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A Rose by Any Other Name?

Rethinking the Similarities and Differences between Male and Female
Genital Cutting

In this article, we offer a critical examination of the tendency to segregate discussion of surgical alterations to the male and female genitals into separate compartments—the first known as circumcision, the second as genital mutilation. We argue that this fundamental problem of definition underlies the considerable controversy surrounding these procedures when carried out on minors, and that it hinders objective discussion of the alleged benefits, harms, and risks. We explore the variable effects of male and female genital surgeries, and we propose a scale of damage for male circumcision to complement the World Health Organization’s categorization of female genital mutilation. The origins of the double standard identified are placed in historical perspective, and in a brief conclusion we make a plea for greater gender neutrality in the approach to this contentious issue.

Keywords: [circumcision; female genital mutilation; genital surgeries; medical ethics; human rights; gender equality; cultural relativism]

By this it appears how necessary it is for any man that aspires to true Knowledge, to examine the Definitions of former Authors; and either to correct them, where they are negligently set down; or to make them himselfe. For the errors of Definitions multiply themselves, according as the reckoning proceeds; and lead men into absurdities, which at last they see, but cannot avoyd, without reckoning anew from the beginning; in which lyes the foundation of their errors.

—Thomas Hobbes, *Leviathan*

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The cutting of healthy genital organs for non-medical reasons is at its essence a basic violation of girls' and women's right to physical integrity. This is true regardless of the degree of cutting or the extent of the complications that may or may not ensue.

—Anika Rahman and Nahid Toubia

Female Genital Mutilation: A Guide to Worldwide Laws and Policies

“Comparisons are odious,” says the proverb, and in recent times none more so than efforts to compare male and female genital alterations. Only recently has it become possible to speak in the same breath about male and female genital alterations, or what are generally referred to as male circumcision and female genital mutilation (FGM). Until the 1990s, it was generally assumed, at least in Anglo-American societies, that the former was so trivial and the latter so horrific that any attempt to compare the two was offensive. When the Canadian ethicist Margaret Somerville began speaking out against circumcision of infant boys, she was attacked by feminists who accused her of “detracting from the horror of female genital mutilation and weakening the case against it by speaking about it and infant male circumcision in the same context and pointing out that the same ethical and legal principles applied to both” (2000:211). The anthropologist Kirsten Bell similarly found that, when she drew comparisons between the two surgeries for her U.S. college students, the reaction was “immediate and hostile. How dare I mention these two entirely different operations in the same breath! How dare I compare the innocuous and beneficial removal of the foreskin with the extreme mutilations enacted against females in other societies!” (2005:125). Both these groups would appear to be in agreement with Doriane Coleman, who has argued that any analogy between the two forms of genital alteration “has been rejected as specious and disingenuous [since] traditional forms of FGM are as different from male circumcision in terms of procedures, physical ramifications and motivations as ear piercing is to a penilectomy” (1998:736). There we have the conventional U.S. view, which is echoed by the tenor of the commonly used terms: circumcision is no worse than ear piercing, whereas any form of FGM is the equivalent of penis amputation.

Despite this discouragement, a number of scholars have essayed such dangerous comparisons and, in the process, have done more to extend a sense of the horror of FGM to male circumcision than to trivialize the former with the alleged mildness of the latter. (Hereafter, we use the terms *FGM* and *male circumcision* or *male genital mutilation* [MGM] when discussing cultural perceptions of the two practices, and otherwise the terms *female genital alteration* [FGA] and *male genital alteration* [MGA] as a way to avoid evoking the emotional response that our culture invests in the practices.) Sirkuu Hellsten argues that “male genital mutilation should not be considered in isolation from female genital mutilation” (2004:248–249). Hellsten observes that campaigns against the former have not been as vigorous or well supported as those against the latter, and she attributes this to the perception that FGA is “a more violent and socially suppressive practice” (2004:249), with “more serious and damaging physical, as well as psychological or social, implications” (2004:249). Because FGA, at least in contemporary Western societies, is not considered to confer any health benefits, it lacks the most compelling rationale in our health-conscious age. MGA, however, with its ever-changing panoply of advantages, has not only

been tolerated as “a minor harm” but frequently encouraged “as part of a particular religious or cultural tradition, or as a measure promoting individual or public health” (Hellsten 2004:249). Hellsten concludes that, “from a human rights perspective, both male and female genital mutilation, particularly when performed on infants or defenceless small children . . . can be clearly condemned as a violation of children’s rights” (2004:249).

Writing from an anthropological rather than an ethical perspective, Kirsten Bell provides a searching critique of the dominant discourses on male and female genital alteration and argues that the terms in which FGA is condemned by international agencies require review, and that this scrutiny “must be accompanied by a similar willingness to scrutinize male circumcision and recognition that perceptions of one are fundamentally implicated in understandings of the other” (2005:140). Bell particularly notes the contradictory policies of international health organizations, “which seek to medicalize male circumcision on the one hand, oppose the medicalization of FGA on the other, while simultaneously basing their opposition to female operations on grounds that could legitimately be used to condemn the male operations” (2005:131). A similar argument is put forward by R. Charli Carpenter in a brief critique of the double standard inherent in the UN approach to “harmful traditional practices,” which, while claiming to be concerned with children, focus exclusively on women and girls and ignore “the most obvious one of all—the genital mutilation of infant boys, euphemistically known as . . . circumcision” (2004:309).

Working along similar lines, but from a legal standpoint, Christine Mason (2001) has explored the paradox whereby an adult female (in Australia) cannot elect mutilating forms of cosmetic genital surgery for herself yet has the legal right to alter the penis of her son. She argues that “changes are required to educate against both male and female infant genital surgery whilst also amending the existing legislation in order to permit adult consent to such procedures” and concludes that this would both protect children and allow freedom of minority practices when a person is old enough to give informed consent (Mason 2001:67). Marie Fox and Michael Thomson (2005a) have addressed what they see as the “problem” of MGA—itsself a provocative approach, because most medical discourse on the subject has traditionally pictured the foreskin as the problem and circumcision as the solution. They argue that the reluctance to characterize medically unwarranted circumcision as a legal or ethical problem is largely attributable to the way in which it has been defined in contrast with FGM, with the result that FGM of any kind is constructed as morally and legally unacceptable within a civilized society, whereas MGA is characterized as a standard or even benign medical intervention. As they point out, this dichotomy goes back to the debates over the propriety of genital surgeries as a response to nervous and behavioral problems in the mid-19th century, when “both male and female circumcision were justified in terms of managing sexuality; yet while clitoridectomies soon declined, with other forms of female genital mutilation becoming a focus for domestic and international outrage, male circumcision became routinized” (Fox and Thomson 2005a:464).

Central to Fox and Thomson’s argument is the concept of the “harm/benefit assessment which lies at the heart of the male circumcision debate” (2005a:463), and they suggest that the permissive attitude of legal and ethical authorities derives from

traditional constructions of male bodies as resistant to harm or even in need of being tested by painful ordeals, and of female bodies, by contrast, as highly vulnerable and thus in need of greater protection. They criticize the fortresslike separation of male circumcision from FGM and suggest that the real issue in the debate is child protection: “Whether we should be subjecting any children to . . . procedures involving the excision of healthy tissue” (Fox and Thomson 2005a:467). In a further article, Fox and Thomson (2005b) develop these arguments and criticize medical and legal authorities for neglecting the rights of children and failing to undertake a full cost-benefit analysis of the effects that routine circumcision has on males. Oddly enough—and demonstrating the pervasive power of the “tough male” stereotype—although Fox and Thomson emphasize that circumcision is always risky surgery, with a high proportion of adverse outcomes relative to its needfulness, they neglect the most obvious and universally experienced harm of all: the deprivation of an integral, visually prominent, and erotically significant feature of the penis.

A Definitional Issue

Part of the reason for the hostility encountered by Somerville and Bell is related to the problems of definition that hinder objective discussion of surgical modifications—whether forcible or voluntary—to the male and female genitals. This difficulty is vividly expressed in the fact that alterations to the genitals of girls or women are usually referred to as female genital mutilation, whereas comparable alterations to the genitals of boys and men are designated circumcision—which sounds, and is evidently meant to sound, far less serious. As we have shown, many of those who deplore operations on women as FGM have no objection to similar surgery on boys. In the traditional societies that practice these forms of initiations, however, FGA has cultural significance similar to the meanings ascribed to MGA of boys (Beidelman 1997; Setel 1999:ch. 2). As Hellsten observes, “all forms of genital alteration” (2004:249–250) are derived from ideas of the place of human sexuality in society, are intended to alter sexual function in some way, and are performed in the belief that the procedure—no matter how physically injurious—will in some way improve the subject’s life.

From an ethical perspective, the procedures look even more similar, for as Bell comments, “each operation involves an unnecessary bodily violation that entails the removal of healthy tissue without the informed consent of the person involved” (2005:130). Moreover, as ritual forms of genital alteration are medicalized under the influence of Western health agencies and educational institutions, defenders of MGA justify the procedure with medical rationales that are strikingly similar to those used to support excision of female genitalia. Several countries where FGA is common have, under Western pressure, banned the practice, but die-hard supporters are now as likely to defend it as a valid measure of health promotion as a cultural necessity. In the Gambia, women have demonstrated in favor of mothers’ right to circumcise their daughters, declaring that “female circumcision is our culture” (Daily Observer 2002), whereas in Egypt Muslim doctors have stated that the health benefits of female FGA include reduced sexual desire, lower risk of vaginal cancer and AIDS, less nervous anxiety, fewer infections “from microbes gathering under the hood of the clitoris,” and protection against herpes and genital ulcers (Gollaher 2000:193,

195, 199). Less committed observers point out that proven sequelae include clitoral cysts, labial adhesions, urinary tract infections, kidney dysfunction, sterility, and loss of sexual feeling, but defenders of FGA are claiming no more than what advocates of MGA have asserted for decades.

Considering the similarities between the male and female genitals, the nature of the surgery, the justifications offered, and the support (in Western societies) for the principle that the genders should be treated equally, it may at first seem surprising that male and female genital alteration enjoy such strikingly different reputations, at least in Anglophone countries. The first is regarded as a mild and harmless adjustment that should be tolerated, if not actively promoted, and the second as a cruel abomination that must be stopped by law, no matter how culturally significant to its practitioners. Although the term *genital cutting* has been introduced in the hope of calming the debate, and although some culture-focused feminist critics have sought to “challenge western polemics” (James and Robertson 2002), it is still generally true that not to call genital alteration of women or girls “female genital mutilation” results in accusations of trivializing the offence, but to call genital alteration of boys “male genital mutilation” is likely to elicit accusations of emotionalism, even by those who agree that routine circumcision of males is unnecessary and should generally not be performed (Nye 2005). Although the World Health Organization (WHO) and other international agencies devote substantial resources on programs to eradicate FGA, they have been conspicuously silent about MGA. It is only recently that MGA has been raised as a human rights issue at the United Nations, and to date no serious discussion of the topic has occurred, let alone any action (Svoboda 2002, 2004).

It might be thought that the reason for this double standard lies in the greater physical severity of FGA, but this is to confuse cause with effect. On the contrary, it is the tolerant or positive attitude toward MGA and the rarity of FGA in Western societies that promote the illusion that the operation is necessarily more sexually disabling, and without benefit to health, when performed on girls or women. A second reason for the double standard is that, although MGA is thought to designate a single surgical procedure, the term *female circumcision* is expansive, referring to any one or more of several different procedures. These have been defined by the WHO (1996) as follows:

Type 1: Excision of the prepuce with or without excision of part or all of the clitoris

Type 2: Excision of the clitoris together with partial or total excision of the labia minora

Type 3: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

Type 4: Unclassified (includes a wide variety of mutilations not falling into Types 1 through 3)

The severity of FGA depends on which of, as well as how, these operations are performed, and it is true that the most extreme forms (involving the amputation of the external genitalia, with or without infibulation) are significantly worse than even the most radical foreskin amputation. But it should be remembered that the most

extreme forms of FGA are comparatively rare, and that MGA in general is far more common on a world scale than FGA: about 13 million boys, compared with two million girls annually (Denniston et al 2001:v).¹ Quantity is not the whole story, but the vigorous efforts to protect the two million girls contrast sharply with the absence of interest in protecting the larger number of boys.

But the effects of MGA are also highly unpredictable, depending on how much penile tissue is removed, on the skill of the surgeon, on the precise configuration of penile blood vessels and nerve networks, on the genetically determined length of the foreskin, and on the eventual size attained by the penis at puberty and maturity. The more tissue excised, the greater the damage to the penis and the greater the effect on sexual functioning and capability. Although equivalent quantities of tissue may be lost, outcomes will be worse in cases where the penis grows larger in maturity, where the infant or boy has only a short foreskin, or where the unpredictable locations of blood vessels and nerves mean that important connections are severed. Because the slack ("redundant") surface tissue is needed to accommodate the enlarged penis when tumescent, a severe alteration will render erections painful or even impossible (Boyle et al. 2002; Hammond 1999; Peterson 2001; Warren et al. 1996; Williams and Kapila 1993). A further common outcome among boys circumcised in infancy, especially when the operation excises a large quantity of penile shaft skin (as is the U.S. norm, particularly when the Gomco clamp is used), is that scrotal skin gets pulled up onto the penis shaft as the wound heals, and even more when the penis enlarges at puberty (Cold and Taylor 1999; Money and Davison 1983; Taylor et al. 1996; Zwang 1997).

Is It Possible to Classify the Types of MGA?

Selecting appropriate terminology to discuss genital alteration may at first appear a straightforward task, but, although much effort has gone into categorizing the types of female genital alteration, surgeries on the penis are classified by a single term. Because MGA, even when nontherapeutic, is construed as harmless, there have been few efforts to provide MGA with a classification system similar to that constructed for FGA; yet in principle such a project should be no more difficult than devising a scale to measure damage to female genitals. Some attempts have already been made: Hanny Lightfoot-Klein (1989) has set out the similarities, and the Swiss-Palestinian authority, Dr. Sami Aldeeb Abu-Sahlieh, has offered the following definitions:

Type 1: This type consists of cutting away in part or in totality the skin of the penis that extends beyond the glans. This skin is called foreskin or prepuce.

Type 2: This type is practiced mainly by Jews. The circumciser takes a firm grip of the foreskin with his left hand. Having determined the amount to be removed, he clamps a shield on it to protect the glans from injury. The knife is then taken in the right hand and the foreskin is amputated with one sweep along the shield. This part of the operation is called the *milah*. It reveals the mucous membrane (inner lining of the foreskin), the edge of which is then grasped firmly between the thumbnail and index finger of each hand, and is torn down the center as far as the corona. This second part of the operation

is called periah. It is traditionally performed by the circumciser with his sharpened fingernails.

Type 3: This type involves completely peeling the skin of the penis and sometimes the skin of the scrotum and pubis. It existed (and probably continues to exist) among some tribes of South Arabia. Jacques Lantier describes a similar practice in black Africa, in the Namshi tribe.

Type 4: This type consists in a slitting open of the urinary tube from the scrotum to the glans, creating in this way an opening that looks like the female vagina. Called subincision, this type of MGA is still performed by the Australian aborigines. [2001:9]

This classification is useful as far as it goes, but it is obvious that the vast majority of MGA operations performed today fall within Type 2, that Type 1 is uncommon, and that Types 3 and 4 are confined to a few traditional (tribal) societies and are rare. It also neglects the vital fact that there is no precise definition of the foreskin and thus no precise definition of what is removed by MGA. The foreskin is not a discrete organ but a double-layered extension of the surface tissue of the penis; where the foreskin starts and the rest of the penis ends is a matter for judgment. The foreskin is generally described as a cap that fits over the glans, but the point at which the doubling of the tissue begins can be anywhere along the penis shaft and shifts according to the degree of tumescence. On average, the doubling of tissue begins well beyond the corona of the glans, as the position of the MGA scar on circumcised men (usually seen at about half an inch to an inch below the glans) testifies. Moreover, the length of the foreskin varies enormously from one individual to another, meaning that the same “standard” cut will be more severe on a boy with a short foreskin than on one who had more tissue to begin with. Because the severity and harm of the surgery depends primarily on how much of the loose penile tissue is removed, and whether it is mainly the outer (skin) layer or the inner (mucous membrane) layer, MGA Types 1 and 2 listed above can easily be broken down into an indefinite number of divisions (10, 20, or 30 percent, etc., of the foreskin), with both the visible damage and the impact on sexual sensation and sexual function increasing at each step.

The severity of the operation is also affected by whether it removes the frenulum, the sensitive “bridle” on the underside of the penis, adjoining the cleft in the glans. This is now known as the frenular delta and is understood to support one of the body’s densest concentration of fine-touch nerve receptors, whose specific function is to detect and transmit pleasurable touch (Cold and Taylor 1999; McGrath 2001; Taylor et al. 1996). Where the foreskin is still adherent, as it is in nearly all infants and commonly in boys up to the age of about eight, forcibly tearing it from the glans adds a further dimension of both injury and pain. The damage often extends to the parts of the penis that remain, and the pain is severe (Taddio et al. 1997). Nor is it just a matter of losing nerve endings: The destruction of the sliding mechanism of the foreskin back and forth over the glans, and thus of the stimulation and lubrication it affords, is another serious effect of MGA. Yet it is a harm that cannot be picked up by the sort of “sensitivity studies” that have appeared in the wake of Masters and Johnson’s much cited but deeply flawed study (1966).²

To assist the development of an objective measuring stick for MGA damage we suggest the following provisional five-point scale:

Type 1

Excision of the portion of the foreskin extending beyond the glans. This corresponds to the original Judaic operation of bris (before the institution of periah—tearing the foreskin from the glans—in the Hellenic period; Glick 2005:31, 43–45); most of the foreskin and all of the frenulum left; a fair degree of sliding functionality retained.

Type 2

Excision of the foreskin at a point partway along the glans; some foreskin and all of the frenulum left; some sliding functionality retained.

Type 3

Excision of the foreskin at the corona of the glans, leaving glans fully exposed but retaining frenulum; little sliding functionality retained; frenular nerves kept.

Type 4

Excision of the foreskin at the corona of the glans, also excising frenulum; little sliding functionality; no frenular nerves left.

Type 5

Excision of the foreskin at the point where the foreskin joins the main penis shaft skin; all foreskin excised; all frenular nerves lost; zero sliding functionality.

It would be interesting to know the proportion of MGA operations falling into each of these categories. The vast majority would probably be the most severe, Types 4 and 5, particularly in the United States, in which the “high and tight” look is favored by the obstetricians and urologists who perform most of the procedures, and whose preference is facilitated by the Gomco clamp, a device that ensures maximum loss of tissue, as well as a slow and painful operation (Glick 2005:196–197; Miller and Snyder 1953; Wan 2002).

With respect to FGA, it is also possible to break the WHO definition down more precisely into at least seven procedures:

- a nick to the clitoris
- separation of the clitoral hood or prepuce, without amputation of tissue
- removal of the clitoral hood
- excision of the labia minora
- excision of the labia majora
- excision of part or all of the clitoris
- stitching up the vaginal orifice

The main difference between FGA and MGA can now be seen to consist in the fact that the severity of FGA increases as the number of procedures rises, thus bringing more parts of the genitals under the knife, whereas the severity of MGA primarily depends on how much of a single element of the genitals is amputated. It is the variety of the procedures constituting FGA, in contrast with the unitary nature of MGA, which promotes the illusion that the first is a cruel and injurious form of torture called FGM, whereas the second is a mild surgical adjustment called circumcision.

Effects on Sexual Function

The effects of FGA and MGA on sexual function are variable and uncertain. It is commonly said by opponents of FGA that the operation, especially in its extreme forms, destroys all sexual sensation and can even reduce or eliminate sexual desire. This assertion was originally questioned by Lightfoot-Klein (1989:80–102), and her doubts have been confirmed by others, including F. E. Okonofua and colleagues (2002), although the point is still disputed. The dominant view would still be that of Ruth Macklin: “Most (but not all) women permanently lose the ability to achieve sexual pleasure” (1999:67). Conversely, advocates of MGA insist that the procedure has no meaningful impact on sexual sensation, or even that it improves a male’s sex life.³ Much of the latter argument is based (by analogy with the clitoris) on the anatomically erroneous assumption that the most intense innervation of the penis is in the glans. It is now known that the densest concentrations of blood vessels and nerves is found in the foreskin itself, whereas the glans is relatively insensitive and equipped mainly to detect discomfort and pain—as Henry Head and colleagues discovered nearly a century ago:

The glans penis is an organ endowed with protopathic and deep sensibility only. It is not sensitive to cutaneous tactile stimuli. . . . Sensations of pain evoked by cutaneous stimulation are diffuse and more unpleasant than over normal parts. [Head et al. 1920:274–277]

Head also found that the sensitivity of the glans was not significantly affected by MGA, a finding that largely nullifies many of the studies since Masters and Johnson, most of which have sought to do no more than this.⁴

The overwhelming consensus from ancient times until the 18th century, however, has been that the foreskin makes a major contribution to sexual sensation and function (Darby 2005:ch. 2). In fact, it is precisely the erotic significance of the foreskin that explains the determination of 19th-century doctors to remove it to discourage unauthorized forms of sexual activity, such as masturbation. Observing that boys masturbated by manipulating their foreskin and girls by stimulating their clitoris, the physicians concluded that circumcision and clitoridectomy were the appropriate responses to stop these behaviors. Sander Gilman notes that the late-19th-century German authority Hermann Rohleder advocated circumcision for male masturbators and burning of the clitoris with acid for female; Gilman comments that “circumcision and clitoridectomy were seen as analogous medical procedures” (1993:65). The inescapable conclusion is that, although the glans–clitoris and foreskin–clitoral

prepuce may be anatomically analogous, the correct analogy in functional or physiological terms is foreskin–clitoris.

A Recent Study of FGA

Although MGA must alter sexual functionality, sexual pleasure is a highly subjective response, and it is difficult to arrive at quantitative data on this issue. Although MGA usually reduces the pleasure of fine touch and gentle manipulation (by excising the relevant nerves found only in the foreskin), MGA does not eliminate the capacity for sexual pleasure, and in most cases it does not normally inhibit erection or ejaculation, although a severe operation may result in these outcomes. These points are sometimes presented as a positive reason for MGA, but much the same is true of all but the most severe forms of FGA. A recent study by Okonofua and colleagues (2002) in Nigeria examined 1836 women who had been subjected to either FGA type 1 (71 percent) or type 2 (24 percent). They found no significant differences between cut and uncut women in the frequency of reports of sexual intercourse in the preceding week or month, the frequency of reports of early arousal during intercourse, and the proportions reporting experience of orgasm during intercourse. There was also no difference between cut and uncut women in their reported ages of menarche, first intercourse, or first marriage in the multivariate models controlling for the effects of socioeconomic factors. The authors accordingly concluded that female genital cutting did not attenuate sexual feelings, although the practice could render women more vulnerable to adverse health outcomes, particularly reproductive tract infections. The final conclusion—that “female genital cutting cannot be justified by arguments that suggest that it reduces sexual activity in women and prevents adverse outcomes of sexuality” (Okonofua et al. 2002:1089)—will probably seem curious to Western readers. Okonofua and colleagues are saying that arguments in favor of FGA on the ground that it curtails sexual activity and inhibits the inclination to promiscuity are invalid because FGA does not have these effects. It must be assumed that, although their article was ultimately published in a British medical journal, they were primarily addressing a Nigerian audience that believes that female sexual activity should be restricted and that FGA is an efficient means to this end. The contrast between this perspective and Western discourse is striking: Articles in U.S. medical journals or mass media that find or report that MGA makes little or no difference to male sexual activity often present this as a positive reason why MGA of infants should be performed.

Toward Gender Equity?

Given the respective numbers affected and the fact that some MGA outcomes are worse than some instances of FGA, there is no justification for perpetuating the gender discrimination that has characterized discussion of these issues. Indeed, a female victim of forced circumcision during a “holy war” by Islamic extremists in Indonesia commented afterward that what was done to the men was worse than what the women suffered: “I know the men suffered more than us women. The circumcision hurt them more than it did to us because their scars could not heal fast. Several of the men I knew got serious infections after suffering from severe bleeding”

(Murdoch 2001).⁵ Such a statement would come as a shock to Kirsten Bell's students, who "did not think that carving up male genitalia had any damaging effects on male sexuality so long as . . . the man retained the ability to ejaculate"; the only procedure they considered at all equivalent to any form of FGA was amputation of the penis (Bell 2005:127). By contrast, even the slightest interference with the female genitals is likely to be regarded as disabling, or at least as an intolerable violation, as illustrated by a revealing episode in Seattle in the early 1990s. Confronted by demands from African immigrants to circumcise their little girls, the Harborview Medical Center sought to demonstrate both its cultural sensitivity and its concern for child welfare by finding a middle course, and a group of doctors agreed to consider making a nick in the clitoral hood, without removing any tissue. But even this mild compromise proved unacceptable to the local community: After being flooded with protests, the hospital abandoned its plan (Macklin 1998b:14).

Boys have often been treated with less solicitude. If, as Fox and Thomson argue, the male body in general is regarded as less susceptible to injury than the female, the penis seems to be the most invulnerable part of all, nearly any injury to which (short of amputation) is construed as harmless. The authors report a British legal case from 1974 in which a Nigerian woman was convicted of assault occasioning actual bodily harm for having scarred her two sons (ages 9 and 14) by making incisions with a razor on their cheeks in accordance with the custom of the Yoruba tribe to which she belonged. The court held that this practice carried the potential for serious injury to the eyes if the boys had moved their heads and suggested that it was this risk that distinguished the practice from the ritual circumcision also practiced by the tribe, which it accepted as perfectly lawful (Fox and Thomson 2005b:178 n. 12). Yet there are many reported cases in which a boy undergoing circumcision has not merely faced the potential of losing his penis but really has lost it, either by amputation during the surgery or from subsequent infection (Colapinto 2001).⁶ On the basis of the court's reasoning, MGA should thus be considered at least as unlawful as the slashing of cheeks, assuming that loss of a penis is at least as harmful as reduced vision.

The Lessons of History

To compare female and male genital alteration is not to trivialize the enormity of the first, as some feminists seem to fear, but to recognize that the physical similarities between the two are real and that they share a similar cultural logic—so much so that they deserve equally rigorous ethical scrutiny. Because many feminists come from countries in which MGA is tolerated or even the norm, such as the United States, campaigners against FGA are inclined to stress how much worse it is than MGA, and in the process they tend to excuse or even affirm the latter.⁷ It is remarkable how closely the terms of the current discussion re-create debates surrounding Isaac Baker Brown, the mid-Victorian exponent of clitoridectomy as a cure for masturbation and nervous complaints. Brown's opponents similarly chose to isolate the case against clitoridectomy from the case for circumcision, playing up the harm of the former while minimizing the impact of the latter; as the *Medical Times and Gazette* editorialized, clitoridectomy was infinitely worse than

circumcision because “instead of taking away a loose fold of skin it removes a rudimentary organ of exquisite sensitiveness, well supplied with blood vessels and nerves, and the operation is . . . occasionally attended with serious bleeding; in these respects it differs widely from circumcision” (1867:391). Brown was at least consistent in his view that, so long as a male or female remained capable of reproduction, neither had been mutilated. Because the debate over clitoridectomy was conducted in terms of its difference from or similarity to male circumcision, the medical profession’s rejection of the former cleared the way for the widespread adoption of the latter. The result has been a double standard on genital alteration that has endured to this day (Darby 2005:ch. 7; Moscucci 1996). So persistent has it been that we now find the WHO conducting two quite separate research projects: one to find evidence for the harm of FGA, another to find evidence for the benefits of MGA. Naturally each comes up with the goods, because the result is guaranteed by the starting assumption.

This is the fundamental reason why Western agencies like the United Nations and the WHO have defined FGA as an atrocity that must be stopped while ignoring the comparable operation on boys. The answer is historical, relating to our comfort with the familiar, the example of the Jewish people, and the relentless devaluation of the foreskin as a body part. Millennia of Semitic custom and a century of routine MGA in English-speaking countries have desensitized us into seeing the procedure as a mild adjustment and the result as acceptably normal. It took decades for procircumcision doctors to institutionalize MGA, but it was always easier to win acceptance for that procedure than for similar operations on females, because it was mentioned in the Old Testament. Although the Jews were seen as proto-Christians, and (both in the United States and Britain) increasingly admired as exemplars of sanitary wisdom as the 19th century advanced (Glick 2005:ch. 6), genital alteration of girls was perceived as an outlandish rite, performed by obscure barbarians whose example did not warrant emulation. This was despite the fact that some Victorian authorities condemned masturbation by girls nearly as vigorously as among boys, and a variety of genital surgeries was recommended and sometimes performed (Hodges 1997). By the 1890s, however, a British enthusiast was reluctantly forced to conclude that these remedies had been found “ineffectual and unsatisfactory” (Yellowlees 1892). In the United States, by contrast, doctors performed a variety of operations on the female genitals to cure nervous and other complaints until the 1950s,⁸ while as late as the mid-1970s FGA (here meaning excision of the clitoral hood) was being recommended as an enhancement by some medical journals (Wollman 1973) and popular magazines (Isenberg and Elting 1976).

Changing attitudes to the body also played a role in promoting MGA. Where the foreskin (at least up until the mid-19th century) had been valued as “the best of your property” (Darby 2005:ch. 2), Victorian doctors succeeded in “reconfiguring the phallus” (Miller 2002), thereby demonizing it as a source of moral and physical decay. They fully appreciated the importance of the mobility of the loose penile tissue (foreskin) for sexual functionality (Spratling 1895; Yellowlees 1892). The clitoris, by contrast, was so highly regarded that many obstetricians considered it part of their duty to enlighten women as to its importance: Regretting that so few women seemed alive to its potential, one of Baker Brown’s opponents commented:

I am sorry that females have not as much knowledge of the clitoris as we have, for if that were the case I am sure there were very few who would consent to part with it, and when questioned about it afterwards say, "Oh, I have only had a little knot removed." Verily they know not the nature of that little "knot."

He thus thought it perfectly proper for doctors to educate patients as to the sexual function of body parts about whose potential they were ignorant or misinformed (Moore 1866:699). The case of the foreskin is rather different. Although there is an increasing body of medical literature attesting its anatomical and physiological significance,⁹ Margaret Somerville is surely right to remark that, although we would be horrified at the suggestion that girls' breasts should be removed as a precaution against later breast cancer, we scarcely blink at the suggestion of removing the foreskin as a prophylactic against cancer of the penis or HIV. The reason is simply that "we value breasts—we see it as a serious harm to women to lose them—and we do not value foreskins, in fact they are often devalued—spoken of as ugly, unaesthetic and unclean. Yet both are part of the intact human body, and both have sexual and other functions" (Somerville 2000:204).

A trace of this attitude may be detected even in such effective critics of routine MGA as Fox and Thomson, who touch only lightly on the most basic human rights consideration of all in MGA debate: All mammals have foreskins; males are what they are because that is how they have evolved. The objective of some circumcision evangelists seems to be nothing short of trying to reconstruct human anatomy, perhaps secretly hoping that, if they circumcise enough newborns, future generations will be born prepuce free. Evolution, however, appears to be favoring ever-longer foreskins in males (Cold and McGrath 1999), suggesting that they improve survival chances and reproductive health rather than the reverse. Instead of trying to rewrite nature, the medical profession could more usefully examine how males can best protect their health and enjoy their sexuality with the standard equipment nature has given them. When we accept the fact that foreskins are as integral to males as breasts are to females, and that males have as much right to a complete penis as women to their clitoris or labia, then we can formulate strategies to combat sexually transmitted and other diseases that are both effective and ethically based. Violating the genital integrity of a child or poorly informed adult as a prophylactic against avoidable diseases is, at best, putting the cart before the horse, and at worst a breach of human rights.

The Problem with Double Standards

Despite what some activists claim, refusal to confront MGA actually makes the task of eradicating FGA more difficult. Supporters of FGA in cultures that still practice it are quick to identify the double standard in the attitude of Western agencies that seek to eradicate FGA while tolerating, or even promoting, MGA. They point out that "American parents circumcise their newborns so that the sons will look like the fathers. . . . What, they ask, gives Americans the right to apply a different standard to African women?" (Gollaher 2000:200). The American Academy of Pediatrics (AAP) opposes all forms of FGA as examples of genital mutilation that members are

advised they should refuse to perform and should actively discourage (AAP, Committee on Bioethics 1998). This position sharply contrasts with the AAP's equivocating disapproval of the equivalent procedure on boys. The remote possibility of a potential health benefit to MGA is regarded by the AAP as sufficient to justify categorizing the operation as a medical precaution rather than a culturally mandated mutilation (AAP, Committee on Bioethics 1998:172–173, 200; Dritsas 2001). In its 1999 policy statement the AAP Task Force on Circumcision acknowledged that MGA was “not essential to the child’s well being” but went on to say that it was “legitimate for parents to take into account cultural, religious and ethnic traditions . . . when making this decision.” Objecting to this concession, Dr. Thomas Bartman drew attention to the AAP policy on FGA, issued by its Committee on Bioethics in 1998, and commented:

Although female genital mutilation (FGM) exists in many horrendous variations, that statement clearly included within its definition of FGM “excision of the skin surrounding the clitoris” [paragraph 6]. In that report the Committee also clearly stated that pediatricians should “decline performing all medically unnecessary procedures to alter female genitalia” [paragraph 41]. Furthermore, under the heading “Cultural and Ethical Issues” the Committee stated that the parents’ cultural, societal, and religious beliefs do not give them the right to consent to a medically unnecessary procedure for their child. [Bartman 2000:681]

In reply, the chair of the Circumcision Task Force, Dr Carole Lannon, stated: “The critical distinction between female genital mutilation and male circumcision is the potential medical benefits of male circumcision. These potential benefits warrant a parental role in decision making about this procedure.”

No other medical association that has issued a policy on MGA has found sufficient “potential benefits” to justify the procedure. Where Americans view neonatal MGA “not essential” for health, the Royal Australasian College of Physicians (2004) states that “there is no medical indication for routine male circumcision”; the Canadian Pediatric Society (1982, 1989, 1996) has called it a “mutilative” and “obsolete” operation; and the British Medical Association ([BMA] 2006) points out that there is rarely any clinical need for MGA, and that “parental preference alone is not sufficient justification for performing a surgical procedure on a child.”¹⁰ Considering these judgments, it is difficult to know what to make of this extraordinary leap from cultural imperative to speculative (“potential”) health advantage. Dr. Lannon states that it is the possibility of a “medical benefit” that authorizes submission to parental wishes in the case of boys, and that it is the absence of any such possibility that forbids any surgical procedure on the genitals of girls, no matter how significant it may be to the cultures that have traditionally practiced such rites. But one wonders whether it is culture or medical science that is really in the driver’s seat here. The evidence thought to show a “potential health benefit” for MGA may in fact be an artifact of its cultural acceptability and long history in U.S. society. By the same token, the absence of any culturally conditioned demand for FGA has discouraged researchers from seeking evidence of the potential advantages of such surgery.¹¹ It is the cultural demand for MGA that generates the research that appears to implicate

the foreskin in whatever disease is holding the public's attention (Goldman 2004). In a culture that values science, medical (usually miscalled scientific) justifications for cultural rituals must be found, hence the numerous horror stories about the terrible risks of retaining normal human anatomy (Van Howe et al. 2005). As Lawrence Drietas (2001) has eloquently argued, the cultural tail would appear to be wagging the scientific dog.

It is perhaps inevitable that one's opinions about male and female genital mutilation will be conditioned by one's own socialization and culture. In one study of five childhood mutilations (artificial cranial deformation, Chinese foot binding, female infanticide in 19th-century India, female genital alteration, and male genital alteration, both in North America and in developing countries), surprising similarities were found in the reasons for these practices. Although it was claimed that they were intended to benefit the child, they resulted in overall harm to the child; the actual or imagined benefits are only for others: parents, surgeons, midwives, and "society" (Svoboda 2001). Western observers have little difficulty in labeling the other four practices as violent human rights violations, yet they have trouble objectively analyzing their own practice, male circumcision. This form of cultural blindness is understandable. All over the world, as Richard Shweder (2002:216–251) has commented, people recoil and say "yuck" to each other's childhood body mutilation practices while justifying their own practices and saying "yuck" to cultures that have not adopted their customs.

Conclusion

Just how difficult it is to escape from cultural assumptions is revealed in an exchange between Ruth Macklin and Robert Baker that further highlights the problems inherent in claiming universal human rights as a basis for stopping FGA while ignoring the problem of MGA. Macklin sought to ground her critique of ethical relativism in an appeal to universally held standards of human rights—or at least rights that she believed ought to be universally held—and on this basis condemned FGA because it was harmful to the child and violated her integrity as a person. Macklin's argument was trumped by Robert Baker (1998), a self-proclaimed cultural relativist, who criticized her for focusing exclusively on "female genital mutilation" while ignoring "male genital mutilation." He notes that female genital alteration may take a variety of forms and male genital alteration usually only one, but he points out that "the feature common to both forms of circumcision is that the operation desensitizes responses to sexual stimulation." As Baker aptly observes, "once one appreciates that cultures that circumcise females typically circumcise males as well, the claim that circumcision is discriminatory, or anti-female, becomes questionable" (1998:442–443). In her reply, Macklin (1998a) tellingly criticizes Baker for misidentifying human rights as pertaining to a culture or society rather than to individuals, but she seems not to have heeded his call for consistency in the application of human rights principles: continuing to focus on the harm of female genital alteration, she makes no mention of male genital alteration at all.

The way forward, in our opinion, is not to abandon the concept of universal human rights, as argued by Baker, but to attempt to apply them consistently, without discrimination on the basis of gender.

Notes

1. Because accurate statistics on circumcision are not kept, these figures are the roughest of estimates, although it can be said that the vast majority of these boys are from Muslim families, most of whom are probably done between the ages of four and eight. For a discussion of circumcision statistics in the United States and Britain, see the Appendix.

2. For critiques of Masters and Johnson, see Foley (1966), Hodges and Fleiss (2000), Sorrells and colleagues (2007), and the incisive deconstruction by Young (n.d.).

3. It can in certain rare cases, such as severe tightness or shortness of the frenulum, although less drastic or even nonsurgical methods of treating these problems are now readily available.

4. For a sample of recent research, see Fink and colleagues (2002), Bleustein and colleagues (2003), and Masood and colleagues (2005). It will be noted that most of these studies refer to circumcision in adulthood, the effects of which cannot necessarily be extrapolated to circumcision in infancy or childhood, when neuronal pathways that depend on nervous stimulation are not developed, and the operation is likely to be both riskier and more damaging. See Immerman and Mackey (1997, 1998).

5. The men experienced greater harm because it seems that the women suffered only nicks to their clitoris, whereas the men had their entire foreskin amputated.

6. In South Africa, ritual circumcision among the Xhosa is responsible for dozens of deaths each year, as well as hundreds of horrific penile injuries, leading to a plea from the South African Medical Association for action "to halt the carnage" (South African Medical Association 2003). See also Sidley (2006). Willis (2003) reports that the extreme penile mutilations (entailing subincision as well as circumcision) practiced by the Pitjantjatjara people of the central Australian desert have severely inhibiting effects on the men's sex lives. The frequent bloodletting required must also pose grave risks of infection.

7. We are far from wishing to denigrate the efforts of feminists to combat FGM, and we appreciate that FGM holds its prominent place in feminist discourse because it has become the symbol par excellence of patriarchy and the cruelest instance of male power over and violence toward women. But we would point out that in patriarchal societies it is not only the women who are oppressed, but also the young men, who can attain adult (oppressor) status and access to women only by completing arduous and often painful initiation ordeals. This is the main reason why young men in societies that practice circumcision around puberty look forward to the rite.

8. For examples, see Dawson (1915), Eskridge (1918), McDonald (1958), and Rathmann (1959). Even in recent times there are cases of girls being subjected to trimming operations in the interests of parental concepts of genital normality; for a disturbing personal account, see Robinett (2006).

9. Generally, Taylor and colleagues (1996); Cold and Taylor (1999). More recently, Kim and Pang (2007) found significantly reduced sexual satisfaction after circumcision, whereas Sorrells and colleagues (2007), using a light-touch test, concluded that a circumcised penis is markedly less sensitive than one with its foreskin in place.

10. See also Finland Central Union for Child Welfare (2003). Past and current policy statements of most organizations that have issued policies on routine circumcision are conveniently collected at the statements page of Circumcision Information and Resource Pages (2007).

11. There is in fact evidence that female circumcision reduces the risk of HIV infection in women (Stallings and Karugendo 2005), but given Western cultural preferences it is unlikely that there will ever be clinical trials to test and confirm the possibility.

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Appendix: Genital Alteration Statistics

Statistics for the United States are the subject of uncertainty and debate. It is generally thought that the incidence of neonatal circumcision (under six months) is between 50 and 60 percent, but there is no agreement as to exactly where, or as to whether, the incidence is rising, falling, or stationary. Figures from the National Hospital Discharge Survey show that the rate was 60 percent in 1988, rose to 67 percent by 1995, then fell to 65 percent by 1999. The incidence of male genital alteration varies significantly by region, however, and nearly all the reduction has occurred in the West, particularly California, where it fell from 63 percent in 1979 to 36 percent in 1999. In the Northeast the rate remained constant at about 65 percent over the same period, whereas in the Midwest and South it actually increased—from 74 to 81 percent and 55 to 64 percent, respectively (Centers for Disease Control n.d.). These data may be compared with the slightly lower figures calculated by the (anticircumcision) Circumcision Information and Resource Pages (2007), which claims that the incidence fell as low as 55.9 percent by 2003, and the contrasting

claim by (procircumcision) Nelson and colleagues (2005) that the incidence of the practice is rising, or at least that it rose significantly between 1988 and 2000 as parents “recognized the benefits.” They claim that the incidence was as low as 48 percent in 1988, a big drop from the 85 percent-plus for 1979 proposed by Edward Wallerstein (1980:217).

Whatever the figures, they suggest that the stance of the American Academy of Pediatrics (AAP) has had very little impact on practice. U.S. pediatricians have been officially recommending against routine male genital alteration (MGA) since 1971, but they have not been unified on this issue. Edgar Schoen (a long-time agitator for universal neonatal circumcision) and the editors of AAP journal have been fighting a relentless rearguard action in support of the procedure, and the pediatricians are, in any case, only a small part of the medical services industry. Most MGAs are done by obstetrician-gynecologists and (at later ages) by urologists, and these have evidently not felt bound by the AAP attitude, meaning that many physicians continue to advise MGA. Many others will do it if either parent asks. For Schoen’s latest blast at AAP policy, see Schoen (2006).

There are recent and probably accurate figures for Britain in Cathcart and colleagues (2006). This reports a declining rate of MGA from 1997 to 2003, and an overall incidence of no more than 3 percent of boys by age fifteen. Because most of these procedures are stated as being to correct phimosis, the authors suggest that the incidence is five times higher than it should be (given the expected incidence of pathological phimosis and recurrent balanitis, the only genuine medical indications for the procedure). At the same time, the British Medical Association ([BMA] 2006) has issued a policy on MGA that points out that there is rarely any clinical need for this procedure, warning that “to circumcise for therapeutic reasons where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate,” and suggests that, if it were shown that MGA without clinical need was prejudicial to a child’s well-being, it is likely that a legal challenge on human rights grounds would be successful. Note that the BMA is doubting the validity of therapeutic MGA of minors (to correct a problem); it does not even consider the possibility of MGA as a prophylactic against conceivable future problems.

This policy is in striking contrast with the attitude in the United States, where MGA of normal healthy infants and boys is still widely performed as a surgical prophylactic against the future risk of (pretty unlikely) diseases and problems. The difference illustrates the overriding importance of national medical culture and the difficulty of reaching any scientifically based consensus on this highly emotional issue.