

Cultural Bias and Circumcision: The AAP Task Force on Circumcision Responds

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The members of the American Academy of Pediatrics (AAP) Task Force on Circumcision appreciate the opportunity to respond to the concerns raised by Frisch et al in their commentary, "Cultural Bias in AAP's 2012 Technical Report and Policy Statement on Male Circumcision."

The central claim of these authors is that the conclusions of the task force report are culturally biased, leading the task force to a flawed understanding of what constitutes trustworthy evidence and to conclusions that are far from those reached by physicians in most other Western countries. The "obvious" cultural bias to which they refer apparently has its genesis in "the normality of non-therapeutic male circumcision in the US." All of the commentary authors hail from Europe, where the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis. In contrast, approximately half of US males are circumcised, and half are not.¹ Although that heterogeneity may lead to a more tolerant view toward circumcision in the United States than in Europe, the cultural "bias" in the United States is much more likely to be a neutral one than that found in Europe, where there is a clear bias against circumcision. Yet, the commentary's authors have, at no point, recognized that their own cultural bias may exist in equal, if not greater, measure than any cultural bias that might exist among the members of the AAP Task Force on Circumcision. If cultural bias influences the review of available evidence, then a culture that is comfortable with both the circumcised penis and the uncircumcised penis would seem predisposed to a more dispassionate analysis of the scientific literature than a culture with a bias that is either strongly opposed to circumcision or strongly in favor of it.

The task force's process was systematic, objective, comprehensive, and transparently documented in its technical report.¹ Members of the AAP Task Force on Circumcision were recruited on the basis of area of expertise. There was no consideration or knowledge of the individuals' beliefs concerning circumcision at the time of their appointment. Unlike other published policy statements and reports on circumcision, the task force did not selectively choose which articles to review, but reviewed all of the available literature identified in a comprehensive search and evaluated those manuscripts by using previously established, nationally recognized guidelines to determine the quality of the data being reviewed.² Some articles were reviewed but not cited in the technical report, either because they were not data-based studies, the quality of the study was seriously flawed, or the findings of the study did not meaningfully address the specific area of task force inquiry.

Frisch et al present opinions that reflect a review of the literature that is not comprehensive, systematic, or unbiased. For example, the authors

dismiss the data related to urinary tract infection on the grounds that no randomized controlled trial has been performed, despite the fact that there is good evidence from other studies that suggest a preventive benefit of circumcision. At the same time, they readily dismiss 3 randomized controlled trials and 11 other studies that provide good to fair evidence of a reduction in HIV acquisition associated with circumcision. They claim that these data are “contradicted by other studies, which show no relationship between HIV infection rates and circumcision status,” yet support that claim with only a single reference to a review article authored by the vice president of an organization opposed to circumcision. We would refer the reader to the task force’s technical report for a comprehensive review of the literature related to the potential benefits of circumcision.¹ Notably, the World Health Organization has concluded that the data strongly support a benefit of male circumcision with regard to prevention of HIV infection and has issued guidelines for its use, both for adults/adolescents and for neonates.³

COMPLICATIONS

Frisch et al charge that members of the AAP Task Force on Circumcision “consider the foreskin to be a part of the male body that has no meaningful function in sexuality.” They additionally claim, “Recent studies ... suggest that circumcision desensitizes the penis and may lead to sexual problems in circumcised men and their partners.” In fact, many of these studies were reviewed by members of the task force but were not cited in the technical report, either because the findings were equivocal, they did not support a benefit or detriment with regard to sexual function and pleasure, or because the relevance to

individuals undergoing circumcision during infancy was questionable. For example, the authors cite 5 studies to support the claim that “the foreskin is a richly innervated structure that protects the glans and plays an important role in the mechanical function of the penis during sexual acts.” Of these 5 studies, 4 were histologic studies that were not designed to correlate anatomic findings with physiologic or functional roles.^{4–7} Members of the task force appreciate that the foreskin has nerve fibers: the task force clearly recommends adequate pain control for infants undergoing circumcision. However, the task force did not move beyond what these studies actually reveal (the foreskin has nerve bundles and pain fibers, the foreskin contains Meissner corpuscles, the inner surface of the foreskin resembles a mucous membrane) to speculate about the effect that circumcision might have on sexual function or pleasure. The fifth study cited was designed to determine whether the absence of the penile-cavernosus reflex is a reliable indicator of a pathologic sacral lesion and did not evaluate implications for sexual function or pleasure.⁸ In sum, of the 5 studies, not one sought to evaluate whether the foreskin protects the glans or whether it “plays an important role in the mechanical function of the penis during sexual acts.”

The authors cite 2 articles as evidence that “circumcision desensitizes the penis.” One of these is not a study and does not present data.⁹ The other revealed that perception sensitivity to vibration decreases after circumcision.¹⁰ Neither the clinical implications nor impact on sexual experience were evaluated.

Finally, Frisch et al cite 7 studies to support their contention that circumcision may lead to sexual problems in circumcised men and their partners.

Four of the studies involved only men circumcised as adults^{11–14} or some men circumcised as adults.¹⁵ Men circumcised as adults most frequently have the procedure performed for medical reasons, which introduces both physical and psychological factors that may affect their reporting of sexual difficulties. In 2 of the studies cited by Frisch et al, a significant number of men reported improved satisfaction after circumcision.^{11,13} Interestingly, another of their cited studies¹⁴ concluded that circumcision had neither a negative nor a positive effect on the female partner’s perception of sexual satisfaction, a conclusion that contradicts that of Frisch et al. The shortcomings of the study by Sorrels et al¹⁶ are discussed in our technical report. Finally, the study by Frisch et al used a cross-sectional survey of Danish men that found that circumcised men were more likely to report sexual difficulties than uncircumcised men.¹⁷ Circumcised men represented only 5% of 2343 sexually experienced survey respondents, and only 15% of those circumcised men ($n = 17$) had the procedure in the first 6 months of life. Attributing these findings to decreased penile sensitivity is a stretch. It seems far more likely that the findings are attributable to the kinds of social bias the authors attribute to the AAP task force. Male circumcision is rare in Denmark, rare enough that circumcised males are epidemiologic outliers, which may lead some of them to feel “different,” leading to anxiety about sexual experiences with women who perceive a circumcised penis as abnormal. In addition, because many of the circumcised men had the procedure performed later in life, some likely for medical reasons, they are far from representative of a group of men circumcised as infants. It should be noted that the findings of the Danish survey contrast starkly to

those of 2 randomized controlled trials from Africa, which are discussed in the AAP technical report.^{18,19}

AGE AT CIRCUMCISION

A central claim of Frisch et al is that if circumcision is to be performed before an age at which an individual can decide for himself, there must be a compelling reason for doing so. They argue that there is no compelling reason for performing a circumcision before sexual debut and additionally claim that “sexually transmitted HIV infection is not a relevant threat to children.”

Underlying the authors' views are several presuppositions that reflect the ideal, but not the reality, of human decision making. The first of these is that the responsible use of condoms will “provide close to 100% reduction in risk for any STIs.” We agree, and fully support efforts to make sexual activity as safe as possible through the routine use of condoms. However, despite huge educational efforts, many individuals around the world do not use condoms consistently. If they did, sexually transmitted infection and HIV would decline to the point of nonexistence. The added protective benefit of circumcision exists precisely because responsible condom use is far from universal. In 2011, 39.8% of sexually active high school students in the United States reported not using a condom during their last sexual intercourse.²⁰ Condoms represent one of several tools for reducing the risk of infections transmitted during sexual contact. Circumcision is another.

The claim that “sexually transmitted HIV infection is not a relevant threat to children” is incorrect given the US data. In 2011, sexual debut occurred at or before age 13 years for 6.2% of US high school students, and most people in the United States are sexually active before the age at which they would possess

the legal authority to consent to a circumcision.²⁰ A nationwide sample of adolescent females between the ages of 14 and 19 years estimated that 4 in 10 sexually active adolescent females have a sexually transmitted infection (defined as human papillomavirus, chlamydia, trichomoniasis, genital herpes virus, or gonorrhea).²¹ National HIV surveillance data show that, in 2008, there were at least 2266 HIV infections among US adolescents 13 to 19 years of age.²²

ETHICAL ISSUES

Frisch et al claim that “the AAP report lacks a serious discussion of the central ethical dilemma with, on one side, parents' right to act in the best interest of the child ... and, on the other side, infant boys' basic right to physical integrity in the absence of compelling reasons for surgery.” The authors' argument about the basic right to physical integrity is an important one, but it needs to be balanced by other considerations. The right to physical integrity is easier to defend in the context of a procedure that offers no potential benefit, but the assertion by Frisch et al of ‘no benefit’ is clearly contradicted by the published scientific peer-reviewed evidence. Although task force members did not find the data sufficiently compelling to justify a recommendation for routine neonatal circumcision, we did find that the benefits are substantial enough to allow parents to make this decision for their male children. This stance is very similar to that of The Canadian Medical Society, the British Medical Association, and the Royal Australasian College of Physicians. Frisch et al appeal to the ethical precept “First, do no harm,” but they fail to recognize that in situations in which a preventive benefit exists, harm can also be done by failing to act. Whereas there are rare

situations in which a male will be harmed by a circumcision procedure, it is also true that some males will be harmed by not being circumcised. Simply because it is difficult to identify exactly which individuals have suffered a harm because they were not circumcised should not lead one to discount the very real harms that might befall some men by not being circumcised. There is no easy answer to this issue ethically. Regardless of what decision is made on behalf of a young male, harm might result from that decision. That is precisely why the AAP task force members found that this decision properly remains with parents and that parents should have information about both potential benefits and potential harms as they make this decision for their child.

TASK FORCE ON CIRCUMCISION 2012

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