cells on the inner foreskin.<sup>193</sup> The 1999 AAP task force report distinguished the foreskin from outer penile skin only because it did not characterize the foreskin simply as "skin."

#### G. 1999 AAP ONLINE BROCHURE AND FURTHER MISCHARACTERIZATION

However, although the 1999 AAP task force report in *Pediatrics* did not label the foreskin simply "skin," the AAP continues to refer to it simply as "skin" in the information it provides specifically to parents. At the AAP web-site, the online brochure *Circumcision: Information for Parents* omits any mention of the specialized tissues and structures that constitute the foreskin. The online brochure simply calls the foreskin, "skin that covers the end of the penis."<sup>194</sup>

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190. AAP 1999, *supra* note 19, at 687.

191. See Robert S. Van Howe, *Cost-effective Treatment of Phimosis*, 102 *PEDIATRICS* 966, abstract e43 (1998) (abstracting the results of a study on treatments for phimosis); see also Robert S. Van Howe, *Cost-effective Treatment of Phimosis* (visited Mar. 9, 2000) <<http://www.pediatrics.org/cgi/content/full/102/4/e43>> (relating the full text of the article, abstracted in 102 *Pediatrics*, and comparing the cost effectiveness of methods of treating phimosis).

192. See Robert S. Van Howe, *Cost-effective Treatment of Phimosis* (visited Mar. 9, 2000) <<http://www.pediatrics.org/cgi/content/full/102/4/e43>> (finding topical therapy to produce a "75% savings compared with circumcision").

193. See AAP 1999, *supra* note 19, at 687 (noting that Taylor's study "suggests that there may be a concentration of specialized sensory cells in specific rigid areas of the foreskin but not in the skin of the penile shaft"). This statement misapprehends Taylor's clearly stated results. See Taylor et al., *supra* note 127 and accompanying text (finding that the presence of nerve endings similar to those in the finger-tips "firmly separate[s]" foreskin from true skin).

194. American Academy of Pediatrics, *Circumcision: Information for Parents* (visited July 25, 1999) <<http://www.aap.org/family/circ.htm>> [hereinafter AAP 1999 online brochure].

This online brochure suffers from other mischaracterizations as well. The brochure presents a ten-fold UTI risk factor for not circumcising, reflecting the results of Wiswell's retrospective studies, rather than the more methodologically sound 3.7 relative risk figure.<sup>195</sup> The online brochure downplays complications as "rare and usually minor,"<sup>196</sup> with no mention of the possibility of serious complications. The brochure neither presents complication rates, nor does it provide any explanation for the profession's lack of knowledge about such rates.

Additionally, in its section labeled *Reasons Parents May Choose Not to Circumcise*, the brochure overlooks the growing number of parents and professionals that consider infant male circumcision a human rights issue.<sup>197</sup> This section also incorrectly characterizes the statement that "the foreskin is necessary to protect the tip of the penis," as a "belief."<sup>198</sup> However, the AAP disseminated a similar position as fact in the 1980s.<sup>199</sup> Likewise, the word "belief" in the heading appears to be strategically placed by the AAP so as to cast doubt on and downplay statistically proven information which relates the increased risk for meatitis and meatal stenosis after circumcision.<sup>200</sup> Additionally, the 1999 AAP online brochure erroneously claims that available pain measures are "effective," implying that they can eliminate the pain of circumcision. Additionally, the online brochure fails to advise parents that long-term behavioral effects have been demonstrated, the extent of which are unknown.

#### H. FEMALE GENITAL MUTILATION, ETHICAL CONSIDERATIONS, AND INTERNATIONAL VIEWS ON INFANT MALE CIRCUMCISION

The 1999 AAP online brochure ends with a section on female circumcision. The brochure lists some of the cultural reasons why some immigrant parents from Africa desire the range of female genital alterations.<sup>201</sup> It fails to mention that many medical practitioners, as well as parents from these cultures, assert unproven rationales of health and cleanliness—similar to rationales which are presented in this country in support of male circumci-

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195. See *id.* (providing a ten-fold risk figure); *but cf.* To et al., *supra* note 161 and accompanying text (providing a relative risk figure of 3.7).

196. AAP 1999 online brochure, *supra* note 194.

197. See *infra* Part III(G) (listing groups of physicians, nurses, lawyers, and others working to oppose routine neonatal circumcision).

198. AAP 1999 online brochure, *supra* note 194.

199. See *supra* note 121 and accompanying text (relating information contained in a 1984 AAP brochure on caring for the uncircumcised penis).

200. Compare AAP 1999, *supra* note 19, at 687 (observing that "circumcised infant boys had a significantly higher risk of penile problems (such as meatitis)"), with AAP 1999 online brochure, *supra* note 194 (putting a spin on the statements that circumcision increases the risk of meatitis and meatal stenosis by leading with the word "belief").

201. See AAP 1999 online brochure, *supra* note 194 (closing with a paragraph on female circumcision).

sion.<sup>202</sup>

The AAP Committee on Bioethics published a 1998 position statement entitled *Female Genital Mutilation* (FGM) in which the AAP specifically "encourage[d] its members to . . . decline performing all medically unnecessary procedures to alter female genitalia."<sup>203</sup> There are varying degrees of FGM. However, the AAP noted that the rough equivalent to male circumcision, removing only the clitoral hood, as well as simply a ceremonial incising of any part of the female genitalia, would likely be held as violations of United States criminal law.<sup>204</sup>

This encouragement to practitioners was in congruence with the approach of another AAP Committee on Bioethics article on the role of informed consent and parental permission in pediatric care. It warned, "[a]lthough physicians should seek parental permission in most situations, they must focus on the goal of providing appropriate care . . . ."<sup>205</sup> Similarly, the authors of *Caring for Gravely Ill Children*, also published in *Pediatrics*, were quite aware that "professionals must maintain an independent obligation to protect the child's interests," not those of the parents.<sup>206</sup> En-

202. See RONALD GOLDMAN, CIRCUMCISION: THE HIDDEN TRAUMA 73-74 (1997) (comparing and contrasting the attitudes held by defenders of male and female circumcision, listing as justifications notions of cleanliness and health); Abbie J. Chessler, *Justifying the Unjustifiable: Rite v. Wrong*, 45 BUFF. L. REV. 555 (1997) (same).

203. American Academy of Pediatrics Committee on Bioethics, *Female Genital Mutilation*, 102 PEDIATRICS 153 (1998).

204. See *id.* at 153, 155 (referring to Department of Defense Omnibus Appropriations Act, 18 U.S.C.A. § 116 (1998)). The text of § 116 is as follows:

- (a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both.
- (b) A surgical operation is not a violation of this section if the operation is-
  - (1) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner; or
  - (2) performed on a person in labor who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place of its performance as a medical practitioner, midwife, or person in training to become such a practitioner or midwife.
- (c) In applying subsection (b)(1), no account shall be taken of the effect on the person on whom the operation is performed of any belief in the part of that person, or any other person, that the operation is required as a matter of custom or ritual.

205. American Academy of Pediatrics Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 314 (1995).

206. Alan R. Fleischman et al., *Caring for Gravely Ill Children*, 94 PEDIATRICS 433, 433 (1994). The author further stated, "[T]he authority society gives parents to control their children's lives is not absolute. Because children are no longer considered the property of their parents, and society recognizes that children may have interests independent of their

couragement to place the best interests of the child over the cultural wishes of parents was justly present for any type of FGM, yet such encouragement to avoid surgery was utterly lacking for the now admitted medically unnecessary alteration of male genitalia. The AAP apparently considered awareness of ethical conflicts, particularly regarding an awareness of to whom the physician owes a duty (the child, i.e., the patient, not to the parents), as pertinent in the case of an immigrant cultural practice such as female circumcision. This consideration appears to be considered by the AAP as immaterial in the case of our own culture's practice of not-medically-necessary infant male circumcision.

Ironically, what may have ultimately induced the grudging change in the AAP's policy on circumcision may not have been a sense of professional responsibility, but a growing sense of international professional isolation. The 1999 AAP task force cited position statements of Canadian and Australian medical organizations in 1996, which found no medical rationale for the support of routine infant male circumcision.<sup>207</sup> The Fetus and Newborn Committee of the Canadian Paediatric Society examined, and cited, existing cost-benefit analyses for circumcision in relation to UTI and penile cancer.<sup>208</sup> Even with the inflated and flawed UTI risk information available in 1996, the Society recommended simply and clearly in the abstract of their report that "[c]ircumcision of newborns should not be routinely performed."<sup>209</sup>

### III. LEGAL THEORIES FOR TRADE ASSOCIATION LIABILITY

With an understanding of the scientific data available to the 1989 and 1999 AAP task forces on circumcision, analysis can now turn to the legal argument that the AAP breached a duty of care and should be held liable for that breach. Tort law allows courts to examine the sufficiency of industry-wide practices and standards.<sup>210</sup> This even applies to the technical field

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families, limits to parental authority are justified when necessary to protect a child's well-being." *Id.* at 434 (citation omitted).

207. See AAP 1999, *supra* note 19, at 686 (citing the 1996 reports of the Australian College of Paediatrics, the Australian Association of Paediatric Surgeons, and the Canadian Paediatric Society).

208. See Fetus and Newborn Committee, Canadian Paediatric Society, *Neonatal Circumcision Revisited*, 154 CANADIAN MED. ASS'N J. 769, 775-76 (1996) (devoting two pages of the report to cost-benefit analysis and citing numerous cost-benefit analyses including those of Ganiats et al., *supra* note 133, Lawler et al., *supra* note 133, and Robert S. Thompson, *supra* note 68).

209. Fetus and Newborn Committee Canadian Paediatric Society, *Neonatal Circumcision Revisited*, 154 CANADIAN MED. ASS'N J. 769, 769 (1996).

210. The principle was best stated by Justice Learned Hand:

There are, no doubt, cases where courts seem to make the general practice of the calling the standard of proper diligence; we have indeed given some currency to the notion ourselves. Indeed in most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; *a whole calling may have unduly lagged* in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are

of medicine.<sup>211</sup> Some medical organizations have grudgingly acknowledged that a customary practice is not dispositive and can become obsolete.<sup>212</sup> Part III(A) will engage in a theoretical examination of medical trade association liability. Parts III(B), III(C), III(D), and III(E) advance legal foundations on which to assess liability against the AAP for its negligent promulgation of obsolete standards to physicians and obsolete advice to parents concerning circumcision. Part III(F) presents evidence upon which a court could ascribe a self-serving motive, beyond mere negligence, to the AAP's position on circumcision. Part III(G) discusses how some medical and legal professionals are organizing to oppose the medical practice of circumcision.

A. THEORETICAL EXAMINATIONS OF MEDICAL TRADE ASSOCIATION LIABILITY  
FOR FAULTY PRACTICE GUIDELINES

Professor Troyen A. Brennan of Brigham and Women's Hospital, notes, "[p]ractice guidelines are standardized specifications for managing particular clinical problems and are intended to improve the outcomes of medical care by increasing adherence to standards of care."<sup>213</sup> He continues that "[t]hey are also meant to make medicine more cost-effective by eliminating unnecessary procedures."<sup>214</sup> When a hospital, physician, or patient relies upon practice guidelines issued by a medical trade association, does the patient harmed by treatment in accordance with the guidelines have a cause of action against the issuer of the guidelines if there was negligence in their creation?

Professor Arnold J. Rosoff formulated three possible theories for

precautions so imperative that even their universal disregard will not excuse their omission.

*The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932) (emphasis added). There may also come a time when an entire industry or profession has lagged in not abandoning a practice or device.

211. For example, see *Nowatske v. Osterloh*, 543 N.W.2d 265 (Wis. 1996), which explained the standard of care as follows:

The standard of care applicable to physicians in this state can not be conclusively established either by a reflection of what the majority of practitioners do or by a sum of the customs which those practitioners follow. It must instead be established by a determination of what it is reasonable to expect of a professional given the state of medical knowledge at the time of the treatment in issue. . . . In most situations physicians, like other professionals, will revise their customary practices so that the care they offer reflects a due regard for advances in the profession. An emphasis on reasonable rather than customary practices, however, insures that custom will not shelter physicians who fail to adopt advances in their respective fields and who consequently fail to conform to the standard of care which both the profession and its patients have a right to expect.

*Id.* at 272.

212. See *id.* (quoting the Amicus Curiae brief for the State Medical Society of Wisconsin: "Plaintiffs can always, if appropriate, present evidence regarding the 'state of medical science' to show that a professional custom is obsolete or unreasonable.").

213. Troyen A. Brennan, *Practice Guidelines and Malpractice Litigation: Collision or Cohesion?*, 16 J. HEALTH POL., POL'Y & L. 67, 67 (1991).

214. *Id.*

medical society liability.<sup>215</sup> First is a theory of negligence while analyzing or translating experimental or review data.<sup>216</sup> Second is “using data that the developer knew, or should have known, were inaccurate or insufficient.”<sup>217</sup> His last theory of medical society liability is for failing to “keep its guidelines continually updated and [to] replace obsolete standards as technology and knowledge move forward.”<sup>218</sup> On this last basis, Rosoff notes that courts appear more likely to enforce revision in response to new knowledge, as opposed to new devices, because no monetary outlay would be necessary.<sup>219</sup> The previous parts of this Note, Part I (Circumcision and Medical Practice Under the 1989 AAP Report) and Part II (The 1999 AAP Report), should have sufficiently raised, if not answered, a question of fact concerning the AAP’s failure in each of these three areas.

When a plaintiff suffers from complications due to a circumcision, the AAP could be named as a codefendant along with the hospital and physician. This could be done under the rubric of negligence as applied to the following factors: (1) in establishing the standard of care; (2) for endorsing the uncertain medical benefits of this procedure; and (3) for neglecting to note and explain the known and possible adverse effects. Alternatively, the suit could stem from a lack of informed consent.

However, Brennan envisioned four practical obstacles for plaintiffs seeking to impose liability on medical associations that issue guidelines, such as the AAP. First, courts tend to restrict the duty of care to the treating physician.<sup>220</sup> Second, courts might be concerned that imposing liability could dissuade potential guideline issuers from promoting the general health of the public.<sup>221</sup> Third, courts might balk at imposing liability for a guideline which is arguably only a “review article” that may have “failed to consider all aspects of a particular question.”<sup>222</sup> Fourth, if the guideline issuer is a governmental entity, the Federal Tort Claims Act probably pre-

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215. See Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 HEALTH MATRIX 369, 392 (1995) (proposing theories for possible liability).

216. See *id.* at 392 (listing this as an obvious theory of liability).

217. *Id.*

218. *Id.*

219. See *id.* at 392 n.66 (inferring this after analyzing the reasoning in cases such as *Washington v. Washington Hosp. Center*, 597 A.2d 177 (D.C. 1990), (holding a hospital and physicians liable for not following new treatment studies that contravened conventional wisdom)).

220. See Brennan, *supra* note 213, at 78 (expressing it as “doubtful that courts would find individual physicians paralyzed or rendered powerless by guidelines issued by medical or research institutions”). However, this argument does not address a physician’s possibly reasonable reliance on the analysis of his professional organization.

221. See *id.* at 79 (noting that “[e]xtending the duty to care to these third parties would chill their interest in an activity that benefits the general welfare,” and that “product standard setting groups, can have duties to care,” but, “there is usually some direct relationship between the third party and the product, as for instance when the third party inspects a specific product which later causes injury”).

222. *Id.*

cludes liability.<sup>223</sup>

B. *SNYDER V. AMERICAN ASSOCIATION OF BLOOD BANKS*

A ground-breaking decision, which assessed tort liability upon a medical trade association for negligently disseminated guidelines, despite the obstacles envisioned by Brennan, was *Snyder v. American Ass'n of Blood Banks*,<sup>224</sup> handed down by the New Jersey Supreme Court in 1996. In August of 1984, the plaintiff, William Snyder, contracted AIDS from a blood transfusion with contaminated blood.<sup>225</sup> At the time of the transfusion, there was no test that could detect HIV in donated blood.<sup>226</sup> However, a surrogate testing procedure for hepatitis B contamination of blood showed promise for identifying blood donors who had contracted AIDS and potentially could transmit it through their blood.<sup>227</sup> Unfortunately, the American Association of Blood Banks (AABB) rejected adoption of the surrogate testing.<sup>228</sup>

The New Jersey Supreme Court, in *Snyder*, examined and ruled against each of the four obstacles to liability discussed in Brennan's article when the AABB raised them as defenses. The court framed Brennan's first obstacle, the treating physician defense, as the argument that "the AABB had no immediate connection with either the donor or with Snyder."<sup>229</sup> Citing prior New Jersey case law, the court formulated the rule to say:

The determination of the existence of a duty ultimately is a question of fairness and policy . . . [I]mportant are the nature of the risk posed by the defendant's conduct, the relationship of the parties, and the impact on the public of the imposition of a duty of care. . . . The absence of a contractual or special relationship is not dispositive.<sup>230</sup>

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223. See *id.* at 80 (citing guidelines issued by the National Institute of Health as an example).

224. 676 A.2d 1036 (N.J. 1996).

225. See *id.* at 1038 (providing the background which showed an overwhelming likelihood that Mr. Snyder contracted HIV from contaminated blood provided during his surgery).

226. See *id.* at 1038 (explaining that no direct test for HIV transmission through contaminated blood existed in 1984).

227. See *id.* at 1039-48 (tracing the development of the theory that AIDS was spread by exposure to contaminated blood and the development of the rationales for the use of surrogate testing).

228. See *Snyder*, 676 A.2d at 1048 (relating how the AABB rejected use of the surrogate test to screen blood contending that it would result in the rejection of too many healthy blood donors and cost too much). Basically, the AABB rejected the surrogate test on a hasty and not fully informed cost-benefit analysis, even though studies had been published in the medical literature essentially proving that AIDS could be transmitted through donated blood. See *id.* at 1049 (stating that the AABB knew of the risk of AIDS).

229. *Id.* at 1048; see also Brennan, *supra* note 213, at 78 (discussing the possible use of the treating physician defense).

230. *Snyder*, 676 A.2d at 1048 (citations omitted).

The court noted that, "[b]y words and conduct, the AABB invited blood banks, hospitals, and patients to rely on the AABB's recommended procedures," and thus the absence of a contractual relationship was not dispositive.<sup>231</sup> The treating physician defense did not help the AABB escape a duty of care to patients who were treated by hospitals and physicians, because these patients were receiving blood products pursuant to standards promulgated by the AABB. The AABB knew that these standards were widely followed by hospitals and physicians.<sup>232</sup>

It is possible to apply the *Snyder* court's reasoning, concerning the treating physician defense, to the 1992 edition of AAP Guidelines for Perinatal Care, which reflects the 1989 AAP task force report's policy on circumcision, as well as to the 1989 report itself. Contained in each edition of the guidelines is the disclaimer: "The guidelines should not be viewed as a body of rigid rules. They are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or type of practice."<sup>233</sup> Notwithstanding this disclaimer, if a plaintiff can show direct reliance on these AAP publications, or that hospital administrators and physicians relied on such information provided by the AAP—as the dominant source of analysis and research in the field—then the AAP should be held liable for negligently crafting recommendations.<sup>234</sup>

Kimberly J. Todd, in her article in the *University of Toledo Law Review*, noted that the evolving use, by plaintiff patients and defendant physicians, of practice guidelines as evidence of the standard of care should alert a medical society to the foreseeability of harm if those guidelines prove faulty.<sup>235</sup> Todd noted three medical malpractice cases involving individual

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231. See *id.* at 1048 (reasoning that fairness and policy allow liability because the "AABB [had] sought and cultivated . . . responsibility for the safety of blood and blood products," which induced treating physicians to rely on AABB standards).

232. See *id.* at 1041 (describing the overwhelming adherence to AABB standards by organizations supplying blood and blood products).

233. AAP GUIDELINES 1992, *supra* note 134, at ii; see also AAP GUIDELINES 1988, *supra* note 134, at ii (using the same language of disclaimer); AAP GUIDELINES 1983, *supra* note 134, at ii (using the same language of disclaimer).

234. Cf. Kimberly J. Todd, *Snyder v. American Association of Blood Banks: Expansion of Trade Association Liability—Does It Reach Medical Societies?*, 29 U. TOL. L. REV. 149, 174 (1997) (arguing that *Snyder* allows a court to go beyond the treating physician's liability if the treatment decision was made based on the standard of care set by the dominant source of information in that industry).

235. See *id.* at 173 & n.173 (comparing the foreseeability language in *Snyder* to the fact that patients and physicians rely on published guidelines to establish the standard of care). Further, she asserted that:

The courts' deference to practice parameters indicates a belief that the medical societies which develop the parameters have a high level of influence over their members. . . . [A]ny medical society that places itself in a position in which others rely heavily on its standards (to ensure the safety of their treatment) should have a duty to act with due care when producing those standards.

*Id.* (citations omitted).

physicians and hospitals where AAP guidelines were used as either exculpatory or inculpatory evidence of the standard of care.<sup>236</sup> Thus, by the AAP having at least constructive knowledge of hospital and physician reliance, the lack of privity of contract between a parent who chooses to circumcise and the AAP can be overcome.

The *Snyder* opinion also confronted Brennan's second obstacle to extending liability: the possible reluctance of medical organizations to issue guidelines out of fear of future liability.<sup>237</sup> As it was stated in the *Snyder* opinion, extraneous concerns "should not have diverted the AABB from its paramount responsibility to protect the safety of the blood supply."<sup>238</sup> It went on to state:

Recognition of that responsibility should have led the AABB to consider more carefully the risks to recipients from the transfusion of infected blood. When balanced against the devastating risks from a disease such as AIDS, the imposition of a duty of care on the AABB does not, in our opinion, offend the public policy favoring open debate on controversial scientific issues.<sup>239</sup>

Thus, the court concluded that the balancing of various factors inherent in its test concerning liability would not chill open debate in scientific circles, but would instead spur responsible scientific consideration of effects on the public.<sup>240</sup>

The paramount responsibility of the AAP is promoting the health of children. As the AAP's own mission statement explains the organization's purpose, it is "to attain optimal physical, mental and social health and well-being for all infants, children, adolescents and young adults."<sup>241</sup> The AAP's mission is not to satisfy the extraneous concerns of parental or physician choices in "esthetics, religion, cultural attitudes, social pressures, and tradition."<sup>242</sup> The AAP should inform the public of its failure to find clear medi-

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236. See *id.* Todd cites *Birchfield v. Texarkana Mem'l Hosp.*, 747 S.W.2d 361, 364 (Tex. 1987) and *Boyd v. Louisiana Med. Mut. Ins. Co.*, 593 So.2d 427, 429-30 (La. Ct. App. 1991) for the use of AAP practice parameters and reports in an inculpatory manner and cites *Parker v. Southwest La. Hosp. Ass'n*, 540 So.2d 1270, 1274 (La. Ct. App. 1989) for the use of AAP practice parameters in an exculpatory manner.

237. See Brennan, *supra* note 213, at 79 (expressing the concern that liability "would chill [the medical associations'] interest in an activity that benefits the general welfare"). However, such activities can hardly benefit the general welfare if they are not conducted under the usual scientific protocols for evaluating data.

238. *Snyder*, 676 A.2d at 1050.

239. *Id.*

240. See Todd, *supra* note 234, at 175 (noting that the rule adopted in *Snyder* weighs the probability and importance of risk of injury against the policy of facilitating scientific debate).

241. American Academy of Pediatrics, *AAP Fact Sheet* (visited Jan. 24, 2000) <<http://www.aap.org/visit/facts.htm>>.

242. AAP 1989, *supra* note 3, at 390 (choosing to facilitate parental concerns); see also AAP 1999, *supra* note 19, at 691 (same). Over the last century, the medical profession created this parental tradition, largely under discredited theories of causation. The AAP, in disregard of

cal benefits from this surgery, while fully disclosing the risk of adverse outcomes known to occur. In sum, it should discontinue the classification of this surgery as acceptable medical care for infant boys.

Returning to the obstacles Brennan's article raised concerning trade association liability on medical guideline issuers, the *Snyder* opinion also addressed Brennan's third impediment: that of imposing liability for expressing an opinion on a medical uncertainty.<sup>243</sup> The court ruled that "[t]he foreseeability, not the conclusiveness, of harm suffices to give rise to a duty of care."<sup>244</sup> The court then found that the evidence supported the factual finding that the AABB knew or should have known that AIDS could be transmitted by blood, and therefore there was a foreseeable risk that a recipient of a blood transfusion could contract the disease from donated blood.<sup>245</sup>

An analysis of the foreseeability of harm from the AAP's failure to disavow circumcision, therefore, requires a focus on the issue of complications. While the sampling methods and operational definitions in existing studies of complication rates are problematic, these methodological problems do not affect the fact that circumcision indisputably poses *some* risk of harm. The scientific disputes over these studies involve the numerical magnitude of the rates, not the existence, of complications. Likewise, in analyzing complications, knowledge of the extent of the types of harm associated with circumcision is expanding as researchers discover more about the structural and functional characteristics of the foreskin. Thus, as time passes and knowledge accumulates, it becomes more and more foreseeable to the AAP that circumcision can cause great harm.

Conversely, the *existence*—not just the magnitude—of the possible benefits from circumcision is in dispute. In examining benefits, the 1989 AAP's report's crediting of five methodologically unsound studies—which asserted a causal link between lack of circumcision and STD rates—over one methodologically sound study finding no relationship—or possibly an inverse relationship—is negligent scientific analysis.<sup>246</sup> A large number of studies on circumcision exist. However, it was and is the AAP's responsibil-

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scientific method, is now maintaining that parental cultural tradition through failing to expose the flimsiness of circumcision's benefits and by placing this tradition above the health interests of infant boys.

243. See Brennan, *supra* note 213, at 79 (relating the concern for penalizing a medical society for choosing the wrong stance on a medical uncertainty). However, the efficacy of routine circumcision is only an uncertainty because the profession as a whole, and the AAP in particular, has failed to responsibly and thoroughly investigate after more than a century of performing it.

244. *Snyder*, 676 A.2d at 1049.

245. *Id.*

246. See *supra* notes 83-86 and accompanying text (emphasizing the fact that each study used by the 1989 AAP report to support the hypothesis that circumcision conferred a benefit in preventing STDs was flawed); cf. FAIGMAN ET AL., *supra* note 16, at 48 (noting the fundamental scientific principle that for any scientific analysis of contradictory studies, methodology is central to evaluating the worth of the findings of each study).

ity to base recommendations on the methodologically sound material among those studies because that is how science works. The dilemma of scientifically evaluating data on circumcision was much simpler for the AAP to resolve, than was the dilemma of evaluating the many unknowns residing in the newly emerging research into whether AIDS was transmitted through blood, which the AABB had to resolve. Therefore a court should more readily impose liability in a potential suit versus the AAP, due to the many years of research and the established scientific methods for evaluating the findings.

The AABB in *Snyder* also raised Brennan's fourth obstacle, a possible qualified immunity defense.<sup>247</sup> The court dismissed this defense, however, noting that the AABB did not contract with a governmental agency, and that mere mention of AABB standards and inspections by a governmental agency could not create qualified immunity.<sup>248</sup> Finally, the court addressed a related defense of charitable immunity. The court found that the AABB could not meet the state statutory requirement of being "organized exclusively for charitable purposes" because the organization promoted the interests "of its dues-paying members."<sup>249</sup>

Like the AABB, it is unlikely that the AAP could successfully claim charitable immunity. The AAP has a standing committee on medical liability with responsibilities that include monitoring federal and state legislation concerning medical liability and developing legislative strategies to change current state laws through the development and dissemination of model bills.<sup>250</sup> This would appear to promote the business interests of its dues-paying members. In *Snyder*, Justice Pollock wrote, "[o]ur opinion does not visit liability on the AABB because it was on the wrong side of a scientific debate. . . ."<sup>251</sup> He further stated, concerning professional associations involved in public health care, "[t]he associations' commitment to public health should not immunize them from liability for the negligent discharge of their obligations. *Nor should the associations enjoy immunity when they [1] stubbornly reject persuasive evidence, [2] unreasonably prolong the debate, and [3] fail to inform their constituents of threats to the public health.*"<sup>252</sup> The 1989 and 1999 AAP task forces engaged in all three of these practices to some extent. The task forces failed to cite many methodologically sound studies adverse to the practice of circumcision, debated the efficacy of circumcision for dec-

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247. Compare *Snyder*, 676 A.2d at 1051-54 (relating the defendant's assertions of qualified immunity based on the AABB's relationships with the federal Food and Drug Administration and the New Jersey Department of Health), with *Brennan*, *supra* note 213, at 80 (discussing immunity defenses).

248. See *Snyder*, 676 A.2d at 1052-54 (implying that privity of contract between the AABB and a governmental agency would be necessary for immunity).

249. *Id.* at 1054.

250. See American Academy of Pediatrics, *Committee on Medical Liability* (visited Jan. 27, 1999) <<http://www.aap.org/visit/coml.htm>> (outlining the duties of this committee).

251. *Snyder*, 676 A.2d at 1055.

252. *Id.* (emphasis added).

ades, and failed to inform parents of the full range of complications. Thus, the AAP should not enjoy charitable immunity. Analogizing from *Snyder*, the AAP should be held liable for the negligent promulgation of standards for the profession.

C. *WEIGAND V. UNIVERSITY HOSPITAL OF NEW YORK UNIVERSITY MEDICAL CENTER*

Under similar facts, the Supreme Court for New York County, in *Weigand v. University Hospital of New York University Medical Center*,<sup>253</sup> followed the reasoning of *Snyder* in imposing a duty of care on the AABB.<sup>254</sup> However, the plaintiff in *Weigand* also brought two additional causes of action against the AABB beyond the claims brought in the *Snyder* case. The plaintiff in *Weigand* also alleged a failure to advise about alternative sources of blood and a failure to warn of the risk of transmission of HIV through blood.<sup>255</sup> The court dismissed these informed consent causes of action against the AABB, citing the lack of potential economic benefit to the AABB, and held that informed consent duties concerning the safety of the blood supply resided only with the hospital and physicians.<sup>256</sup> In this case, the treating physician defense was successful against causes of action based on informed consent.

It is possible to distinguish the facts surrounding the AABB in *Weigand* from the facts surrounding the AAP in potential circumcision liability cases. The AAP publishes and sells a brochure, specifically for parents, entitled, *Circumcision: Pros and Cons*.<sup>257</sup> The AAP must realize some economic benefit through the sale of this brochure and others, even though the AAP is a non-profit organization. Additionally, the AAP has knowingly introduced its information into the decision making process of parents by making it directly and indirectly available to parents, either online or in doctors' offices. Thus, the AAP has created a professional advisory relationship between itself and parents on medical matters and should be held accountable if its recommendations are both formulated in a scientifically irresponsible manner and produce harmful results.

Therefore, under the reasoning of *Snyder* and *Weigand*, the AAP should be held liable for failure to obtain informed consent for every infant who undergoes a circumcision and whose parents can show that they would

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253. 659 N.Y.S.2d 395 (N.Y. Sup. Ct. 1997).

254. See *Weigand v. Univ. Hosp. of New York Univ. Med. Ctr.* 659 N.Y.S.2d 395, 400 (N.Y. Sup. Ct. 1997) (citing the reasoning in *Snyder* as persuasive in imposing a duty of care toward a 1983 recipient of contaminated blood on the AABB).

255. See *id.* at 401 (addressing the allegations of the plaintiff).

256. See *id.* (dismissing the informed consent causes of action by finding that the facts did not meet the requirement of "a special relationship between the parties, frequently involving an existing or potential economic benefit to the defendant").

257. AMERICAN ACADEMY OF PEDIATRICS, BROCHURE NO. HE0175, CIRCUMCISION: PROS AND CONS (1995) [hereinafter AAP 1995 brochure].

have made a different decision had the AAP provided full and accurate information on complications as well as the benefits of leaving their child intact. The loss of a healthy foreskin is an injury that can produce a damage award.<sup>258</sup> A judgment and award for damages is even more appropriate where a child suffers complications, and the parents can show that the particular complications were omitted from the AAP materials on which they relied.

#### D. SECTION 324A OF THE RESTATEMENT (SECOND) OF TORTS

The holding of the *Snyder* case reflected reasoning contained in section 324A of the Restatement (Second) of Torts. The language of section 324A, Liability to Third Person for Negligent Performance of Undertaking, is as follows:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking, if

- (a) his failure to exercise reasonable care increases the risk of such harm, or
- (b) he has undertaken to perform a duty owed by the other to the third person, or
- (c) the harm is suffered because of reliance of the other or the third person upon the undertaking.<sup>259</sup>

The first issue under a section 324A analysis is whether a duty of care exists. That the information provided to the other party be "necessary" to protect the third party, presents problems of interpretation.

Ralph Wellington and Vance Camisa, in an article in the *Wayne Law Review*, examined decisions involving trade association liability and product safety standards and found that courts could read the necessity requirement liberally.<sup>260</sup> Wellington and Camisa cited a California case which found that since a trade association had "specifically undertaken a duty when the association tested a member company's perlite ores for dangerous toxic substances, . . . it was 'reasonable for [the trade association] to believe that [all of] its members [would] rely on the tests.'"<sup>261</sup> These authors also cited a United States district court case applying Pennsylvania law which found contractual permission, rather than obligation, to inspect a workplace as sufficient to impose a duty of care upon a trade association, once it had

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258. See Llewellyn, *supra* note 74, at 13 (relating an award of \$65,000 for the loss of a foreskin without informed consent).

259. RESTATEMENT (SECOND) OF TORTS § 324A (1965).

260. Ralph G. Wellington & Vance G. Camisa, *The Trade Association and Product Safety Standards: Of Good Samaritans and Liability*, 35 WAYNE L. REV. 37, 39-45 (1988) (citing cases which did not require absolute necessity for the imposition of a duty of care).

261. See *id.* at 39-40 (quoting *Martinez v. Perlite Inst.*, 120 Cal. Rptr. 120, 125 (1975)).

negligently performed an inspection.<sup>262</sup> Although the AAP has no obligation to pediatricians to review the state of knowledge on issues in pediatric care, it has gratuitously undertaken a mission to do so. It would be reasonable for a court to find that AAP information on circumcision may become necessary for the protection of patients when an individual pediatrician is unable or does not thoroughly investigate all the available medical literature on this surgery and instead relies on an AAP investigation.

Kimberly J. Todd examined the issue of a liberal reading of the duty of care and cited an Alabama case that excluded a trade association's lack of control of its industry from the analysis.<sup>263</sup> The court found that even though the voluntary standards represented the prevailing opinion of members in the association, the association recognized that the safety of third parties was the reason for making the standards.<sup>264</sup> Thus, the association was charged with foreseeability of harm to those third persons once the problem was analyzed and the standards were adopted without reasonable care.<sup>265</sup>

Indeed, trade associations are already aware of exposure to liability for negligently promulgated standards disseminated to its members. In addressing tort liability, the Association Law Handbook, published by the American Society of Association Executives, warns:

Even when it does not seem that the association intended to be responsible for advice given by others or endorsements of the products or services of others, the association could be found to have assumed that responsibility, such as through helping to determine what advice would be given or through testing the products or services endorsed.<sup>266</sup>

It would be absurd for the AAP to deny that it undertook a duty of care to parents and a duty necessary for the health of infants when it chose to investigate circumcision and disseminated its findings directly to parents as

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262. See *id.* at 42-43 (citing *Clark v. Employers Mut.*, 297 F. Supp. 286, 289 (E.D. Pa. 1969)).

263. See Todd, *supra* note 234, at 164. She notes:

[T]he fact that the standards promulgated by a trade association are based on a voluntary consensus of its members, does not, as a matter of law, absolve the trade association of a duty to exercise reasonable care when it undertakes to promulgate standards for the "needs of the consumer." The [trade association's] standards explicitly mentioned that they were for the "needs of the consumer" and that safety was one of the primary considerations for which they were formulated. This, the court reasoned, made it foreseeable to [the trade association] that injury to consumers could result from its failure to act with reasonable care, thus creating a duty.

*Id.* (quoting *King v. Nat'l Spa and Pool Inst., Inc.*, 570 So.2d 612 (Ala. 1990) (other citations omitted)).

264. See Todd, *supra* note 234, at 164 (citing the *King* court's observation that the trade association professed to create the standards to guide consumers).

265. See *id.* (citing the *King* court's finding of a duty of care).

266. JERALD A. JACOBS, ASSOCIATION LAW HANDBOOK 157 (3d ed. 1996).

an authoritative professional opinion.

Once a court acknowledges a duty of care, a plaintiff must still demonstrate proximate cause in order to prevail. Subsections (a), (b), and (c) of section 324A of the Restatement (Second) of Torts set forth the methods for demonstrating causation. For purposes of examining the AAP's conduct, subsection (b) is inapplicable because Comment d and its illustrations appear to require an explicit contract between the principle parties for the performance of a duty owed to the third party.<sup>267</sup> Therefore a potential plaintiff, in a case against the AAP, would have to demonstrate proximate cause under subsections (a) or (c).

Subsection (a) requires that the failure in the duty of care increases the risk of harm.<sup>268</sup> The AAP's change in position from the 1975 report to the 1989 report could sufficiently show an increase in the risk of harm. Without scientifically adequate bases for the change in recommendation concerning circumcision, the AAP increased the risk by influencing readers to elect an unnecessary surgical risk. Wellington and Camisa found a court which applied the subsection (a) causality test when the court denied summary judgment, "finding that the [trade association] drew its conclusions without reasonable care, thus increasing the risk of harm to the plaintiff through its recommendations."<sup>269</sup> Therefore, the AAP's conduct could meet a test for causation of harm under subsection (a) of section 324A.

The last method of establishing causation through the use of section 324A is by demonstrating subsection (c)'s requirement of reliance.<sup>270</sup> If a hospital, physician, or patient can prove reliance upon the recommendation of a medical society and can show that this reliance resulted in injury, then the plaintiff could establish causation. Wellington and Camisa note that it may be difficult for an employee to demonstrate reliance because the employee "may not be aware of the trade association whose member supplies products to his employer."<sup>271</sup> Likewise, an infant patient and his parents may often be unaware whether a hospital and its physicians relied on analysis supplied by the AAP. Therefore, this should be a question presented to the defendant during discovery.

However, parents may very well base their decision on information obtained directly from the AAP. The AAP, by virtue of the fact that it sells its *Circumcision: Pros and Cons* brochure in bundles of 100 costing twenty-five to thirty dollars, effectively creates a situation where physicians, hospitals,

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267. See RESTATEMENT (SECOND) OF TORTS, § 324A cmt. d (1965) (stating that "a managing agent who . . . agrees with [the owner to maintain a building] . . . is therefore subject to liability . . ."). Illustrations 2 and 3 to Comment d both involve employer-employee contracts.

268. See *id.* § 324A(a) (noting that the failure to exercise care must increase the risk of harm).

269. See Wellington & Camisa, *supra* note 260, at 48 (1988) (quoting *Kohr v. Johns-Manville Corp.*, 534 F. Supp. 256, 258 (E.D. Pa. 1982)).

270. See RESTATEMENT (SECOND) OF TORTS, § 324A(c) (noting that reliance can satisfy causality).

271. Wellington & Camisa, *supra* note 260, at 57.

and individuals can buy the brochures and distribute them directly to parents.<sup>272</sup> Thus the third parties—the parents—are made aware of the recommendations of the trade association—the AAP. The AAP has survey data showing that only 74.1% of pediatricians discuss circumcision with parents.<sup>273</sup> A sizeable percentage of parents may be making a decision on whether to circumcise without direct input from a physician and perhaps based only on the information contained in brochures supplied by the AAP. Oddly, in the AAP's survey, it did not ask pediatricians whether they relied on AAP advice, provided it to parents, or knew whether parents had made their decisions based on AAP materials. By virtue of the fact that the AAP is a "medical" organization made up of pediatricians, parents could be justified in treating these brochures as medical advice.

Although the brochure ostensibly presents the issue of whether to circumcise as a decision for parents to make after consulting with their physicians, certain inaccuracies and omissions appear to be designed to induce parents to choose the surgery without bothering to ask their pediatrician. The first line begins, "Circumcision is one of the oldest known surgical procedures in medicine."<sup>274</sup> This statement implies that the practice of this surgery is normal, well established, and therefore not worthy of concern. This statement also inaccurately implies that Muslims and Jews practiced circumcision in antiquity for medical reasons. Both implications are false.<sup>275</sup>

Next, while the AAP admits circumcision to be "far less common worldwide,"<sup>276</sup> the AAP fails to mention that only a minority of males worldwide are circumcised.<sup>277</sup> The brochure warns parents that if they choose not to circumcise they may need to explain their choice to their son later.<sup>278</sup> However, considering the growing number of medical practitioners and parents choosing and advocating against this surgery, the same warning could apply to parents who choose to circumcise.<sup>279</sup> The AAP's warning to parents that they will have to explain to their sons why they did not

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272. See AAP 1995 brochure, *supra* note 257 (listing the purchasing terms for the brochure).

273. See American Academy of Pediatrics, *Periodic Survey #37: Attitudes and Experiences Regarding Counseling on Circumcision* (visited Jan. 23, 2000) <<http://www.aap.org/research/ps37exs1.htm>> (outlining the results of a recent survey of physician attitudes and experiences, without examining the influence of AAP material either supplied by physicians to parents or obtained by parents directly).

274. AAP 1995 brochure, *supra* note 257.

275. See THOMAS J. RITTER, M.D., SAY NO TO CIRCUMCISION 25-1 (1992) (noting that circumcision is performed in Judaism strictly for religious reasons); see also *supra* Parts I(E)-(F), and II(D)-(F) (delineating risks of circumcision and why parents must carefully consider their choice).

276. AAP 1995 brochure, *supra* note 257.

277. See RITTER, *supra* note 275, at 16-1 (comparing the number of countries that do and do not perform routine "medical" circumcisions).

278. AAP 1995 brochure, *supra* note 257.

279. Cf. RITTER, *supra* note 275, at 21-1 (citing a National Center for Health Statistics report that the 1990 U.S. rate of circumcision was dropping to 59%).

choose to circumcise is an inappropriate scare tactic designed to induce parents to make a decision without learning of the considerable medical debate surrounding circumcision.

Under the section of the brochure concerning reasons to circumcise, "research studies" in support of the practice are mentioned.<sup>280</sup> However, in the section dealing with reasons not to circumcise, the AAP neglects to mention that there are research studies that do not support, and even warn against the procedure, for physical, mental health, and ethical reasons.<sup>281</sup> By its failure to list further sources of information (pro and con) about this procedure, the brochure gives the impression that the AAP position is representative of the views of all medical professionals, which is not the case.<sup>282</sup> For all of these reasons, the brochure invites parents to rely on it alone as the only necessary information they need to make an informed choice whether to circumcise their sons or not.

Therefore, under section 324A of the Restatement (Second) of Torts, the AAP, gratuitously or for consideration, renders research services directly to parents and physicians necessary for the protection of infant boys. The AAP's failure to follow fundamental scientific procedure—placing experimental methodology first in evaluating the significance of results, as well as taking care to find all pertinent material—constitutes a failure to exercise reasonable care. This failure to exercise reasonable care results in an increase in the risk of harm to infant boys, because infants can suffer harm from circumcision due to the reliance parents and physicians place upon the AAP.

#### *E. N.N.V. v. AMERICAN ASSOCIATION OF BLOOD BANKS*

Recently, a California Court of Appeal, on facts similar to those in the *Snyder* case, chose not to assess liability upon the AABB.<sup>283</sup> In *N.N.V. v.*

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280. AAP 1995 brochure, *supra* note 257.

281. See *supra* Parts I(E)-(G) (citing to material explaining circumcision's potential for harm versus the alternative of not circumcising and its lack of proven risk).

282. See *Doctors Opposing Circumcision* (visited Jan. 27, 1999) <<http://faculty.washington.edu/gcd/DOC/>> (delineating the views of the organization); *Nurses For the Rights of the Child* (visited Jan. 27, 1999) <<http://www.cirp.org/nrc/#Picture>> (outlining the activities of this organization); Betty Katz Sperlich et al., *R.N. Conscientious Objectors to Infant Circumcision: A Model for Nurse Empowerment* (visited Jan. 27, 1999) <[http://www.cirp.org/nrc/R.N.\\_Conscientious\\_Objecto.html](http://www.cirp.org/nrc/R.N._Conscientious_Objecto.html)> (relating the fact that in 1995 the Registered Nurses Association of British Columbia passed a resolution condemning routine circumcision and that, through mediation, about half (24) of the Maternal-Child nursing staff at St. Vincent's Hospital in Santa Fe, New Mexico, won conscientious objector status to routine circumcision from the hospital, thus exempting them from being present during a circumcision); see also *National Organization of Circumcision Information Centers* (visited Jan. 27, 1999) <<http://nocirc.org>> (providing the organization's mission statement and information about circumcision).

283. Compare *N.N.V. v. Am. Ass'n of Blood Banks*, 89 Cal. Rptr. 2d 885, 892-93 (Cal. App. 4th 1999) (relating the facts surrounding *N.N.V.*'s surgery and use of HIV contaminated

*American Ass'n of Blood Banks*, ("N.N.V."), an infant born on September 23, 1984, underwent surgery to correct a congenital heart defect two and a half months later.<sup>284</sup> It was afterward discovered that the blood used for N.N.V.'s surgery was HIV positive.<sup>285</sup> The appellate court upheld summary judgment for the AABB, holding that "the AABB owed no duty to N.N.V. to adopt particular standards."<sup>286</sup> It further noted that even if a duty of care existed, the plaintiff had "failed to raise any triable issues of fact showing the AABB acted unreasonably in rejecting recommendations given the scientific and medical knowledge available at the time."<sup>287</sup> In examining the duty of care, the court used the rule that in a particular case, "public policy and other considerations may lead a court to conclude no duty [of reasonable care] toward the plaintiff existed."<sup>288</sup> These other considerations consisted of:

- (1) the foreseeability of harm to the plaintiff, (2) the degree of certainty that plaintiff suffered injury, (3) the closeness of the connection between the defendant's conduct and the injury suffered, (4) the moral blame attached to the defendant's conduct, (5) the policy of preventing future harm, (6) the extent of the burden to the defendant and the consequences to the community of imposing a duty to exercise care . . . (7) and the availability, cost, and prevalence of insurance for the risk involved.<sup>289</sup>

Considerations 1 and 3 through 6 are pertinent for examining the argument that the AAP has, and has breached, a duty of care with regard to its recommendations on circumcision. This part of this Note will demonstrate that even assuming *N.N.V.* was correctly decided and *Snyder* incorrectly decided concerning the existence and performance of a duty of care by the AABB to recipients of blood products in the early 1980s, the facts surrounding the AAP and circumcision are distinguishable.

The *N.N.V.* court noted that while it may have been foreseeable to the AABB that AIDS could be transmitted through blood and blood banks would follow its recommendations, the claim against the AABB necessitated a showing that the AABB was negligent in not recommending three procedures to screen the blood supply.<sup>290</sup> These procedures were direct questioning of blood donors' sexual preference, directed donations from patient-selected donors, and surrogate testing of blood for the presence of

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donor blood), *with Snyder v. Am. Ass'n of Blood Banks*, 676 A.2d 1036, 1038 (relating the facts surrounding Snyder's surgery and use of HIV contaminated donor blood).

284. See *N.N.V.*, 89 Cal. Rptr. 2d at 892-93 (relating the facts surrounding the surgery).

285. *Id.* at 893.

286. *Id.* at 909.

287. *Id.* at 910-11.

288. *Id.* at 896.

289. *N.N.V.*, 89 Cal. Rptr. 2d at 896.

290. See *id.* at 898 (recasting the factual basis for the plaintiff's claim).

hepatitis B antibodies.<sup>291</sup> The court quickly disposed of the claims that the AABB should have recommended direct questioning and directed donations, noting the lack of any studies in 1984 which supported either of these methods of screening the blood supply.<sup>292</sup>

However, as the *Snyder* and *N.N.V.* opinions outlined in their reviews of the research history, there was growing evidence throughout 1983 and 1984 that AIDS was transmitted through blood products and some blood banks had begun surrogate testing.<sup>293</sup> The *Snyder* opinion also focused on recommendations by the AIDS Task Force of the Centers for Disease Control at meetings with the AABB that surrogate testing be adopted, and on AABB internal memos essentially admitting that that AIDS was being transmitted during blood transfusions.<sup>294</sup> Although the *Snyder* court found the evidence sufficient to make the likelihood of harm foreseeable to the AABB, the *N.N.V.* court found the evidence unclear as to the foreseeability of harm.<sup>295</sup>

With circumcision and the AAP, the foreseeability of harm to infants is known, because complications do occur. More importantly however, both the 1989 and 1999 AAP task forces chose to ignore and/or downplay evidence of the loss of specialized tissue in the foreskin and the occurrence and evidence of long-term behavioral effects. Many studies were available to the AAP at the time of each report, and a potential plaintiff could raise a triable issue of fact as to why the AAP either ignored or downplayed the findings.

The *N.N.V.* court ruled that the plaintiff had presented no evidence that either direct questioning of the donor, or surrogate testing of his blood, would have prevented the donor from donating the blood used for *N.N.V.*'s surgery.<sup>296</sup> Nor did the plaintiff present evidence that all of the

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291. See *id.* (listing the procedures and tests which the plaintiff claimed the AABB should have used to screen the blood supply).

292. See *id.* at 899 (finding no studies to support either screening method).

293. See *Snyder v. Am. Ass'n of Blood Banks*, 676 A.2d 1036, 1041-48 (N.J. 1996) (detailing at length the history of the scientific research and debate over AIDS, blood products, and surrogate testing up through August 23, 1984); see also *N.N.V.*, 89 Cal. Rptr. 2d at 890-92 (relating a similar history through December 6, 1984).

294. See *Snyder*, 676 A.2d at 1044-46. (quoting the testimony of Dr. Donald Francis of the CDC AIDS Task Force). Dr. Francis perceived the AABB's resistance to surrogate testing, and to the acknowledgment of blood a medium for AIDS, as "ridiculous" and "alarming". *Id.* at 1045. The court's opinion also took note of internal AABB memos authored by Dr. Joseph Bove, chairman of the AABB Committee on Transfusion Transmitted Disease, one of which warned that "additional transfusion related cases . . . [of AIDS] will surface." *Id.* at 1046.

295. Compare *id.* at 1049 (ruling that "ample evidence supported the conclusion that blood transmitted the AIDS virus"), with *N.N.V. v. Am. Ass'n of Blood Banks*, 89 Cal. Rptr. 2d 885, 910 (Cal. App. 4th 1999) (finding that conflicting evidence did not make it reasonably foreseeable to the AABB that surrogate testing of blood would have lessened the transmission of AIDS).

296. See *N.N.V.*, 89 Cal. Rptr. 2d at 900-01 (ruling that *N.N.V.* had only engaged in the assumption, without evidence, that these procedures would have shielded him from AIDS).

family or friends who might have been potential directed donors were free from HIV.<sup>297</sup> Thus the court ruled that N.N.V. had failed to establish the third requirement of the test for imposing a duty of care, that of a close connection between the AABB's refusal to adopt methods suggested by the CDC's AIDS Task Force and N.N.V.'s contraction of AIDS.<sup>298</sup>

In a potential case against the AAP for negligence in its recommendations concerning circumcision, unlike with blood donation, there would be no range of choices. The choice involved would be either to circumcise or not to circumcise. This would approximate a choice to transfuse or not to transfuse. A proper analogy, from the identity of the blood donor in the *N.N.V.* transfusion case, to a potential case involving circumcision, would be to a choice among devices for accomplishing circumcision. Neither the 1989 nor 1999 AAP task forces, nor anti-circumcision activists, have expressed much concern about meaningful differences among these devices.<sup>299</sup> Thus, the plaintiff would merely have to show that the parents would have avoided the harm by choosing not to circumcise.

As to the fourth requirement, that of moral blameworthiness, the *N.N.V.* court noted that AIDS was a very new issue under scientific investigation, and that N.N.V. did not establish "what 'known medical science' the AABB was ignoring."<sup>300</sup> Thus, the court ruled that no moral blame should be placed upon the AABB.<sup>301</sup> With circumcision and the AAP, however, the controversy is not new and there is plenty of known medical science which the AAP did apparently ignore. Thus, a court could easily attach moral blame to the AAP's actions.

The court in *N.N.V.* dismissed the fifth and the sixth considerations, the policy of preventing future harm and the burden on the defendant, with the argument that the AABB could not be penalized for choosing the wrong side in a freshly emerging scientific debate.<sup>302</sup> The court further lamented the situation where the standard of care should ever be "evaluated

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297. *Id.*

298. *Id.*

299. See AAP 1999, *supra* note 19, at 687-88 (noting that the *Gomco* clamp, the *Mogen* clamp, and the *Plastibell* device are all commonly used, and not mentioning any concern over differences in these devices, only concern that the persons using each be skilled); AAP 1989, *supra* note 3, at 389 ("Clamp techniques (e.g., *Gomco* or *Mogen* clamps) or a *Plastibell* give equally good results."); *id.* (citing also to *Gee & Ansell*, *supra* note 98, at 827, for a lack of meaningful difference in complication rates between the two devices); see also RITTER, *supra* note 275, at § 2-4 (focusing on the harm of circumcision regardless of the device used).

300. *N.N.V.*, 89 Cal. Rptr. 2d at 901.

301. See *id.* at 902 ("We conclude the AABB conduct in recommending against direct questioning, directed donations and surrogate testing warrants no moral blame.")

302. See *id.* (finding the mere existence of a debate among scientists, especially when the defendant represented the majority opinion at the time, sufficient to negate an objective of preventing future harm); *id.* at 903 (finding the burden of litigation too onerous to place upon the AABB for making the wrong decision in a debate among scientists).

by the ad hoc judgments of a lay judge or lay jurors aided by hindsight."<sup>303</sup> However, the court failed to recognize that the plaintiff was probably not seeking a determination that the AABB chose the wrong side in a scientific debate, but that the AABB allowed the unscientific motivations of cost and supply of blood to influence its choice.<sup>304</sup> As the United States Supreme Court opinion in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* observed concerning the admissibility of scientific evidence, "[t]he focus, of course, must be solely on principles and methodology, not on the conclusions that they generate."<sup>305</sup> Additionally, contrary to the rule cited by the *N.N.V.* court, there is a strong legal tradition of allowing expert testimony to challenge the prevailing standard of care.<sup>306</sup> It is proper for a fact finder to hear expert testimony on the scientific method, view the available scientific evidence, and then to decide whether the standard-setting defendant, in its establishment of the standard of care, acted with scientific or unscientific motivations. The *N.N.V.* court recognized this principle in its mooted examination of the breach of a standard of care.<sup>307</sup> The court would have held the AABB in breach if it had "failed to use the knowledge, skill and care ordinarily exercised by members of the relevant community."<sup>308</sup>

In a potential case against the AAP for its position on circumcision, the claim would not be based upon the assertion that the AAP made the wrong choice in a scientific debate. The claim would be that in establishing a standard of care and in issuing guidelines—as was demonstrated throughout Parts I and II above—the AAP failed to follow well-established principles of scientific analysis. The AAP glossed over methodological problems and flaws in the UTI and STD research upon which it relied. It ignored research findings concerning complications, STDs, and cancer that contradicted its positions, instead of explaining why these findings should not receive credit. It misstated findings on complication rates such that they would support its position. Additionally, the AAP failed to pursue trails of evidence about behavioral effects of circumcision, physical characteristics of the foreskin, and possible monetary and vindictive motivations that may

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303. *Id.* at 904 (quoting *Osborn v. Irwin Mem. Blood Bank*, 7 Cal. Rptr. 2d 101, 125(1992)).

304. *See N.N.V.*, 89 Cal. Rptr. 2d at 901 (quoting the brief of appellant *N.N.V.*: "Rather than institute measures to protect patients, . . . the AABB elected to pursue a course of action to merely diminish the perception of the danger of AIDS and reduce questioning about the safety of the blood supply.").

305. 509 U.S. 579, 595 n.11 (1993) (finding FED. R. EVID. 702 applicable to established as well as novel scientific techniques).

306. *See N.N.V.*, 89 Cal. Rptr. 2d at 903 ("[A]n expert is not permitted to 'second guess an entire profession' as to what the standard of care should have been."). *But see supra* notes 210-12 and accompanying text (allowing challenges to the standard of care of an entire profession).

307. *See N.N.V.*, 89 Cal. Rptr. 2d at 909 (choosing to address the issue of a breach of the standard of care only after already ruling that the AABB owed no duty of care to *N.N.V.*).

308. *Id.* at 909-10.

have influenced the proponents of circumcision upon whom the AAP relied.<sup>309</sup>

The opinion of Justice Amos in *N.N.V.*, while concurring in not finding the AABB in breach of a duty of care, dissented from the majority's refusal to hold the AABB to a standard of care.<sup>310</sup> He observed that under the majority's refusal to apply a standard of care upon the AABB, the hypothetical result could occur whereby the AABB would not have been required to recommend the ELISA test for the presence of the AIDS virus in blood once it had become available.<sup>311</sup> Justice Amos also noted that, without the imposition of a duty of care upon the AABB, monetary "considerations of the members of the AABB" would likely influence "the decision making process and may pose an obstacle to change or reconsideration of standards."<sup>312</sup> Thus, one of the three justices on the appellate panel found it proper to impose a duty of care on the standard setting and guideline issuing activities of a medical trade association. In a potential case against the AAP, a court should similarly impose a duty of care upon the AAP as a guideline issuing trade association. Under the considerations used in the *N.N.V.* case, it should also find the AAP in breach of that duty for failing to analyze circumcision in a scientifically proper manner.

*F. POSSIBILITY THAT EVIDENCE MIGHT SUPPORT FRAUDULENT  
MISREPRESENTATION RATHER THAN NEGLIGENCE*

This Note has argued that the 1989 and 1999 AAP's task forces' disregard for scientific protocol in analyzing the available data, led to negligent performance of a duty of care. This section, however, will analyze a potential intentional and fraudulent misrepresentation claim against the AAP, based upon the work of the 1989 task forces on circumcision. In 1983, Hugh C. Thompson, the chair of the 1975 AAP task force, authored an editorial relating the deep and emotional division within the 1975 AAP task force.<sup>313</sup> The forthright admission by the chair of the 1975 task force that

309. See *infra* Part III(F) (presenting evidence that motivations other than the health of infant boys have influenced the AAP circumcision task forces and pro-circumcision researchers).

310. See *N.N.V.*, 89 Cal. Rptr. 2d at 917 (Amos, J., concurring and dissenting) (concurring that the AABB did not breach a duty of care, but dissenting with the majority's finding that no standard of care should apply to the AABB in this case).

311. See *id.* at 917 (Amos, J., concurring and dissenting) (extrapolating a hypothetical result under the majority's refusal to impose a duty of care).

312. *Id.*

313. See Hugh C. Thompson, *supra* note 12, at 940 (exposing the internal conflict that occurred on the committee). Thompson wrote:

The ad hoc committee was sharply divided in its opinions, and the resulting statement was a compromise that stated there was "no *absolute* medical indication for *routine* circumcision of the newborn." The words *absolute* and *routine* were meant to convey a different impression from the conclusion of the [1971] AAP Committee on the Fetus and the Newborn.

*Id.*

there were deep divisions of opinion due to the information available at the time displayed an appropriate attitude toward the publishing of scientific findings. When the available information did not support a conclusion, it was appropriate to say that no conclusion was possible.<sup>314</sup>

In contrast, the bias of the chair of the 1989 task force, Edgar J. Schoen, was revealed in a 1987 letter to the editor of a medical journal.<sup>315</sup> The letter contained a sarcastic poem that also appeared to impart veiled personal attacks on opponents of routine neonatal circumcision.<sup>316</sup> This bias helps to explain all the misleading statements that appeared in the 1989 report, which appear to have been designed to induce faulty inferences in the reader.<sup>317</sup>

Also pertinent to an evaluation of the conduct of the 1989 AAP task force, is a law review article examining the role of medical practice guidelines which observed, "[p]hysician specialists may realize economic gains when particular guidelines are promulgated."<sup>318</sup> The author, John D. Ayres,

314. See AAP 1975 report, *supra* note 10, at 611 (1975) ("There is no absolute medical indication for routine circumcision of the newborn. . . . Therefore, circumcision of the male neonate cannot be considered an essential component of adequate total health care.")

315. Dr. Schoen crafted this poem as follows:

Ode to the Circumcised Male

We have a new topic to heat up our passions—the foreskin is currently top of the fashions.

If you're the new son of a Berkeley professor, your genital skin will be greater, not lesser.

For if you've been circ'ed or are Moslem or Jewish, you're outside the mode; you are old-ish not new-ish.

You have broken the latest society rules; you may never get into the finest of schools.

Noncircumcised males are the "genital chic"—if your foreskin is gone, you are now up the creek.

It's a great work of art like the statue of Venus, if you're wearing a hat on the head of your penis.

When you gaze through a looking glass, don't think of Alice; don't rue that you suffered a rape of your phallus.

Just hope that one day you can say with a smile that your glans ain't passe; it will rise up in style. *Id.*

Edgar J. Schoen, Letter to the Editor, 141 AM. J. DISEASES CHILDREN 128 (1987).

316. See *id.* (using labels and terms such as "Berkeley professor," "society rules," "genital chic"). Dr. Schoen seems ignorant of the fact that, considering the lack of a solid medical foundation for performing circumcision, if anything could be termed a *fashion*, it would be the alteration of infant male genitalia to suit the *cultural (i.e. cosmetic)* tastes of many American parents. He seems further ignorant of the fact that if there is now a cultural preference for circumcision among parents in the United States, it is largely the result of decades of erroneous assurances of medical justifications disseminated to the public by the medical profession. This is an error that his poem and his chairmanship of the 1989 AAP task force have perpetuated.

317. See generally *supra* Part I (explaining how the 1989 AAP task force omitted findings and used sentence structure in an apparent effort to obscure results that questioned the utility of circumcision).

318. John D. Ayres, *The Use and Abuse of Medical Practice Guidelines*, 15 J. LEGAL MED. 421, 436 (1994).

also warned, “[p]atient selection bias and institutional and personal financial gains introduce ‘subtle biases into the conduct, analysis, or reporting of research results that may escape even careful peer review.’”<sup>319</sup> Consequently, the author recommended, “[c]omplete disclosure of economic interests in parameter development must be included within the body of the guideline. Medical specialty societies, insurers, physicians, or any party that participates in guideline formation should acknowledge any economic self-interests inherent in the procedures that might be incorporated into a guideline.”<sup>320</sup>

There is evidence—on which to build a case—that the AAP, as a representative of pediatricians who collectively stood to gain, had a monetary stake in promoting the continuation of circumcision. A 1987 statement of Dr. Thomas Wiswell—the author of the late 1980’s articles reporting lower UTI rates among circumcised baby boys—addressed monetary incentives with circumcision. The *Boston Globe*, in a June 22, 1987 article, quoted Dr. Wiswell as saying, “I have some good friends who are obstetricians outside the military, and they look at a foreskin and almost see a \$125 price tag on it. Each one is that much money. Heck, if you do 10 a week, that’s over \$1,000 a week, and they don’t take that much time.”<sup>321</sup> Both obstetricians and pediatricians perform circumcisions and therefore stood to gain economically from the continued practice.

A reasonably prudent medical society, with the health interests of infant boys as a main concern, should have taken notice of this statement by Dr. Wiswell. It should then have been hesitant to base its change of position on his research, especially once it recognized methodological problems in the research. Circumcision, a medical procedure without any sound evidence of a benefit to health, should have been classified as experimental. Once proponents of this procedure displayed an acute awareness of monetary reward, the AAP could have further downgraded circumcision to a purely cosmetic—and possibly harmful—procedure, with all the ethical permutations this would have toward using parental consent.<sup>322</sup>

The AAP’s choice in ignoring the obvious and vociferous bias of Dr. Schoen, and further choice in placing him as chair of the 1989 task force, is evidence that the AAP was more interested in buttressing the continued practice of circumcision than in objectively evaluating scientific evidence. Then, to base a change in policy on the “new evidence” of Dr. Wiswell, when he seemed well aware of an industry monetary incentive to promote circumcision, and when the AAP task force had recognized methodological problems with his UTI studies, reinforces suspicion that the AAP let non-

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319. *Id.* at 442.

320. *Id.* at 438.

321. Betsy A. Lehman, *The Age-Old Question of Circumcision*, BOSTON GLOBE, June 22, 1987, at 41 (quoting Dr. Wiswell).

322. See *supra* notes 201-06 and accompanying text (discussing ethical considerations in general and as applied to female genital mutilation).

medical motives determine its recommendations. Finally, for the AAP to not disclose the monetary incentives that existed to promote the procedure is irresponsible and as is being argued here, possibly deceptive.

#### G. PROFESSIONAL ORGANIZATIONS OPPOSING CIRCUMCISION

Some doctors and nurses have begun to organize and voice their opposition to the legitimacy of circumcision as a medical practice.<sup>323</sup> Additionally, there is now an organization of lawyers committed to challenging the legality of circumcision.<sup>324</sup> These professionals have challenged all infant circumcisions, medical or otherwise, on the bases of constitutional, criminal, and international human rights laws, and have offered their services to plaintiffs in civil cases against individual physicians and hospitals.<sup>325</sup> This Note has proposed, however, that it has specifically been the AAP that has violated a duty of care by decades of erroneously and falsely touting medical benefits and lack of risks involved with circumcision.

It should also be noted that a jury can award meaningful damages for the removal of an infant's foreskin without the consent of his parents. David J. Llewellyn, an Atlanta attorney, wrote an article relating the facts and outcome of this 1992 lawsuit brought against the Jackson Hospital and Clinic in Montgomery, Alabama.<sup>326</sup> Following a trial for the performance of the circumcision without the consent of the mother, a jury awarded \$10,000 in past damages and \$55,000 in future damages.<sup>327</sup> Obviously, this jury was persuaded by the expert testimony presented that the pain suffered was compensable, and that the foreskin had value as a part of a child's body in his present and future life. This is helpful for any future action against the AAP involving a claim of lack of informed consent. Parents that can show that they would not have chosen to circumcise their son, had they known the full extent of complications and the functional value of the foreskin, should have a valid informed consent claim if they or their physician relied upon AAP materials.

#### IV. RECOMMENDATIONS

The AAP, as a medical trade association, has an ethical and, as was ar-

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323. See *supra* note 281 and accompanying text.

324. See Attorneys for the Rights of the Child (visited Jan. 27, 1999) <<http://www.noharm.org/ARC.htm>> (presenting the views of this organization).

325. See *id.* (presenting legal strategies for the organization and legal practitioners willing to take on circumcision medical malpractice cases against individual physicians and hospitals); see also Chessler, *supra* note 202, at 573-75 (drawing similarities between the cultural justifications given for female genital alterations in other countries and those given for infant male circumcision in this country). The author then proposes constitutional and international human rights legal attacks upon physicians and hospitals for any alteration of any child's genitals and analyzes the potential utility of each. *Id.* at 586-603.

326. See Llewellyn, *supra* note 74 (relating the story of the \$65,000 award of total damages for the removal of a baby boy's foreskin without the consent of his parents).

327. *Id.*

gued here, a legal responsibility to provide accurate and truthful advice to parents and physicians concerning circumcision and the health of baby boys. The 1989 report of the AAP Task Force on Circumcision was not an accurate and truthful accounting of the state of scientific knowledge concerning the medical efficacy of circumcision. The 1999 AAP Task Force on Circumcision policy statement also has flaws and may likewise be culpable for failing to adhere to the generally accepted scientific and professional preference for valuing methodology in assessing the soundness of existing information. The responsible course of action for the AAP would be to admit that the evidence does not now support, and never has supported, the continued routine performing of circumcision on infant males. The AAP should alert pediatricians and obstetricians that, collectively, they have been engaging in an irresponsible and uncoordinated century-long experimental effort to blame the foreskin for whatever illness can possibly be ascribed to it and to recommend the amputation of this body tissue as the necessary prophylactic. It is time for the AAP to stop perpetuating a history of flawed justifications for circumcision and to begin working to halt the practice. Like the AAP position taken for alterations on the genitals of female minors, the AAP and ACOG should officially encourage their members to inform parents that they will not perform painful and medically unnecessary procedures that alter normal, healthy, and functional genitalia.

In the alternative, assuming that the AAP, ACOG, and individual physicians can reasonably hypothesize beneficial utility that a century of research has failed to prove, circumcision should be comprehensively reclassified as experimental and/or cosmetic surgery and thus be subject to all the laws governing such therapies. Parents who still choose this surgery for their baby boys should do so only after a much more rigorous informed consent process. All infants who then undergo this surgery should be made part of nationwide prospective research studies into the true complication rates and health results, pro and con, that this surgery holds for men. In any future brochures or publications on the subject, the AAP and ACOG should fully disclose the medical profession's succession of erroneous rationalizations used to justify circumcision for more than a century. Additionally, the AAP should disclose alternative sources of information, so that it does not convey to parents the false impression that there are no medical professionals who oppose, or who have opposed, routine circumcision of infants.

If the preceding actions are not undertaken voluntarily, the AAP and ACOG should be named as co-defendants in legal actions involving circumcisions that have resulted in serious injury or death. In addition to damages, claimants should seek injunctive relief to enforce upon these medical trade associations the responsible action called for under existing or new law reflecting the duties required under section 324A of the Restatement (Second) of Torts. In all jurisdictions, courts and legislatures should be urged to adopt law embodying the reasoning of the New Jersey Supreme Court in the *Snyder* case. Whether or not serious injury occurred during a circumcision, parents

who feel they were misled by information supplied by the AAP and physicians should explore causes of action based on lack of informed consent, negligent misrepresentation, and possibly even fraudulent misrepresentation.

Medical societies, like other trade associations, should not be insulated from judicial review for practices that they both recommend and engage in. Judicial scrutiny for the proper use of the scientific method is a necessary safeguard for a public that consumes recommended or available medical services. This scrutiny must be applied in judging the motivations for, and processes of, decision making in standard setting medical organizations—such as the AAP—when they are engaged in publishing authoritative guidelines. As has been demonstrated above with regard to the AAP's analysis of circumcision, a professional medical organization may not always follow scientific methods, nor consider all the important variables, both of which can perpetuate an unnecessary or harmful standard of care within a specialty.

#### CONCLUSION

The AAP has failed to classify circumcision as experimental or cosmetic and to inform parents of the full and true nature of this procedure. If the AAP can, in good faith, still permit routine circumcision to be called medical practice, it must call for, or itself fund and promote, thorough prospective studies of circumcision and obtain reliable information about this surgery. A tragedy, such as that which befell little Dustin Evans, Jr., should not fail to be ascribed to complication statistics for circumcision, through being reclassified as only a rare consequence of anesthesia. Dustin Evans, Jr.'s death must be classified as a complication of circumcision. Absent responsible action, with the continued routine practice of this surgery, the AAP and ACOG may well find themselves named as codefendants—either by plaintiffs or by defendant physicians and hospitals—in every action brought for a botched or nonconsensual circumcision. Additionally, Attorneys for the Rights of the Child, and the groups of medical personnel opposed to circumcision, will undoubtedly continue to explore every legal avenue to put a halt to this unnecessary and harmful surgery.

As author Anne Briggs observed, in her book *Circumcision: What Every Parent Should Know*, "the vast majority of the men in both developed and undeveloped countries of the world are uncircumcised."<sup>328</sup> The American public should question why there is no outcry in these areas of the world for the supposedly *proven* health advantages of this surgery. In 1980, Edward Wallerstein, in *Circumcision: An American Health Fallacy*, pointed out, "Today circumcision is a solution in search of a problem."<sup>329</sup> This statement unfortunately still rings true twenty years later. The AAP, through a failure to follow scientific protocol, should not perpetuate harm on baby boys and their parents, in order to cover up past harm.

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328. BRIGGS, *supra* note 1, at 164.

329. WALLERSTEIN, *supra* note 1, at 197.