

The 2012 AAP Policy Statement: Skinning the New Policy on Circumcision

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The American Academy of Pediatricians (AAP) caused a stir in the medical, and more so, in the human rights fields when it issued a policy statement on August 27, 2012, concluding that circumcision of male newborns has preventive health benefits that outweigh the risks of the procedure.¹ The turnaround earned criticisms from activists who wanted to outlaw the procedure. The AAP's move seemed so sudden that there were those who questioned the motive of the people directly involved in the modification of the policy statement.² However, an analysis of the development of the present AAP policy statement revealed that it was not so sudden after all. Neither was it a whimsical reversal, as the AAP records would show.³ Although the question of whether there are specific interests and ulterior motives may not be erased, it is a fact that the new policy statement stepped on the shoulders of the previous statements to reach its present conclusion and had been a work-in-progress since 1975.

Earlier AAP Policy Statements on circumcision

From 1971, the American Academy of Pediatricians has been making policy statements on circumcision. Its long-standing policy was a recommendation that circumcision not be a routine procedure for male infants, as seen in its 1971, 1975, 1977, 1989, 1997, 1999, and even in the 2012, policy statements. The excerpts of these policy statements are as follows:

1971

"There are no valid medical indications for circumcision in the neonatal period."⁴

1975

"The Committee on Fetus and Newborn of the American Academy of Pediatrics stated in 1971 that there are no valid medical indications for circumcision in the neonatal period. The present committee has undertaken a review of data to support arguments 'pro' and 'con' circumcision of the newborn, and finds no basis for changing this statement."⁵

1977

"There are no medical indications for routine circumcisions, and the procedure cannot be considered an essential component of health care."⁶

¹ American Academy of Pediatrics Task Force on Circumcision, *Circumcision Policy Statement*, 130(3) PEDIATRICS 585, 585-586 (2012), <http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1989>.

² See Doctors Opposing Circumcision, *Commentary on American Academy of Pediatrics 2012 Circumcision Policy Statement*, (Aug. 26, 2012, Sept. 4, 2012 revised), http://www.doctorsopposingcircumcision.org/pdf/2012-08-26A_Commentary.pdf.

³ The Circumcision Reference Library, *American Academy of Pediatrics Policy Statements*, (Mar. 15, 2008), <http://www.cirp.org/library/statements/aap/>.

⁴ AMERICAN ACADEMY OF PEDIATRICS COMMITTEE ON FETUS AND NEWBORN, STANDARDS AND RECOMMENDATION FOR HOSPITAL CARE OF NEWBORN INFANTS 110 (5th ed. 1971), *excerpt available at* <http://www.cirp.org/library/statements/aap/#1971>.

⁵ Hugh C. Thompson, et al., *Report of the Ad Hoc Task Force on Circumcision*, 56(4) PEDIATRICS 610, 610 (1975), *available at* <http://www.cirp.org/library/statements/aap/#a1975>.

⁶ AMERICAN ACADEMY OF PEDIATRICS COMMITTEE ON FETUS AND NEWBORN, STANDARDS AND RECOMMENDATION FOR HOSPITAL CARE OF NEWBORN INFANTS 66 (6th ed. 1977), *excerpt available at* <http://www.cirp.org/library/statements/aap/#a1977>.

1989 (Addendum to the 1975 Policy Statement)

“Since the 1975 report, new evidence has suggested possible medical benefits from newborn circumcision. Preliminary data suggest the incidence of urinary tract infection in male infants may be reduced when this procedure is performed during the newborn period. There is also additional published information concerning the relationship of circumcision to sexually transmitted diseases and, in turn, the relationship of viral sexually transmitted diseases to cancer of the penis and cervix.”⁷

1997

“It is emphasized that newborn circumcision is an elective procedure to be performed at the request of the parents when the infant is physiologically and clinically stable. Because of the lack of hard scientific data, a firm recommendation for appropriate method of pain control was not provided. The AAP has recently convened a task force to review new information available since the writing of the Guidelines with the goal of making specific recommendations on this issue.”⁸

1999

“Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision. In the case of circumcision, in which there are potential benefits and risks, yet the procedure is not essential to the child’s current well-being, parents should determine what is in the best interest of the child.”⁹

The common thread in all of the above policy statements is that the AAP was not recommending circumcision as a routine procedure for the care of newborn baby boys. Nonetheless, it is noticeable that the policy has loosened over time from the almost rigid policy. It considered new evidence for possible medical benefits of the procedure as stated in the 1999 Policy Statement, albeit emphasizing that the procedure was not essential. The 1999 Policy Statement was subsequently reaffirmed in 2000 and 2005.¹⁰ It was in 1975, however, that AAP began considering some medical factors relating to positive effects of circumcision, foremost was the hygiene of a circumcised penis.¹¹

The 2012 AAP Policy Statement

As mentioned in the outset, the AAP released its new policy statement on circumcision in August 2012. It relevantly states that:

“Systematic evaluation of English-language peer-reviewed literature from 1995 through 2010 indicates that preventive health benefits of elective circumcision of male newborns outweigh the risks of the procedure. ... Although health benefits are not great enough to recommend routine circumcision for

⁷ American Academy of Pediatrics Task Force on Circumcision, *Report of the Task Force on Circumcision*, 84(2) PEDIATRICS 388, 388 (1989), <http://pediatrics.aappublications.org/content/84/2/388.abstract>.

⁸ William Oh & Gerald Merenstein, *Fourth Edition of the Guidelines for Perinatal Care: Summary of Changes*, 100(6) PEDIATRICS 1021, 1022 (1997), excerpt available at <http://www.cirp.org/library/statements/aap/#a1997>.

⁹ American Academy of Pediatrics Task Force on Circumcision, *Circumcision Policy Statement*, 103(3) PEDIATRICS 686, 686 (1999), <http://pediatrics.aappublications.org/content/103/3/686.full>.

¹⁰ Joseph D. Dickerman, *Circumcision in the time of HIV: When is there Enough Evidence to Revise the American Academy of Pediatrics’ Policy on Circumcision?*, 119(5) PEDIATRICS 1006, 1006 (2007), <http://pediatrics.aappublications.org/content/119/5/1006.full>.

¹¹ Hugh C. Thompson, et al., *Report of the Ad Hoc Task Force on Circumcision*, 56(4) PEDIATRICS 610, 610 (1975), available at <http://www.cirp.org/library/statements/aap/#a1975>.

all male newborns, the benefits of circumcision are sufficient to justify access to this procedure for families choosing it and to warrant third-party payment for circumcision of male newborns.”¹²

The wording of the 2012 Policy Statement adhered to the policy of non-recommendation of routine circumcision. It, however, deviated from its predecessors in stating that the health benefits of neonatal circumcision now outweigh the risks of the procedure. The potential benefits are now recognized by the new policy statement. An additional element in the new policy is the AAP’s justification of third-party payment for the cost of the procedure.

The AAP’s new policy is the result of its meta-analysis of peer-reviewed articles of selected topics relating to circumcision.¹³ It should be noted that even before the AAP had come to a conclusion that it should modify its policy statement, there had been published articles which were pushing for a review of the AAP policy. The 1999 Policy Statement left the question of sufficiency of evidence although it had recognized that there were potential medical benefits brought by circumcision. Thus, this was the main topic in Dr. Joseph Dickerman’s¹⁴ commentary published in *Pediatrics*, where he asked the question of when evidence may be considered sufficient to change a policy.¹⁵

Dr. Dickerman posited that medical evidence linking circumcision to prevention of specific diseases was underappreciated, but ample enough to warrant change in the AAP policy. He mentioned three studies conducted in Africa showing that male circumcision has prophylactic effect against Human Immunodeficiency Virus (HIV) and other sexually transmitted diseases such as syphilis, chancroid and genital herpes.¹⁶ Circumcision also allegedly prevents penile cancer and protects circumcised men from human papilloma virus (HPV) infection, which would consequently reduce the risk of women contracting HPV and cervical cancer.¹⁷ Other diseases that are believed to be prevented by circumcision are balanoposthitis, phimosis, paraphimosis, and penile dermatosis.¹⁸ A more immediate benefit for the male infants is the prevention of urinary tract infection (UTI).¹⁹ Dr. Dickerman noted that the AAP enumerated six evidence-based benefits and only one minor risk from the procedure, which was a surgical complication rate of a .2 to .6%.²⁰ With all those factors weighing in favor of circumcision, Dr. Dickerman called for a revision of the policy.

Dr. Edgar J. Schoen, a member of the AAP Task Force responsible for the 1989 Addendum, made a similar argument in *Pediatrics* and urged the acknowledgment of evidence in favor of circumcision.²¹ In his commentary, he disclosed perceived irregularities in making the previous policy statements. According to him,

¹² American Academy of Pediatrics Task Force on Circumcision, *Circumcision Policy Statement*, 130(3) PEDIATRICS 585, 585 (2012), <http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1989>.

¹³ American Academy of Pediatrics Task Force on Circumcision, *Male Circumcision*, 130(3) PEDIATRICS e756, e761 (2012), <http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1990>.

¹⁴ Dr. Joseph Dickerman was affiliated with the Department of Pediatrics, University of Vermont College of Medicine, Burlington, Vermont.

¹⁵ Joseph D. Dickerman, *Circumcision in the time of HIV: When is there Enough Evidence to Revise the American Academy of Pediatrics’ Policy on Circumcision?*, 119(5) PEDIATRICS 1006 (2007), <http://pediatrics.aappublications.org/content/119/5/1006.full>.

¹⁶ *Id* at 1006.

¹⁷ *Id* at 1006.

¹⁸ *Id* at 1006.

¹⁹ *Id* at 1006.

²⁰ *Id* at 1006.

²¹ Edgar J. Schoen, *Ignoring Evidence of Circumcision Benefits*, 118(1) PEDIATRICS 385 (2006), <http://pediatrics.aappublications.org/content/118/1/385.full>.

the original one-liner policy statement in 1971 was an erroneous one as it ignored the published urologic literature at that time. He also stated that there was an anti-circumcision policy until 1987, which was changed by the evidence that the incidence of UTI decreased because of circumcision.²² Prior to his chairmanship of the Addendum Task Force, evidence of health benefits of circumcision was ignored. However, when the new task force was formed in 1999, anti-circumcision sentiment surfaced anew. Despite additional evidence in favor of neonatal circumcision, the 1999 Task Force still issued a recommendation against routine procedure.²³

In response to various calls for a review of evidence on circumcision, the AAP formed a task force in 2007 to conduct a reevaluation of its 1999 recommendation. The task force was meant to be multidisciplinary. A glance at its composition shows that the members came from different committees on *Pediatrics*, including committees on Fetus and Newborn, on Bioethics, on Urology, on Anesthesiology, and on Child Health Financing.²⁴ The task force found that current evidence indicates that neonatal circumcision has health benefits that outweigh the risks of the procedure.²⁵ These are mainly the prevention of those diseases noted by Dr. Dickerman. However, among the diseases reviewed by the task force, there are only a few in which the task force found good evidence that circumcision has a prophylactic effect. Circumcision has a preventive effect against HIV only in heterosexual individuals and against UTIs for infants and boys.²⁶ The review of the rest of the diseases had a non-definitive result due to inconsistent evidence.

The AAP acknowledged that circumcision indeed has health advantages, minimal at that. These “minimal” health advantages still outweigh the risks. Thus, the AAP recommended that circumcision procedure be available for families who choose it, but that it should only be performed to an infant in a stable and healthy condition. The AAP also recommended counseling of families about the potential risks and benefits of elective male circumcision, in a nonbiased manner, to be undertaken by the physician. It also endorsed collaboration of key professional organizations, specifically AAP, the American Academy of Family Physicians, the American Congress of Obstetricians and Gynecologists, the American Society of Anesthesiologists, the American College of Nurse Midwives, and other midlevel clinicians such as nurse practitioners, to develop educational materials for clinicians and parents alike. The purpose of the materials for clinicians would be to enhance practitioner’s skills in communicating the benefits and risks of circumcision to parents; while for parents of male infants, the material would educate and assist them with the care of both circumcised and uncircumcised penises.²⁷

One of the AAP recommendations that seemed to have diverged the most from its earlier policies is the push for third party reimbursement of the procedure. While it is true that AAP did not recommend circumcision as a routine procedure, removing financial impediments to the procedure would likely encourage undecided parents to have the procedure done.

Critique of the 2012 AAP Policy Statement

Regardless of whether the new policy is a wise one, there are areas about the new policy worth examining, especially the recommendation for non-biased discussion between the physician and the parents.

²² *Id* at 385.

²³ *Id* at 385-386.

²⁴ American Academy of Pediatrics Task Force on Circumcision, *Circumcision Policy Statement*, 130(3) PEDIATRICS 585, 586 (2012), <http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1989>.

²⁵ *Id* at 585.

²⁶ *Id* at 585.

²⁷ American Academy of Pediatrics Task Force on Circumcision, *Male Circumcision*, 130(3) PEDIATRICS e756, e757 (2012), <http://pediatrics.aappublications.org/content/early/2012/08/22/peds.2012-1990>.

The concept of a non-biased discussion about circumcision between the physician and the parents sounds like good policy. Nevertheless, it sounds too good to be true. First, the technical report failed to make a thorough review of the risks vis-à-vis the benefits, which may show that the task force either did not want to truly disclose the risks or that it is not equally informed about the details behind those risk statistics. For instance, in relation to the methods and devices used for circumcision, it did not mention that in 2000, there was an FDA warning against circumcision clamps, specifically the Gomco- and the Mogen-type clamps.²⁸ As the FDA 2002 report states, “*the number of reports has gone down since we issued the warning [in 2000], but they continue to come in, and the injuries, rare as they are, continue to be serious.*”²⁹ These serious injuries include laceration, hemorrhage, urethral damage and penile amputation,³⁰ which were hardly mentioned in the task force report. The task force failed to take into consideration the risks that the devices themselves pose. Although the report briefly mentioned some statistics about risks relating to the methods used, it did not identify specific possible consequences.

Secondly, although the task force was said to be multidisciplinary, the members were all in the same general field of medicine – which was pediatrics. Thus, the threat of bias in favor of circumcision would be difficult to overlook, especially when the physicians themselves would benefit from it. Circumcision is not a charitable procedure but for a cost, and thus every good word by the physician for the procedure may be clouded by self-interest in the listener’s perspective. In addition, what would ensure that the physician would take time and effort to truly educate the parents of a male infant so that they could independently decide for themselves whether to choose circumcision or not? Malpractice may be one, but if there is no known or apparent complication from the procedure, the parents who were not fully informed may not have a cause of action or may be deterred from suing in court, if in the end, they realized that it was not for the best interest of their child. The parents would, thus, be left with only a feeling of regret. Also, pediatricians would have a bias towards performing the procedure while the child is young, since children are their area of focus and therefore, their main interest.

Looking at the 2012 AAP Policy Statement with a skeptical eye but also with hope, one can say that it is an improvement over the earlier policies. There is an effort to respect the autonomy of parents in choosing what is best for their child. There is also an effort to explain and to be transparent in how the Task Force reached its conclusion, which gives the readers an opportunity to critically analyze the report and the resultant modified policy. The policy statement still refused to recommend circumcision as a routine procedure. There should therefore be a mechanism for an “informed election” to help parents choose. The recommendation of the AAP for a collaborative work with professional medical organizations and other health providers to develop educational materials to inform parents and other clinicians regarding the risks and benefits of circumcision, may not be sufficient to have an unbiased and non-coercive effect on the parents. It should be noted, however, that pediatricians are not the only ones who conduct circumcision procedures as Ob-Gyn likewise performs neonatal circumcision. This fact, somehow, provides an assurance that the policy was not merely for an ulterior motive as the “business” would not be monopolized by pediatricians. To completely erase the doubt regarding the AAP’s motive, the AAP may need other individuals outside its organization to adequately deal with the cultural, social, legal and other non-medical factors that may be helpful and influential for the parents to reach an informed choice.

²⁸Food and Drug Administration, *Avoiding Patient Injuries from Circumcision Clamps*, FDA Patient Safety News Show 4 (May 2002) <http://www.accessdata.fda.gov/psn/transcript.cfm?show=4>.

²⁹ *Id.*

³⁰ *Id.*

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