

Letters to the Editor

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It's Wise to Circumcise: Time to Change Policy

To the Editor.—

Since 1999, when the American Academy of Pediatrics (AAP) Task Force on Circumcision published its report,¹ new data have accumulated that reinforce the preventive health advantages of newborn circumcision: protection against severe infant urinary tract infection (UTI),² against penile cancer,^{3,4} against human immunodeficiency virus (HIV) infection,⁵ against penile dermatoses (eg, lichen planus and eczema)⁶—including the mechanism by which the foreskin predisposes to HIV infection⁷—and against balanoposthitis and phimosis. Observations from Sweden^{8,9} and from the United States¹⁰ indicate a higher prevalence of UTI in uncircumcised male infants than previously reported. Circumcision also improves genital hygiene throughout life, particularly during infancy and old age.

Powerful new data indicate that circumcision protects against penile acquisition of human papilloma virus (HPV) and that this protection reduces prevalence of cervical cancer in female partners of circumcised men.¹¹ Uncircumcised men were about 3 times as likely to have penile HPV, and female partners of promiscuous uncircumcised men with HPV had a statistically significantly increased risk for cervical cancer.^{11,12}

Findings linking the uncircumcised state to cervical cancer^{11,12} and recent data on multiple medical benefits of newborn circumcision^{2-6,8-10,13-17} make untenable the AAP position opposing routine circumcision.¹ That 1999 statement has been criticized as both misleading and internally inconsistent.¹⁸ One inconsistent aspect of the AAP report is that it opposed routine circumcision despite listing 6 evidence-based benefits of newborn circumcision (protection against UTI, penile cancer, HIV infection, balanoposthitis, and phimosis; and ease of genital hygiene) and only 1 documented disadvantage (possibility of rare minor surgical complications).¹

Social and sexual advantages of circumcision also have been shown. In a survey of California parents,¹⁹ those who chose not to have their newborn boys circumcised were later more likely to be dissatisfied than those who chose circumcision, and parents who decided against the procedure believed that they had been inadequately informed about it. In Texas, 85% of parents chose newborn circumcision²⁰; having a circumcised father and highly educated parents were strong factors in this choice.

On the subject of adult circumcision, 1 study showed no adverse effects on sexual function,²¹ and another study reported that 50% of men circumcised as adults believed that they had benefited from circumcision and that 62% were satisfied with the results.²² These findings support earlier reports of improved sexual function in circumcised men²³ and more sexual satisfaction in female partners of circumcised men,²⁴ mainly because of improved genital hygiene.

Analysis of lifetime effects of newborn circumcision has been hampered by compartmentalization into specialized research interests: internists and others concerned with infectious disease focus on studying sexually transmitted diseases (STDs) in young men; pediatricians focus on severe UTI in infants and on phimosis, balanoposthitis, and genital hygiene in children; penile cancer and hygiene problems occurring more commonly during old age are thus considered mainly in that context. These age-specific advan-

tages of circumcision are rarely consolidated into a comprehensive picture of disease prevention from birth through old age.

Parents of newborn boys should be aware of the lifelong health implications of circumcision status. To properly counsel these parents, pediatricians should be aware of the increasing documented medical evidence favoring newborn circumcision. On the basis of this evidence—much of it published since the 1999 AAP report—the AAP should reassess its position of not routinely recommending circumcision for male newborns.

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ACKNOWLEDGMENTS

Trinh T. To, BS, assisted with research of the topic. The Medical Editing Department of Kaiser Foundation Hospitals provided editorial assistance.

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Home Visiting

To the Editor.—

We read with great interest the article by Olds et al¹ on home visiting by paraprofessionals and nurses. Many of us across the disciplines are indebted to Dr Olds for the seminal work he and his colleagues have conducted over the last several decades demonstrating the efficacy of his nurse home visitation program in preventing a broad array of detrimental maternal health, life course, and child developmental outcomes. Dr Olds' work has been especially instrumental in the field of child abuse and neglect prevention, helping to spur the development of hundreds of preventive home visitation programs across the United States.

The findings reported in *Pediatrics* in September 2002 extend his earlier work by again demonstrating a wide array of positive benefits for mother-child pairs as a result of nurse home visitation, now across 3 different community settings: Elmira, New York, Memphis, Tennessee, and Denver, Colorado. We would like to caution the readers, however, concerning the conclusions they might be tempted to draw from this most recent study, which, on the face of it, appears as if Dr Olds has directly demonstrated the relative efficacy of nurses versus paraprofessionals as home visitors, in a way generalizable to other contexts. Dr Olds and colleagues, themselves, directly caution us, "Because of constraints of sample size and cost, the study was not designed to make direct comparisons between paraprofessionals and nurses."¹

Olds and colleagues attempted to statistically control post hoc for some of the observed nonequivalencies across nurse and paraprofessional home visitor groups occurring during the study's implementation, most notably in the substantially greater turnover that occurred among the paraprofessional home visitors, as well as in a lower intervention dosage paraprofessional home-visited families actually received. However, as reported, a lack of equivalence across the paraprofessional and nurse home visitor groups remains across several additional important factors, preventing direct comparisons of nurses versus paraprofessionals without additional, more careful study. Several examples stand out:

First, paraprofessional home visitors were substantially younger (mean age = 33) than nurse home visitors (mean age = 41),² and earlier research has indicated that worker age and pre-

vious work experience are key predictors of service effectiveness assessments.^{3,4,5}

Second, nurses and paraprofessionals received nonequivalent training: "Because nurses were expected to exercise more independent judgment in helping mothers deal with physical health concerns, the nurses were given more in-depth training on the physical health and development of the mother and child."⁶ In addition, nurses were provided specific training in "solution-focused" therapy techniques, whereas paraprofessionals were trained in an "alternate problem-solving method."⁷

Third, paraprofessionals and nurses implemented different program protocols. Some of these differences were planned,¹ while others were unplanned, resulting from paraprofessionals' discomfort with implementing a protocol that was originally designed for nurses.⁷ Such changes resulted in significantly different emphases in the home visit contents delivered across paraprofessional and nurse groupings, with nurses providing greater attention to personal health during pregnancy and parenting during infancy,⁷ areas in which outcome differences were found.

Fourth, "a sense of competition emerged between the nurse visitors and paraprofessional home visitors," where "performance anxiety emerged among the paraprofessionals themselves that paralleled the anxiety they felt in the presence of the nurse home visitors."² Such competition between treatment groups is a common threat to the internal validity, highlighted in Cook and Campbell's classic work on quasi-experimental research as "demoralization in groups receiving less desirable treatments."⁸ Given the lack of equivalence on a number of important factors across nurse and paraprofessional home visitor groups, differences reported in the magnitude of effects are difficult to attribute solely to the professional status of the service deliverers.

Rather than noting these as study limitations, Olds and colleagues suggest that problems in the implementation of their study design were "inherent in paraprofessional programs" (page 493). They proceed to add: "Although other paraprofessional program models might perform better than the one tested here, the absence of clinically or statistically significant effects for most paraprofessional models tested in randomized trials makes this unlikely" (page 493). Olds and colleagues here do not acknowledge the previous studies of paraprofessional home visitors that have reported important intervention effects,^{9–11} as well as previous studies employing nurses as home visitors that have failed to report significant program effects,^{12,13} leaving the impression that the scientific base has been selectively attended to. A recent meta-analysis has examined home visitation trials targeting parent-child outcomes related to child maltreatment, and has reported that when considering the full array of studies employing nurses and paraprofessionals, program engagement and retention rates are virtually indistinguishable across professional status types, as are observed effect sizes.¹⁴

Most limiting for the broader field, the paraprofessionals used in the Denver trial do not appear as representative, holding substantially less academic preparation and relevant prior training than home visitors employed in numerous other home visiting programs operating across the United States. As noted about the Denver trial, "in order to highlight the contrast between paraprofessional and nurse home visitors . . . [we] refrained from hiring [paraprofessional] applicants who possessed bachelors' level education" (page 80).² Paraprofessionals in the Denver trial held no academic credentials in relevant fields such as nursing, education, psychology, or social work, in direct contrast to paraprofessionals employed in some of the most widely disseminated home visiting programs in the United States, such as those within the Healthy Families America initiative¹⁵ or those employed in PAT ("Parents as Teachers") programs.^{16,17} A national study of Healthy Families America home visitors, for example, noted that 81% of the paraprofessionals held bachelor's degrees or some college experience, and 10% had post-bachelor's graduate training. As well, 85% had previous work experience in home visitation programs, most in the field of early childhood and child abuse and neglect, and 75% of the home visitors held specialized educational training in child development, social work, nursing, or education.¹⁸

Looking beyond the generalizability concerns of the Olds et al study, a number of other well-controlled home visitation studies have reported that nurses, paraprofessionals, and even graduate students can deliver home visiting services that provide positive benefit for at-risk families.¹⁴ Like any study, the Olds Denver trial taken forthrightly must be seen for its contributions as well as its