

Circumcision policy: A psychosocial perspective

Ronald Goldman PhD

R Goldman. Circumcision policy: A psychosocial perspective. *Paediatr Child Health* 2004;9(9):630-633.

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 nontherapeutic neonatal circumcision in English-speaking countries has typically focused on the potential health factors (eg, 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

La politique relative à la circoncision : Une perspective psychosociale

Le débat quant à l'opportunité de la circoncision dans les pays de langue anglaise a généralement été axé sur les facteurs de santé potentiels. On s'attend que les documents de principes des comités d'organisations médicales nationales soient fondés sur des faits probants, mais le caractère litigieux de ce débat laisse supposer la présence d'autres facteurs. Divers facteurs potentiels reliés à la psychologie, à la sociologie, à la religion et à la culture peuvent également être sous-jacents aux décisions de principe. Ces facteurs peuvent influencer sur les valeurs et les attitudes des membres des comités médicaux, sur le processus d'évaluation de la documentation médicale et sur la documentation médicale même. Bien que les professionnels de la santé accordent beaucoup d'importance à la rationalité, il peut être difficile de procéder à l'évaluation rationnelle et objective d'un sujet aussi controversé et émotionnel que la circoncision. Un compromis négocié entre les factions polarisées des comités risque d'introduire des facteurs psychosociaux supplémentaires. Ces possibilités sont spéculatives, non concluantes. Il est recommandé de tenir une discussion ouverte sur les facteurs psychosociaux et d'admettre les préjugés potentiels des membres des comités.

policy statement is based on references that are approximately 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 the policy-makers' personal attitudes and opinions (internal emotional factors) and responses from the social environment (external sociopolitical 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 organizations, 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

Circumcision Resource Center, Boston, Massachusetts, USA

Correspondence: Dr Ronald Goldman, Executive Director, Circumcision Resource Center, PO Box 232, Boston, Massachusetts 02133, USA.

Telephone/fax 617-523-0088, e-mail crc@circumcision.org

COPYRIGHT PULSUS GROUP INC. - DO NOT COPY

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 or professional reasons for supporting circumcision who are against the practice (eg, 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). Minimizing 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 (ie, 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 SOCIOPOLITICAL 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 organizations 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, their 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 (eg, the health of the patient is paramount) and ethics (eg, 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.

REFERENCES

1. Circumcision – The debate goes on. *Pediatrics* 2000;105:681-5. (Lett)
2. Kim D, Lee J, Pang M. Male circumcision: A South Korean perspective. *BJU Int* 1999;83(Suppl 1):28-33.
3. Schoen E. Benefits of newborn circumcision: Is Europe ignoring medical evidence? *Arch Dis Child* 1997;77:258-60.
4. Canadian Paediatric Society, Fetus and Newborn Committee. Neonatal circumcision revisited. *CMAJ* 1996;154:769-80.
5. Hennessey B. *Public Opinion*, 5th edn. Monterey, California: Brooks/Cole Publishing, 1985.
6. American Academy of Pediatrics, Task Force on Circumcision. Circumcision policy statement. *Pediatrics* 1999;103:686-93.
7. American Medical Association. Neonatal circumcision. <www.ama-assn.org/ama/pub/article/2036-2511.html> (Version current at October 6, 2004).
8. The Royal Australasian College of Physicians. Policy statement on circumcision. <www.racp.edu.au/hpu/paed/circumcision/> (Version current at October 6, 2004).
9. British Medical Association. The law and ethics of male circumcision – guidance for doctors. <www.bma.org.uk/ap.nsf/Content/malecircumcision2003> (Version current at October 6, 2004).
10. British Association of Paediatric Surgeons. Statement on behalf of the British Association of Paediatric Surgeons concerning Male Ritual Circumcision. <www.cirp.org/library/statements/BAPS1997/> (Version current at October 6, 2004).
11. Schoen E, Wiswell T, Moses S. New policy on circumcision: Cause for concern. *Pediatrics* 2000;105:620-3.
12. Stein M, Marx M, Taggart S, Bass R. Routine neonatal circumcision: The gap between contemporary policy and practice. *J Fam Pract* 1982;15:47-53.
13. Goldman R. The psychological impact of circumcision. *BJU Int* 1999;83(Suppl 1):93-102.
14. Raynor J, McFarlin D. Motivation and the self-system. In: Sorrentino R, Higgins E, eds. *Handbook of Motivation and Cognition: Foundations of Social Behavior*. New York: Guilford Publications, 1986:315-349.
15. Steele C, Liu T. Dissonance processes as self-affirmation. *J Pers Soc Psychol* 1983;45:5-19.
16. Arkes H, Blumer C. The psychology of sunk cost. *Organ Behav Hum Decis Process* 1985;35:124.
17. Festinger L, Carlsmith J. Cognitive consequences of forced compliance. *J Abnorm Soc Psychol* 1959;58:203-10.
18. Shoemaker C. Deposition: Flatt v. Kantak: Shoemaker Deposition on Informed Consent. <www.boystoo.com/legal/shoemakerdepo.htm> (Version current at October 6, 2004).
19. Fletcher C. Circumcision in America in 1998: Attitudes, beliefs, and charges of American physicians. In: Denniston G, Hodges F, Milos M, eds. *Male and Female Circumcision: Medical, Legal, and Ethical Considerations in Pediatric Practice*. New York: Kluwer Academic/Plenum Publishers, 1999:259-71.
20. Humphreys A, Lowson G. Circumcision is against the Charter, group says. *National Post*, Toronto, 12 February 2001:A1.
21. General Medical Council. Guidance for doctors who are asked to circumcise male children. <www.gmc-uk.org/standards/circum.htm> (Version current at October 6, 2004).
22. Beecham L. GMC issues guidelines on circumcision. *BMJ* 1997;314:1573.

23. Esbensen LS. Circumcision – A half debate. Politiken 2002. <www.courtchallenge.com/news/politik2.html> (Version current at October 6, 2004).
24. Alhadeff V. Circumcision defended to Queensland law body. Australian Jewish News, Sydney edition, June 10, 1994:6.
25. American Academy of Pediatrics. Report of the Task Force on Circumcision. Pediatrics 1989;84:388-91. Erratum in: 1989;84:761.
26. Poland R. The question of routine neonatal circumcision. N Engl J Med 1990;22:1312-5.
27. Thompson H. The value of neonatal circumcision: An unanswered and perhaps unanswerable question. Am J Dis Child 1983;137:939-40.
28. Cold C, Taylor J. The prepuce. BJU Int 1999;83(Suppl 1):34-44.
29. Coursey J, Morey A, McAninch J, et al. Erectile function after anterior urethroplasty. J Urol 2001;166:2273-6.
30. Fink K, Carson C, DeVellis R. Adult circumcision outcomes study: Effect on erectile function, penile sensitivity, sexual activity and satisfaction. J Urol 2002;167:2113-6.
31. Ozkara H, Asicioglu F, Alici B, Akkus E, Hattat H. Retrospective analysis of medicolegal cases and evaluation for erectile function. Am J Forensic Med Pathol 1999;20:145-9.
32. Stinson J. Impotence and adult circumcision. J Natl Med Assoc 1973;65:161.
33. Boyle G, Goldman R, Svoboda J, Fernandez E. Male circumcision: Pain, trauma and psychosexual sequelae. J Health Psychol 2002;7:329-43.
34. Hammond T. A preliminary poll of men circumcised in infancy or childhood. BJU Int 1999;83(Suppl 1):85-92.
35. O'Hara K, O'Hara J. The effect of male circumcision on the sexual enjoyment of the female partner. BJU Int 1999;83(Suppl 1):79-84.
36. Warren J, Smith PD, Dalton JD, et al. Circumcision of children. BMJ 1996;312:377. (Lett)
37. Goldman R. Circumcision: The Hidden Trauma. Boston: Vanguard Publications, 1997.
38. Rhinehart J. Neonatal circumcision reconsidered. Transactional Anal J 1999;29:215-221.
39. Boyle G, Svoboda J, Price C, Turner J. Circumcision of healthy boys: Criminal assault? J Law Med 2000;7:301-10.
40. Povenmire R. Do parents have the legal authority to consent to the surgical amputation of normal, healthy tissue from their infant children? The practice of circumcision in the United States. J Gend Soc Policy Law 1998/99;7:87-123.
41. Re J. Family Court Reports 2000;1:307-14.
42. Svoboda J. Routine infant male circumcision: Examining the human rights and constitutional issues. In: Denniston G, Milos M, eds. Sexual Mutilations: A Human Tragedy. New York: Plenum Press, 1997:205-16.
43. Svoboda J, Van Howe R, Dwyer J. Informed consent for neonatal circumcision: An ethical and legal conundrum. J Contemp Health Law Policy 2000;17:61-133.
44. Goldman R. The growing Jewish circumcision debate. In: Denniston G, Hodges F, Milos M, eds. Flesh and Blood: Perspectives on the Problem of Circumcision in Contemporary Society. New York: Kluwer Academic/Plenum Publishers, 2003:171-94.
45. Hinman F Jr. Circumcision. BJU Int 1999;84:543. (Lett)
46. International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. Ann Int Med 1997;126:36-47.
47. Giannetti M. Circumcision and the American Academy of Pediatrics: Should scientific misconduct result in trade association liability? Iowa Law Rev 2000;85:1507-68.

CORONER'S CORNER

Sudden death of a three-month-old infant while cosleeping on a sofa

The death of the three-month-old infant in question occurred during the summer. The parents described the infant, who was born at term, as a quiet, robust and healthy baby with no past medical problems, who cried only if she was unhappy. There was little known about the perinatal history except that the mother smoked during pregnancy and still smokes. The mother has had several miscarriages and, at the time of writing, has a four-year-old daughter in good health. The three-month-old infant, who always slept on her back, usually in her parents' room, was bottle-fed.

Circumstances of death

The death occurred during a heat wave. During the evening before the death, the parents consumed alcohol; the father is said to have drunk three large cans of beer, while the mother had one can. It is unclear at what time the parents went to bed. They fell asleep on the sofa in the living room.

At the time, the baby was in her own bed in the parents' room. The mother was awakened by the cries of the baby at around 03:00 and fed her. Because the baby would still not sleep and was crying, the father took her with him to the sofa. The mother went to sleep in the bedroom. To keep the baby from falling, the father put her between his legs.

The baby usually woke up at 08:00 and cried for food. It was only around 13:00 that the father awoke to find the baby blue and lifeless. Resuscitation was ineffective, even after a prompt transfer to the hospital and attempts at full cardiopulmonary resuscitation.

The autopsy performed at the medicolegal institute did not provide a cause for death. The lungs were congestive with pulmonary edema, but there were no alveolar hemorrhages, no evidence of massive thorax compression and no hemorrhagic infiltration of the tissues in the neck or thorax. There was no head trauma. The brain examination

continued on next page

revealed none of the classical signs of anoxia or asphyxia. The conclusion of the coroner was accidental death.

There are several important elements in this story:

- an unusual cosleeping arrangement;
- alcohol consumption by the parents (especially the father) before sleep;
- some degree of parental tiredness because the parents woke up quite late the next day; and
- a somewhat 'vulnerable' infant due to exposure to maternal cigarette smoke in utero.

There was also no evidence that the baby was compressed when the father woke up. However, if he was sleeping soundly because of alcohol, the baby could have died of suffocation by compression much earlier on. It is well known that asphyxia by airway obstruction can leave no external traces. The findings at autopsy were nonspecific. These types of findings are seen in babies that die with no cause identified (sudden infant death syndrome [SIDS]) and in babies with evidence of asphyxia (airway obstruction in infants wedged in restricted areas, suffocation by plastic material on the face obstructing the airway, etc) (1).

Some coroners and medical examiners are reluctant to assign a diagnosis of SIDS to any death in bedsharing arrangements; moreover, there is debate in the scientific literature regarding the risks of bedsharing, an age-old tradition in many societies. It is, nevertheless, clear that some sleeping arrangements should be avoided because of an increased risk of sudden infant death (2-5). Sofa sharing, for example, is associated with one of the highest risks (OR 31, 95% CI 9 to 111) (2) when victims of sudden death are compared with an age-matched control group. Furthermore, sofa sharing with a cosleeper who has consumed alcohol is an additional risk factor for sudden death. In addition, the baby reported here had been exposed to tobacco smoke during pregnancy (and after). Currently, prone sleeping has been almost eliminated as a risk factor and maternal smoking during pregnancy has become the most important risk factor for sudden infant death (6-8).

This infant usually slept on her back in her parents' room. Sleeping on the back and room sharing are protective against SIDS (2,5). As is seen in many cases of sudden infant death, parents usually comply with physician recommendations; it is in unusual circumstances, such as when travelling or when very tired (or having consumed alcohol), that they initiate other types of sleeping arrangements that are unsafe.

It is also possible that the infant died of another cause. In this case, the autopsy was performed at a medicolegal institute where the pathologists were not experts in paediatric disease. A study in Quebec (9) showed clearly that when autopsies were performed by a paediatric pathologist

a cause of death was found in three times as many infants as when the autopsies were performed by a pathologist with no paediatric expertise. Unfortunately, when an accidental death is suspected, the case is usually referred to a medicolegal institute.

Even with this caveat, it is important to widely publicize the risks of unsafe sleeping arrangements. Scientists, physicians, and health and child care professionals are still debating whether the small risk associated with cosleeping with a nonsmoking, breastfeeding mother outweighs the benefit gained from bedsharing. The debate will likely continue for some time. Nonetheless, sofa sharing, bedsharing with persons having altered arousal conditions (eg, consumption of medication, drugs or alcohol), and bedsharing on makeshift beds with cushions and pillows are all situations with a very significant risk for sudden infant death that can be modified with public health education.

It is, therefore, critical to alert parents that safe sleeping arrangements are important under all circumstances, especially if they are travelling, very tired or under the influence of substances that decrease arousal. Nobody knows the cause of SIDS, and it appears that some infants are particularly vulnerable. Because we have no means or tests with which to identify these infants, safety precautions for infant sleep must apply to everyone and at all times.

*Aurore Côté MD
Hôpital de Montréal pour enfants
Montreal, Quebec*

REFERENCES

1. Byard R, Krous H. Suffocation, shaking or sudden infant death syndrome: Can we tell the difference? *J Paediatr Child Health* 1999;35:432-3.
2. Blair PS, Fleming PJ, Smith IJ, et al. Babies sleeping with parents: Case-control study of factors influencing the risk of the sudden infant death syndrome. *BMJ* 1999;319:1457-62.
3. Hauck FR, Herman SM, Donovan M, et al. Sleep environment and the risk of sudden infant death syndrome in an urban population: The Chicago Infant Mortality Study. *Pediatrics* 2003;111:1207-14.
4. McGarvey C, McDonnell M, Chong A, O'Regan M, Matthews T. Factors relating to the infant's last sleep environment in sudden infant death syndrome in the Republic of Ireland. *Arch Dis Child* 2003;88:1058-64.
5. Carpenter RG, Irgens LM, Blair PS, et al. Sudden unexplained infant death in 20 regions in Europe: Case control study. *Lancet* 2004;363:185-91.
6. Haglund B, Cnattingius S. Cigarette smoking as a risk factor for sudden infant death syndrome: a population-based study. *Am J Public Health* 1990;80:29-32. Erratum in: 1992;82:1489.
7. Leach CE, Blair PS, Fleming PJ, et al. Epidemiology of SIDS and explained sudden infant deaths. CESDI SUDI Research Group. *Pediatrics* 1999;104:e43
8. Fleming PJ, Blair PS, Platt MW, Smith IJ, Chatler S. The case-control study: Results and discussion. In: Fleming P, Blair P, Bacon C, Berry J, eds. *Sudden Unexpected Deaths in Infancy*. London: The Stationary Office, 2000:77-8.
9. Côté A, Russo P, Michaud J. Sudden unexpected deaths in infancy: What are the causes? *J Pediatr* 1999;135:437-43.