

Bias and Male Circumcision

To the Editor: As a physician without a strong opinion about male circumcision (MC), I found the article by Morris et al¹ in the May 2014 issue of *Mayo Clinic Proceedings* initially convincing, but on closer inspection, it is marred by bias. The authors make no mention of position statements against MC^{2,3} or strong international critique of the American Academy of Pediatrics (AAP) position,⁴ and they omit the AAP's own conclusion that "health benefits are not great enough to recommend routine circumcision for all male newborns."⁵ Ignoring this equipoise, they claim that MC benefits "vastly exceed" risks and suggest that parents who do not authorize MC are unethical and violate the rights of children. The bias does not stop there. Morris et al claim that important analyses were published since the AAP report, but the reference citations are to Morris's own work—one article that is unavailable on PubMed and one without any references likely to affect the AAP policy. Table 4 in their article suggests the risk of penile cancer from nonreceipt of MC is 1 per 1000.¹ However, the AAP notes that up to 322,000 circumcisions and 644 complications may be needed per cancer avoided—possibly more, because the rate is falling and human papillomavirus vaccination (likely to attenuate other benefits of MC) should further lower it, and, in the absence of phimosis, retention of the foreskin may be protective.² They entirely dismiss potential harms of MC on male sexual experience, ignoring male self-report of MC harm that makes MC controversial to begin with. Is the distress of these men irrelevant? Morris has previously claimed that the statement "the foreskin has a functional role" is not "supported by research,"³ which would surely perplex many men who value or miss their foreskins. Although I do not feel strongly about MC, I do believe that any issue deserves a dispassionate review of the facts. Morris et al, who note potential

"cosmetic" advantages of infant MC over adult MC while claiming correction of harelip has "no medical benefit," did not provide a dispassionate review,¹ and readers may want to consider alternative viewpoints.^{2,4}

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In reply—Bias and Male Circumcision

We thank Dr Jenkins for his letter but disagree with his comments. The position statement by the Canadian Paediatrics Society he cites is nearly 2 decades old and will shortly be replaced by a new policy¹ reported to be in line with the affirmative American Academy of Pediatrics (AAP) policy.² Jenkins also refers to a dated, non-evidence-based policy placed on the Internet by the pediatrics division of the Royal Australasian College of Physicians (RACP), but then cites as a reference a withering critique of that flawed policy by Fellows of the RACP and other professional medical bodies that was published in an official journal of the RACP after peer review.³

Jenkins seems unaware that the so-called strong international critique of the AAP position by European doctors

was convincingly rebutted by the AAP's Task Force, who argued persuasively that cultural bias was evident in Europe, not the United States.⁴

Contrary to Jenkins' quote, the AAP concluded that "evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks," "significant complications are rare," and the benefits "justify access to this procedure for families who choose it."² The AAP also stated that "parents should weigh the health benefits and risks in light of their own religious, cultural, and personal preferences, as the medical benefits alone may not outweigh these other considerations for individual families."² When added to the AAP's recommendation that there be unbiased parental education, sterile technique, adequate physician training, effective pain management, and third-party coverage, the policy is as strong a recommendation as might be possible in the current era of autonomy in which even vaccinations can be refused by parents.

Our conclusion that benefits vastly exceed risks is based on a detailed risk-benefits analysis, not an ad hoc "claim." Given this, it would indeed be unethical for parents to deny the right of their male children to the protection afforded by male circumcision against adverse medical conditions, some of which are quite serious or even fatal.

The AAP report considered the literature to early 2010, meaning numerous studies were not cited, not just our own in peer-reviewed journals.

In his discourse on penile cancer, Jenkins refers to the AAP but cites the Canadian Paediatrics Society policy. The AAP's policy states, "909 circumcisions to prevent 1 penile cancer event" and "2 complications...for every penile cancer event avoided."² The study the AAP cites is of higher quality than the one Jenkins "cherry picks." The former accords, moreover, with our 1 in 1000 figure in Table 4 for lifetime prevalence in uncircumcised males. Although the human papillomavirus (HPV) vaccine

will help lower the rate of penile cancer, the vaccine is directed at only the 2 most common oncogenic HPV types, and only half of penile cancers contain HPV. Thus, vaccination and MC should be seen as complementary.⁵ Phimosis, balanitis, and smegma are also risk factors.⁶ It is inconceivable that “retention of the foreskin may be protective.”

Jenkins' claim of “potential harms of MC on male sexual experience” has no scientific support. Self-report is not evidence. Any “controversy” likely stems from misinformation placed on the Internet by lobby groups who dupe gullible men into believing that their sexual problems stem from their infant circumcision. A recent methodologically impeccable systematic review and meta-analysis has established that MC has no adverse effect on male sexual function, sensitivity, or satisfaction.⁷

The “other viewpoints” Dr Jenkins wants us to consider have been dismissed by the AAP Task Force on Circumcision.⁴ Arguments used to discredit the AAP policy have been exposed as spurious.⁸

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Curbside Consultations: A Call for More Investigation Into a Common Practice

To the Editor: In their grounded theory study published in the May 2014 issue of *Mayo Clinic Proceedings*, Cook et al¹ examined the important issue of curbside consultations. They determined via focus groups of selected physicians that curbside consultations are a valuable practice in clinical medicine and suggested that they merit institutional support. A common theme in the focus groups was that curbside consultations foster effective, bidirectional communication that does not occur when using a static resource such as a textbook, Web-based resource, or literature search to answer a clinical question. The perception among physicians was that a curbside consultation is superior to looking up the answer oneself and that cases that are complex or do not fit textbook descriptions of illness benefit most from these informal discussions.¹ We would argue, however, that formal consultation is the criterion standard to which the curbside consultation should be compared.

Known benefits of curbside consultations are improved access to specialty care within some hospital systems and better coordination of care because referring physicians may not receive timely or complete communication from specialists following formal consultation.² Another suggested benefit of curbside consultations is that they save health care organizations money, but we can

find no definitive data proving that this is true.¹ In fact, a curbside consultation might lead an expert to recommend expensive testing that may have been deemed unnecessary if they had interviewed and examined the patient in a formal consultation. Theoretically, some curbside consultations may increase health care costs and expose patients to unnecessary complications. Physicians in the focus groups believed curbside consultations to be valuable because they provide individualized answers that “bolster patient confidence.”¹ However, recommendations provided by specialists who have not had a face-to-face encounter with the patient may be more generalized than personalized and could provide false reassurance if they are based on the exchange of inaccurate information. In our study comparing inpatient curbside consultations with subsequent formal consultations, we found that the physician being sought out for curbside consultation received inaccurate or incomplete information in about half of the cases. This finding was independent of the level of training of the physician requesting the consultation.³ Another study by a neurosurgical group found that information they received over the phone was often inaccurate and their recommendations were often misinterpreted or misrecorded in the patient chart.⁴ These 2 studies examining the quality of information that is exchanged in curbside consultations are small but cautionary.

We believe there are sufficient studies in the literature that comment on physician perceptions about curbside consultations and the amount of time physicians spend doing informal consultations. There is likely a role for curbside consultations; however, the most appropriate clinical settings are still unknown. We urge future studies that (1) determine which types of curbside consultations, if any, are safe and should be encouraged in clinical practice and (2) aim to prove or disprove the theory that curbside consultations save health