

Circumcision Policy: A Psychosocial Perspective

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The debate about the advisability of circumcision in English-speaking countries has typically focused on the potential health factors. The position statements of committees from national medical organizations are expected to be evidence-based; however, the contentiousness of the ongoing debate suggests that other factors are involved. Various potential factors related to psychology, sociology, religion and culture may also underlie policy decisions. These factors could affect the values and attitudes of medical committee members, the process of evaluating the medical literature and the medical literature itself. Although medical professionals highly value rationality, it can be difficult to conduct a rational and objective evaluation of an emotional and controversial topic such as circumcision. A negotiated compromise between polarized committee factions could introduce additional psychosocial factors. These possibilities are speculative, not conclusive. It is recommended that an open discussion of psychosocial factors take place and that the potential biases of committee members be recognized.

Key Words: *Circumcision; Evidence-based medicine; Health policy; Peer review*

The debate about the advisability of non-therapeutic neonatal circumcision in English-speaking countries typically has focused on potential health factors (e.g., prevention of infection and disease). The conflicting opinions and conclusions in the medical literature on circumcision, together with the tenacity with which advocates and critics of circumcision hold on to their viewpoints suggest that deep unrecognized or implicit psychosocial factors are involved (1). The existence of these factors may influence decision-making on national circumcision policies. The present article contends that by taking these factors into account, the policy making process and the policies produced can be improved.

This discussion focuses primarily on American circumcision policy, with pertinent discussion of other countries, because the United States has the highest nonreligious circumcision rate, the most contentious circumcision debate, the most detailed circumcision policy statement, and the most international influence. Circumcision practice in other countries has been introduced by contacts with Americans (2), and American circumcision advocates promote circumcision to other countries (3). In Canada, the circumcision policy statement is based on references that are about 75% American (4).

Policy makers do not change policies unless the pressure to change is greater than the pressure to maintain the status quo (5). These pressures can include policy makers' personal attitudes and opinions (internal emotional factors) and responses from the social environment (external social-political factors). Obviously, psychosocial factors cannot be examined to the degree that empirical data can be. Therefore, the present article explores only plausible options for identifying these factors, with support from psychosocial and medical literature, and statements by members of the American Academy of Pediatrics (AAP) Task Force on Circumcision.

INTERNAL EMOTIONAL FACTORS

The AAP, similar to other English-speaking medical organisations, does not recommend circumcision but accepts it as a parental option (4, 6-10). Circumcision advocates believe that 'substantial medical evidence' favours their view and, because they haven't received the endorsement of circumcision they want from the AAP, they accuse that body of 'anticircumcision bias' (11). Circumcision advocates have never explained why policy-makers would have an 'anticircumcision bias.' Circumcision advocates also have not addressed the fact that there are people who would be expected to have personal, religious, and professional reasons for supporting circumcision who are against the practice (e.g., some circumcised men, Jews, and doctors who stopped performing nontherapeutic neonatal circumcisions).

On the other hand, there are various factors that may contribute to or suggest a bias in favour of circumcision. A survey of randomly selected primary care physicians showed that circumcision was more often supported by doctors who were older, male, and circumcised (12). Minimising evidence of harm and using medical claims to defend circumcision when that evidence is conflicting at best, could be some of the unconscious ways for some male physicians to avoid the emotional discomfort of questioning their own circumcision (13). (Of note, the AAP Task Force on Circumcision was composed of five men and two women.)

Studies also indicate that protecting self-esteem sometimes takes priority over being accurate or correct, and potentially threatening information may be reinterpreted or dismissed, sometimes unconsciously, as a result (14, 15). Other research has demonstrated that people will continue an endeavour once they have invested time and effort (16). To avoid inconsistency between beliefs and experience (i.e., cognitive dissonance), beliefs about circumcision tend to be aligned with the experience of performing circumcisions (17). For physicians who have performed hundreds or thousands of circumcisions (or have chosen circumcision for their own son), the possible use of such psychological

defence mechanisms to deny some of the evidence against circumcision could serve, in part, to protect their self-esteem, which could be adversely affected by the conscious recognition that circumcision may harm infants. A few members of the AAP Task Force on Circumcision have routinely performed circumcisions, and, consistent with the above psychosocial research, those members also tended to be the ones who advocated circumcision (18). This relationship suggests that the attitudes about circumcision of at least some committee members were already set at the start of the policy review, and their attitudes may have been unaffected by what they found in the literature.

EXTERNAL SOCIAL-POLITICAL FACTORS

Social influence can alter scientific inquiry. For example, if circumcision were introduced today, proponents would have the burden of proving that it is safe and effective. Although policy committees agree that this burden has not been satisfied, circumcision is evaluated as a long-standing practice and, as such, it is viewed differently than a new practice. Due to social and professional entrenchment, the burden of proof has shifted to the shoulders of critics. The ubiquity of circumcision in America may influence which questions are researched and which are ignored in American medical circumcision literature. Most American studies that assess the advisability of circumcision focus on the search for a benefit. Accordingly, one AAP Task Force on Circumcision member stated that the committee was formed "to determine if there was scientific evidence to justify circumcision" (18). The answer is limited by the assumption inherent in the statement of the problem. Although claims of benefits generally do not withstand the scrutiny of policy committees, their continued publication over the years has led to medical myths believed by professionals and the public (19).

Policy statements from medical organisations in other English-speaking countries are generally more critical of circumcision, but they still tolerate it. Given the lack of proven safety and effectiveness, the principle of 'first, do no harm,' and the priority of the patient's welfare over parental requests, why have these organizations not published stronger statements opposing circumcision? The answer may be related to the fact that in public discussions about circumcision in Canada and Britain, religious groups were the only ones to defend the practice (20-22). Some Europeans believe that the reluctance to criticize circumcision is due to fear of being accused of religious intolerance (23). This type of concern may have been involved when an investigation of circumcision by Australian authorities was halted after Jewish protest (24). Furthermore, in response to an inquiry about discouraging nontherapeutic circumcision, a representative of the United States Department of Health and Human Services stated that "it is not proper for our Government to adopt a policy that is directly or indirectly critical of a religious practice" (L. Mahoney, personal communication, March 8, 1994).

Social factors may also be present and operating within the AAP Task Force on Circumcision itself. In a deposition related to a circumcision lawsuit, a member of the AAP Task Force on Circumcision admitted that the task force was divided on the question of the advisability of circumcision (18). There are also indications of conflict from previous task forces. In the year following the publication of the 1989 position statement (25), one of the dissenting members of that task force published a review article with a different conclusion (26). In an unusual disclosure, the chair of the 1975 task force revealed that the "committee was sharply divided in its opinions, and the resulting statement was a compromise" (27). This documentation is the most direct evidence that AAP circumcision policy statements have required negotiation and compromise, introducing additional psychosocial factors and making the circumcision policy less evidence-based.

The AAP Task Force on Circumcision's attitude toward recently published reports on different aspects of circumcision is not known because these reports were published after the AAP policy was published (28-43). However, subsequent position statements by several other medical organizations omitted discussion of some or all of this literature. Specifically, the American Medical Association (7) and the Canadian Paediatric Society (4) did not mention the sexual, psychological, human rights, and legal aspects of circumcision. The Royal Australasian College of Physicians' policy briefly mentions psychological trauma and human rights, and discusses legal issues with no mention of sexual issues (8). The British Medical Association's policy briefly mentions sexual and psychological issues, and discusses legal and human rights issues (9).

SUMMARY AND RECOMMENDATIONS

Although medical committee members highly value rationality, a rational and objective evaluation of an emotional and controversial topic like circumcision can be difficult. It is suggested that the potential psychological and social factors surrounding the practice of circumcision could affect the values and attitudes of circumcision policy committee members, the attitude toward evaluating the circumcision literature, and the publishing of circumcision literature itself. If the members are polarized, the process of negotiating to arrive at a consensus statement could introduce additional psychosocial factors that could affect the final policy. These possibilities are speculative, not conclusive.

There are examples of authorities in English-speaking countries who appear to allow religious circumcision practice to inhibit them from taking a more progressive position on this issue. This tendency seems to result in a policy stance that is less evidence-based. Sensitivity to confronting the religious issue is understandable, but it may undermine the core values (e.g., the health of the patient is paramount) and ethics (e.g., first, do no harm) that drive medical decision-making. Policy makers could respond to accusations of religious intolerance rationally and compassionately rather than allow the fear of such accusations to hinder policy development (44). Other recommendations for improving circumcision policy-making include acknowledging any conflicts, paying focused attention to psychosocial factors, and expanding professional and public discussion.

Dealing with psychosocial factors can start with recognizing the potential bias of committee members. Conflict of interest is not just financial. Perhaps future candidates for membership in circumcision policy committees should disclose their circumcision status (previously suggested [45]), number of circumcisions performed, circumcision status of any male children, and religious or ethnic background. Disclosure of this information would help in the assessment of the credibility of the committee and its work. Members of such committees should be held to at least the same standard as peer reviewers. As stated by the International Committee of Medical Journal Editors, "any conflicts of interest that could bias their opinions" should be disclosed, and reviewers "should disqualify themselves from reviewing specific manuscripts if they believe it to be appropriate" (46). Similarly, those responsible for selecting members of circumcision policy committees should be aware of potential members' conflicts of interest to determine if a member should be disqualified. Including more women, to minimize the influence of internal emotional factors, and a member with psychosocial training and background could also help deliberations. Policy statements from other fields, such as psychology, sociology, anthropology, and ethics could expand perspectives and understanding.

In the meantime, medical organizations should be aware of the potential legal implications associated with a flawed policy. A law journal article (47) claimed that the failure to act in a scientifically responsible manner could make a medical society liable for trade association misconduct connected with publishing negligent recommendations on circumcision.

Disclosure: The author is Jewish, circumcised, has no male children, and has not circumcised anyone.

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