A Review of the 2012 American Academy of Pediatrics Circumcision Policy Statement

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Introduction

In August 2012 the American Academy of Pediatrics (AAP) published[1] an update of its 1999 recommendation regarding male circumcision. In contrast to the previous statement that concluded that the potential medical benefits were not sufficient to warrant routine circumcision, the new statement clearly stated that: "***the health benefits of newborn male circumcision outweigh the risks …furthermore justify access to this procedure for those families who choose it.***" No less importantly, ***"as parents are entitled to factually non biased information about circumcision***" it was recommended that they should receive this information from clinicians before conception or in early pregnancy when they are most likely deciding on the option of circumcision. In view of this major pronouncement from what is the preeminent pediatric organization in the United States and one of the major influences on pediatric care worldwide it was felt that this new message should be brought to the attention of a wider audience. As such, this review will highlight those areas of interest and discussion that are relevant to the readers of *Jewish Medical Ethics*.

The health benefits of newborn male circumcision outweigh the risks … furthermore justify access to this procedure for those families who choose

The formal Policy Statement of the AAP was the product of a 5 year review of the recently published peer reviewed scientific evidence by a specially constituted Task Force of the AAP and included representatives from the Committee on Fetus and Newborn, Section on Urology, Section on Anesthesiology and Pain Medicine, Committee on Bioethics and liaisons representing the American Academy of Family Physicians, American College of Obstetrics and Gynecology (ACOG) and the Centers for Disease Control and Prevention (CDC). The conclusions were fully endorsed by the American College of Obstetricians and Gynecologists. The Policy Statement was supplemented by a 29 page Technical Report which included 248 references of the scientific articles reviewed.[2]

Recommendations

Of interest, the major initial focus of the technical report was a discussion of the ethical issues of the procedure. The underlying principle in the Task Force's discussion was that parents are legally and ethically empowered to make health care decisions on behalf of their minor children. These decisions should be based on informed parental consent and reflect their ethical duty as parents "to secure the child's best interest and wellbeing". Furthermore, it was the opinion of the AAP that it is reasonable to take into account the cultural, religious and familial benefits to circumcising the male infant and, thus, the parents'

[1] Task Force on Circumcision, "Circumcision Policy Statement," *Pediatrics*, 2012;130:585-586.

[2] Task Force on Circumcision, "Male Circumcision, Technical Report," *Pediatrics.* 2012;130:e756-785.

determination what is in the best interest of child can include these non-medical variables.

Most importantly, and in contrast to other medical organization's review of the scientific evidence,[3] the AAP Task Force systematically analyzed the published literature and assigned a level of evidence based on the now standardized template for evidence evaluation. Articles that scored 5 or higher (i.e. less hard evidence) were not included in the review.

What was the evidence that the AAP Task Force presented that served as the basis of their conclusions?

Review of the peer reviewed literature published since 1995 noted consistent reports of a "protective effect of 40-60% for male circumcision in reducing the risk of HIV acquisition among heterosexual males in area with high HIV prevalence". In addition, good evidence exists from a randomized controlled trial that circumcision is associated with lower prevalence of other sexually transmitted diseases such as human papillomavirus (HPV), herpes simplex virus type 2 (HSV-2), and bacterial vaginosis. Less strong evidence exists regarding the protective effect for syphilis and no evidence exists that it protects against gonorrhea or chlamydia. While most of these data come from studies in Africa in heterosexual males, the Task Force cited a recent CDC study[4] that analyzed by mathematical modeling what would be the effect of circumcision on the United States population. The CDC concluded that there would be an 8% reduction in HIV infections in non-Hispanic white males and 21% reduction non-Hispanic black males if currently non circumcised males were circumcised. The CDC, thus, noted that such a policy of circumcision in the developed world is also cost effective and, therefore, all parents should be given the choice of circumcision. Good evidence also exists that circumcision reduces the risk of urinary tract infection (UTI) in children under 2 years of age. The reduction is on the order of 3-10 fold (depending on the study). A prospective study noted a decrease from 7-14 UTI cases per 1000 uncircumcised infants as opposed to 1-2 cases per 1000 circumcised infants.

Similarly, there is good evidence that sexual function is not adversely affected in circumcised males

Given the fact that the rate of penile cancer is relatively rare and is declining even in non-circumcised populations, plus the weak quality of the data, the Task Force concluded that it is difficult to measure or even quantitate any beneficial effect of circumcision on the prevalence of penile cancer. As such, the relationship of circumcision to penile cancer was not a major consideration in the formulation of their recommendations. Similarly, they concluded that the contribution of male circumcision in preventing cervical cancer "is likely to be small"

Of major interest was the Task Force evaluation of the oft declared objections to circumcisions resulting from a concern regarding decreased sexual satisfaction and function in circumcised males. In contrast to this unsubstantiated concern, the Task Force emphasized that the all literature reports exactly the opposite e.g. that there is increased sexual pleasure and satisfaction, less penile pain and greater sensitivity in the circumcised male. Similarly, there is good evidence that sexual function is not adversely affected in circumcised males.

Additional issues of interest

The Task Force addressed the issue of medical versus traditional providers. The conclusion based on available data was that the complication rate from non-trained providers was significantly higher than the rate from trained providers. In the opinion of the Task Force, trained providers can be physicians, nurses, or "traditional religious providers" (*Mohalim*). Of interest, they cited an Israeli study[5] that compared the complication rate from non-ritual hospital based

[3] Royal Dutch Medical Association. The non-therapeutic circumcision of male minors, *KNMC*, May 2010.

[4] Samsom SL, Prabhu VS, Hutchinson AB, *et al.* Cost effectiveness of newborn circumcision in reducing lifetime HIV risk among US males, *PLoS ONE* 2010;5:e8723.

[5] Ben Chaim J, Livne PM, Binyamin J, *et al.* Complications of circumcision in Israel: a one year multicenter survey, *Isr Med Assoc J*, 2005;7:368-370.

physician performed circumcisions to "home based circumcisions performed by well-trained ritual circumcisers." Comparing the two groups they found no difference in the complication rate. The key was the level of training, not the academic degree.

Given that circumcision is an elective surgical procedure it was the opinion of the Task Force that there are two key elements of good medical practice that must be incorporated into the provider's routine.

1. Sterility routines and precautions to minimize risk of infection.
2. Proper use analgesia. In particular the Task Force noted that oral sugar containing liquids (e.g. sugar water, sweet wine) are insufficient, while either topical anesthesia ointment or dorsal penile bloc is the preferred way to minimize infant pain.

Given the clear "preventive and public health benefits associated with male circumcision" the Task Force strongly endorses the recommendation that third party reimbursement for circumcision become a standard of the medical insurance industry. In the words of the CDC: "Financial barriers that prevent parents from having the choice to circumcise their male newborns should be reduced or eliminated."

Most importantly, the underlying thread throughout the document was the emphasis on the responsibility (almost phrased as an obligation) of the physician to present in an unbiased manner the information regarding the weight of evidence of the medical benefits of circumcision, so that parents can make a truly informed decision. As such, it is clear that it is the physician's professional obligation (legal and ethical) to raise in a pro-active fashion to all parents the issue of infant circumcision so a decision can be made for the "best interest and benefit of the child."

International Responsa Project

Practical laws that should be observed while in the anatomy lab

Shalom,

I am trying to compile a list of practical laws that should be observed while in the anatomy lab. Shulchan Aruch in Yoreh Deah 367 and 368 lists halachos that apply to Jewish cemeteries:

1. Do any of these laws apply to anatomy lab, assuming that the cadavers are non-Jewish?
2. For instance, is it technically permitted to eat or drink in the anatomy lab?
3. Also, would any of the customs/laws followed by a chevra kadisha apply?
4. For example, is it permitted to pass objects across the cadaver or leave the face uncovered even when not dissecting the face?
5. Also, Shulchan Aruch Orach Chaim 4:18 requires washing hands after touching a cadaver, does this apply to non-Jewish cadavers in the anatomy lab?

Are there any teshuvos or journal articles that deal with these types of questions?

Thank you very much,

Answer:

1. The answer is affirmative.
2. It is not permissible to eat or drink in the described anatomy lab.
3. In general, the Minhagim of the Chevra Kadisha apply only to deceased that they are in charge of, but Minhagiom that have to do with Kvod Hamet apply in every case.
4. Actions and conventions depicted in this question originate with basic dignity – kvod hamet, and therefore apply universally.
5. The obligation to wash the hands after touching the dead exists in any case.

Answered by: Dr. M. Halperin at 6/7/2012