


Why Are We Cutting? A Survey of Cultural Views on Circumcision in the Texas Panhandle

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Abstract

To determine the factors that may contribute to parents' decision to circumcise their son in the Texas Panhandle region, voluntary surveys were distributed to all mothers with term male newborns during the mandatory discharge planning class. The father being circumcised ($P < .0001$), Caucasian ($P < .05$), and some graduate school of the caregiver ($P < .011$) were factors most correlated with newborns being circumcised. Newborns of Hispanic origin, those having Medicaid insurance, and a Catholic affiliation were less likely to be circumcised. No significant correlations were found between circumcision and other ethnic affiliations, caregiver's age, father's involvement, and medical counseling. Of note, one third of caregivers were not counseled by a medical professional about circumcision. While the American Academy of Pediatrics Circumcision Policy Statement is clear that a neutral position must be maintained, this does not preclude having a discussion of the benefits versus the risks of circumcision.

Keywords

circumcision, health behavior, culture

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In 2012, the American Academy of Pediatrics (AAP) asserted that neonatal male circumcision provides enough medical benefit to justify continued access to this procedure on an elective basis, and in 2015, the Centers for Disease Control and Prevention (CDC) issued a statement recommending male circumcision for all infants.^{1,2} The medical benefits cited by the CDC include prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted diseases such as human immunodeficiency virus.² The AAP advised, however, that pediatricians must remain neutral with regard to their recommendations for parents.¹ In practice, taking a neutral stance likely means that familial, cultural, and religious factors will weigh more heavily in parents' decision to circumcise their sons.³⁻⁶ Previous studies have demonstrated that a father being circumcised as well as influence of medical providers played most heavily in a parent's choice.³ In order to better serve our community by understanding the local practices at our institution, a referral center for the Northern Texas Panhandle, we sought to determine what factors most contributed to a decision to circumcise. The Texas Panhandle is home to a diverse population

including refugees from Myanmar, Somalia, Iran, and Iraq.^{7,8} We postulated that the rates of circumcision would be high and that religious and other familial factors would be most influential.

Materials and Methods

Institutional review board approval was obtained for this prospective, observational study in which mothers of term newborn male infants born at Northwest Texas Hospital and cared for in the normal newborn nursery were surveyed from February 5, 2013, to January 31, 2014. Surveys were handed out and collected by the

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discharge planning nurse during the Discharge Planning Class, which is offered and highly recommended to all new mothers. In this class, circumcision is discussed by the discharge planning nurse. The surveys were voluntary and distributed and collected without identifying data. Mothers and babies with complicated perinatal courses were excluded. English and Spanish surveys were provided. No compensation was offered or given for participation in the survey. We collected 291 surveys, 222 of which met the inclusion criteria. Sixty-nine were excluded because mothers stayed in the hospital for more than 3 days and 21 were excluded because parents did not indicate the circumcision status of the baby, resulting in 201 surveys that could be included for study.

Data analysis was conducted by a statistician. A *t* test was used to determine the relationship between the child's circumcision status and the mother's age. A χ^2 test was used to examine the relationship between the child's circumcision status and demographic factors including father's circumcision status, father's involvement, child's ethnicity, religious affiliation, Medicaid status, and counseling performed by a medical professional.

Results

Circumcisions were performed in 87% of the total patients during this period. Represented ethnic groups include a white majority (56%), Hispanics (35%), blacks (5%), and Asians (3.8%).^{5,7} Infant demographics are indicated in Table 1, and Maternal demographics are indicated in Table 2. The circumcision status of the father is the most highly correlated factor with regard to the infant also being circumcised ($P < .0001$). Newborns are more likely to be circumcised if their caregiver identifies as White ($P < .05$) and less likely if their caregiver identifies as Hispanic ($P < .001$). Caregivers whose infants were circumcised had significantly higher education levels than those who were not circumcised (Cramer's $V = 0.27$). In terms of religious affiliation, infants of caregivers who identified as Catholic were significantly less likely to be circumcised ($P < .05$). Infants were less likely to be circumcised if they were covered by Medicaid as opposed to private insurance ($P < .05$). There was found to be no association between caregiver age and circumcision, and of special interest, there was no association between newborn circumcision status and counseling by a medical professional, such as the primary care practitioner, about the procedure ($P = .21$). In fact, approximately one third of caregivers that chose circumcision and 44% of those who chose not to circumcise were not counseled by a medical professional prior to their decision.

Table 1. Infant Demographics.

	Circumcised	Not Circumcised
Average birth weight (g)	3356	3237
Average gestational age (weeks)	39.08	38.96
Father's circumcision status		
Circumcised	72%	37%
Not circumcised	17%	48%
When decision to circumcise was made		
Before birth	49%	26%
After birth	5%	4%
Infant ethnicity		
Caucasian	56%	30%
Hispanic	25%	59%
African American	9%	7%
Middle Eastern	1%	0%
Other	7%	4%

Table 2. Maternal Demographics.

	Circumcised	Not Circumcised
Counseling by a medical professional		
Yes	64%	52%
No	32%	44%
Average age of caregiver level	25.06 years	23.08 years
Educational level		
Some high school	7%	26%
Completed some high school/GED	34%	37%
Some college	36%	26%
Associates degree	4%	0%
Bachelor's degree	2%	0%
Some graduate school	2%	4%
Graduate degree	2%	4%
Father involvement		
Father involved	87%	81%
Father not involved	5%	11%
Religion		
Jewish	1%	0%
Catholic	19%	41%
Protestant	9%	4%
Muslim	1%	0%
Other	53%	41%
Medicaid payer		
Yes	71%	96%
No	20%	4%

Discussion

Neonatal male circumcision is generally performed for cultural/religious reasons and to prevent future medical problems.¹ For newborns, the risk of urinary tract infection

is most often cited although the other medical risks can also be discussed with parents.^{1,2} However, neonatal male circumcision continues to engender much discussion both in the lay press and the medical literature. A debate regarding some of these issues was part of an issue of the *Journal of Bioethics* in 2003.^{5,6} Nevertheless, circumcision rates in the United States have remained more or less static since at least 1979, although there have been ups and downs.^{2,9} Interestingly, geographic influences play a role with some areas of the country having higher circumcision rates than others.² The state of Texas falls within the states that have higher circumcision rates.^{2,9} Moreover, most studies of circumcisions performed in the United States do not include circumcisions performed out of the hospital, which has at least some impact on calculation of numbers.^{2,9} In our area, newborn male circumcisions may be performed in the office, as it is not done in some small rural hospitals, as well as for the convenience of some parents and practitioners. As in previous studies, our study demonstrates that an infant's father being circumcised remains the most consistent factor in determining whether the newborn male would be circumcised. This may be partially related to cultural factors; however, other cultural, educational, and religious influences also play important roles. As can be seen by our data, certain ethnic/cultural backgrounds are more likely to circumcise as opposed to others. The higher rate of circumcision among more educated parents may be related to their familiarity and access to data regarding the health benefits of circumcision. Therefore, the importance of the role of medical providers to guide parents through this process must be emphasized. In a recent study from Denmark, 5% of boys required circumcision at a mean age of 10 for complications related to diseases of the foreskin.¹⁰ All of these required general anesthesia with its adherent risks and inconvenience to the families and patients. Practitioners should be familiar with data such as these as well as the arguments against circumcision, which include it being a violation against a child's rights according to the United Nations' Declaration of the Rights of the Children.^{10,11} Although the AAP and CDC policy statements about the benefits of circumcision are clear, it is important to have a discussion with parents regarding the risks and benefits of newborn circumcision so that traditional factors are supplanted by educated decision making.

Author Contributions

JS: Contributed to conception and design; contributed to acquisition; drafted manuscript; critically revised manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

JM: Contributed to interpretation; drafted manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

JA: Contributed to conception and design; contributed to acquisition; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

KF: Contributed to conception and design; contributed to acquisition.

CS: Contributed to conception and design; contributed to acquisition; critically revised manuscript.

MN: Contributed to conception; contributed to interpretation; critically revised manuscript; gave final approval.

Declaration of Conflicting Interests

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