CIRCUMCISION

A short history of circumcision in the United States: Part 1
Medical science in the service of Victorian morals

The following article was originally given as a paper to the Fourth International Symposium on Sexual Mutilations, held at Lausanne, Switzerland, in August 1996. Although it may seem rather dated today, it blazed the research trail for others, and remains a milestone in the excavation of the true history of medically rationalised circumcision. It is a remarkable pioneering effort to uncover the truth by going back and reading the almost incredible things that doctors did not so long ago, and about which they reported, often with grisly detail, in their own professional journals. The thoroughness of the bibliography alone makes this paper one that no student of the history of circumcision can afford to ignore.

A short history of enforced circumcision in the United States

For the past 130 years the American medical industry has been involved in the business of removing part or all of the external sexual organs of male and female children. While the origins of sexual mutilations among prehistoric and primitive peoples is a matter for theory and speculation, the origin and spread of sexual mutilation in American medical practice can be precisely documented. Seen in the proper context of the entire scope of western history, the modern American enigma of institutionalized sexual mutilation is an historic aberration of profound significance and degree, one that could never have been predicted, and one that perhaps could not have been avoided.

1. Modernization
The introduction and spread of institutionalized secular sexual mutilation was a response to the tremendous social and cultural anxieties engendered by the effects of the rapid modernization and industrialization of the early decades of the nineteenth century. As the traditional rural-agrarian economy was transformed into an urbanized capitalist economy, parallel changes occurred in social structure, governmental and non-governmental institutions, demographics and technology. One significant result of these changes was the ascendancy of the middle class to positions of economic and political power. The emergent middle class was now in a position to reinterpret social mores and redefine the individual for all of society.

As an outgrowth of the middle class, the medical establishment reflected and validated these social changes and offered treatment for the anxieties they inevitably produced, thereby laying the foundations of the modern therapeutic state – defined by Thomas Szasz as the political order in which social controls are legitimized by the ideology of health [1]. For instance, in traditional agrarian society adulthood was considered to begin at puberty. Industrialized, middle class society extended the boundaries of childhood by ore than a decade so that middle class males could receive the specialized professional and academic training required by a modern industrialized society. The formidable anxieties engendered by this transformation found expression in an intensified focus on childhood sexuality. In conformity with middle class social mores, physicians theorized that childhood should be a period of complete asexuality and, consequently, that children should be kept ignorant of sexual and reproductive information until

their delayed marriage. The functional significance of this change was that young people, who in previous generations had been expected to marry and commence sexual activity in early adolescence, were now required to restrain themselves from sexual activity and remain continent until they were in their twenties. Young people who were unable to suppress their sexual drives were subjected not only to social censure, but to medical interventions as well.

2. Supporting medical theories

2.1 Degenerative theory of disease and the notion of reflex neurosis

For reasons unrelated to the rise of the American middle class, two French physicians in the 1820s, Xavier Bichat (1771-1802) [2] and Francois Broussais (1771-1838) [3], developed a new model of disease – the theory degenerative disease. This model postulated that the human body was allotted a finite amount of vital energy which could either be conserved through correct living or permanently lost through wrong living. Energy depletion led to degeneration, which in turn led to the production of disease. Middle class American physicians readily adopted this theory, but they expanded it to imply that manifestations of sexuality necessarily represented life-threatening losses of vital energy. Non-procreative use of the sexual organs, even within marriage, was viewed as dangerous. The result was the formulation of the Reflex Neurosis Theory of Disease, which postulated that the sexual organs and the erotic sensations they produced were the cause of all human disease. To validate this theory, American physicians redefined normal human sexual behaviour, reproductive anatomy and sexual function in terms of pathology.

Pathologization of sexual behaviour

The pathologisation of normal sexual behaviour resulted in the masturbation hysteria. The term masturbation was frequently used in a generalised way to describe any sexual activity outside the context of heterosexual marital coitus for the purpose of procreation, but in practice a diagnosis of masturbation generally followed the discovery of a child's either having sexually stimulated him/herself or having engaged in sexual activity with another person. Physicians relied on spurious logic to support the pathologisation of sexual behaviour. Clinical interviews with patients suffering from what would today be ascribed to the effects of malnutrition, overwork, venereal disease, bacterial or viral infections, mental disorders, and tobacco or alcohol poisoning invariably revealed a past history of masturbatory activity. On this basis it was easy to conclude that masturbation had brought on these conditions. The inhabitants of the United States were at first reluctant to accept the theory that masturbation was harmful, and many resisted doctors' interference in the lives of their children; but the rising flood of articles in medical journals that allegedly proved the harm of masturbation gave physicians the power to overcome this resistance and enforce their own convictions.

Pathologization of sexual anatomy

In order to validate the Reflex Neurosis Theory of Disease, physicians were compelled to pathologize the three distinguishing features of the normal juvenile foreskin, namely, generous length, adherence to glans and narrowness of the preputial orifice. These perfectly natural qualities were demonized under the general diagnosis of phimosis. Physicians coined the term "congenital phimosis" to specify that the adhesion of the immature foreskin to the glans in infants was really a congenital birth defect. They adopted the term "acquired phimosis" to

indicate a fictitious condition in which a previously detached foreskin became adherent as a result of masturbation. The term “hypertrophic phimosis” or “redundancy” indicated a type of phimosis whose sole symptom was a foreskin that doctors arbitrarily deemed to be “too long”.

Since the foreskin is the most highly innervated part of the penis, and since masturbation among normal (not circumcised) boys generally involves manually stimulating and manipulating the foreskin, and sliding the mobile sheath of the penile skin up and own the shaft (the structure of the foreskin facilitated a wide range of motion), masturbation was seen as a cause of reflex disease through the medium of the foreskin. In the absence of the germ theory of disease, American physicians who did not regard masturbation alone as the primary cause of disease, attributed bacterial, viral and fungal diseases, as well as the pathological symptoms of malnutrition, overwork etc, to phimosis. Even in the absence of a diagnosis of phimosis, the foreskin itself was indicted as a cause of disease. Phimosis in females, defined as adherence of the clitoral prepuce to the clitoris, was viewed in much the same light.

Pathologization of sexual function

In accordance with the Reflex Theory of Disease, erotic sensation was redefined as irritation, orgasm was redefined as convulsion and erection was redefined as priapism. Physicians argued that these manifestations of sexual function were both symptoms and cause of disease and, likewise, that stimulation of the genitals could cause problems in distant parts of the body, such as the heart, brain, back, digestive organs and eye.

The pathologization of normal male sexual function soon led to the invention of spermatorrhoea. Physicians defined spermatorrhoea as a serious venereal disease whose sole symptom was the ejaculation of sperm under any condition other than marital intercourse. The release of sperm in nocturnal emissions or masturbation was now classified as a venereal disease as dangerous as any other – if not more dangerous because more people suffered from it more often. Hundreds of case reports published in medical journals all over the western world proved, to the satisfaction of most physicians, that spermatorrhoea was a real and dangerous disease. French physicians such as Claude-Francois Lallemande (1790-1853) and Leopold Deslandes (1797-1852) [4] were the acknowledged world authorities n the treatment of spermatorrhoea. Their preferred treatment was to insert long steel rods, also known as bougies, up the urethra and cauterize the passage, as well as the prostate and seminal vesicle, with silver nitrate. This was supposed to slow the production and halt the loss of sperm. Lallemande also advised amputation of the foreskin in difficult cases of spermatorrhoea and in order to stop masturbation among boys.

In the United States Lallemande’s enthusiasm for circumcision caught the attention of Edward H. Dixon (1808-1880). In his Treatise on the Diseases of the Sexual Organs (1845) he became one of the first north American advocates of both therapeutic foreskin amputation (to correct an existing problem) and of the universal imposition of the ancient Hebrew rite of infant circumcision (as a prophylactic against possible future problems). [6] Dixon claimed that phimosis, which he defined as an elongation of the foreskin, was the primary cause of most serious diseases. At first Dixon and Lallemande were largely ignored, and for the next two decades circumcision was overlooked while other surgical treatments for masturbation, phimosis and spermatorrhoea were developed and trialled.

2.2 Castration

Since surgical amputation of body parts in general was considered thoroughly modern and advanced, physicians experimented with specific amputations of the sexual organs to treat masturbation. In 1842 the Boston Medical and Surgical Journal (now the New England Journal of Medicine) reported that Dr Winslow Lewis of Boston had severed and tied the left spermatic artery of a young man being treated for "excessive masturbation" [7]. In 1843 one of the first reports of castration for masturbation was published by Dr Josiah Crosby of Meredith Bridge, New Hampshire. After cathartics and emetics had failed to cure a 22-year old man, whose health had reportedly been ruined by masturbation, Crosby castrated him and pronounced him cured. [8] The American medical profession responded with interest. Two years later Dr Samuel McMinn published, in the Boston and Medical Surgical journal, a revolutionary report about an insane woman living near Tuscaloosa, who had taken a razor and amputated "the whole of her external organs of generation." McMinn arrived at the scene and fully expected the woman to die from her massive wounds, but she survived. As her wounds healed, her reason miraculously returned. Fascinated by this outcome, McMinn speculated:

And the results of this case may suggest a remedy. Whether it was the great loss of blood, the removal of the organs and the counter-irritation consequent that cured the patient is a question for the consideration of the profession. [9]

The title he gave to his report, however, betrayed his own, and presumably the journal editor's opinion as to the source of the cure. The report was dramatically entitled "Insanity cured by excision of the external organs of generation".

Ten years later, in 1855, Dr William Taylor published a similar report involving a cigar-maker from Philadelphia who had gone insane and hacked off his penis and testicles with a broken bottle. [10] Although he bled profusely, his wounds healed, and his reason returned. No further proof was needed. A revolutionary new surgical approach to masturbatory insanity had been established just as the innovation of aseptic surgery was opening new vistas for surgical ambition. Orthodox American medicine now embarked upon the wholesale amputation of sexual organs as a the preferred cure for a wide range seemingly unrelated conditions. In mental hospitals inmates were castrated on a massive scale in order to stop them from masturbating and thereby restore their sanity. Right up until the beginning of the twentieth century boys caught masturbating were frequently committed to insane asylums where they could be circumcised, castrated and shackled in their cells [11, 12]. Females were subjected to "female castration", a surgery involving the removal of the ovaries, aimed at curing them of hysteria, epilepsy or nymphomania.

2.3 Spermectomy, neurectomy and other treatments

Various other surgeries aimed at eliminating sexual desire and thereby stopping masturbation also were developed. "Spermectomy" was invented as a less drastic alternative to castration, and consisted in the surgical removal of the spermatic ducts rather than the testicles. [13] Neurectomy had a certain vogue in the 1890s. Commonly performed on boys who had been caught masturbating, this involved the physician severing the dorsal nerves of the penis in order to destroy sensation and function completely and permanently. [14, 15] American physicians also resorted to relatively less drastic measures, such as slitting open the urethra [16}, cauterizing

the prostate [17], corporal punishment [18], blistering the penis with caustics, acids or heat [19], flaying the skin of the penis with razor blades [20], sewing the penis shut with metal wire (infibulation) [21], encasing the genitals in plaster or lockable metal cages [22, 23], or fitting the penis with rings studded with sharp teeth to discourage erections [24].

In the case of females, the preferred treatment for epilepsy and masturbation was clitoridectomy. One of the first reports of therapeutic clitoridectomy was published in the San Francisco Medical Press in 1862, the abstract of which explained:

Dr E.S. Cooper, editor of the San Francisco Medical Press, relates two cases of removal by the scalpel of the clitoris in young girls who were inveterately addicted to the habit of masturbation, and for whom there was apparently no alternative but hopeless insanity or an early grave. The result was a perfect cure in one case, and in the other the practice was broken up, and all the mental faculties improved, except the memory, which is not restored. [24]

In the late 1860s the British obstetrician Isaac Baker Brown developed and promoted clitoridectomy as a cure for epilepsy and other mental problems in women. His claims of miracle cures aroused widespread interest at first, but his methods eventually alarmed professionals in the new specialty of obstetrics, and in 1867 his conduct was called into question and expelled from the Obstetrical Society. Although many continued to believe in the value of clitoridectomy, Brown's main offences were an unprofessional degree of self-promotion and failure to obtain informed consent from his patients. (He was in the habit of chloroforming any patients who came to his surgery and performing the operation on them, no matter what the problem they complained of, without telling them what he was going to do.) The British medical press was overwhelmingly in favour of banning Baker Brown, but he was vigorously defended in the United States. The editor of the influential Medical Record strongly criticised the anti-clitoridectomy crusade in England and demanded, "What now will be the chance of recovery for the poor epileptic female with a clitoris?" [26]

3. Circumcision as therapy

On 1 December 1855 the English surgeon Jonathan Hutchinson (1828-1913) published a paper that was to become one of the most influential texts in the history of circumcision advocacy, "On the influence of circumcision in preventing syphilis" [27]. During the 1850s London experienced a massive immigration of Jewish settlers from the ghettos of eastern Europe, attracted by the liberal and tolerant attitude prevailing in England. Hutchinson reported that at the Metropolitan Free Hospital in east London, where many of the immigrants settled, fewer Jews than Englishmen sought treatment for syphilis. Being innocent of any awareness of the principles of statistical analysis, epidemiology, the germ theory of disease or the quarantine effect of ghetto living, Hutchinson asserted that only circumcision could account for the difference in the incidence of the disease. Despite its obvious flaws, Hutchinson's paper was widely reported in foreign medical journals and continued to be cited as authoritative right up until the 1940s. In 1857 it was used as evidence at medical tribunal in Vienna, where a certain Dr Levit (under the influence of a modern western education and possibly impressed by the anti-circumcision movement in reform Judaism in Germany at that time) refused to allow his newborn son to be circumcised. The local rabbinate, under the influence of Dr Joseph Hirschfeld, held up Hutchinson's paper as proof that circumcision was not an outmoded rite, but a modern and

scientifically valid means of avoiding disease. It was sufficient justification for the rabbinate to seize Levit's son and forcibly circumcise him against his father's wishes. Levit was left without legal recourse to protect his own child. [28]

On the strength of Hutchinson's figures, circumcision as a prophylactic intervention now made a cautious reappearance in orthodox American medicine. At a meeting of the Boston Society for Medical Improvement on 12 August 1861, a Dr White presented a paper in which he mentioned that circumcision could prevent masturbation. [29] Seven years later Dr Charles Bliss, of Syracuse, New York, published an account of his success in curing masturbation by partial amputation of the prepuce. [30] In 1869 a learned article by the Baltimore physician A.B. Arnold described the history of circumcision in the religious context of Jews, Muslims and certain African peoples. [30] The new surgery was being legitimised by being placed in a long history, even though it was a non-western and largely Asiatic history.

3.1 The American Medical Association

Hailed in his lifetime as the father of orthopaedics and indeed as one of "the most distinguished benefactors whom the American medical profession has produced for the glory of medicine and the good of mankind" [32], Dr Lewis A. Sayre (1820-1900) was certainly among the most distinguished believers in the therapeutic powers of circumcision. He served as vice-president of the American Medical Association in 1870 and as president in 1880. At the annual meeting of the AMA in 1870 he delivered a remarkable paper entitled "partial paralysis from reflex irritation, caused by congenital phimosis and adherent prepuce" [33]. Supporting his claims with numerous case studies and clinical evidence, and deploying the most scientific methodologies available at that time, Sayre proved to the satisfaction of his audience that a long, adherent foreskin could not only cause paralysis in various limbs, but also hip-joint disease (probably tuberculosis of the hip-joint), hernia, bad digestion, inflammation of the bladder and clumsiness. In each case Sayre reported that amputation of the foreskin had cured the problem. For the rest of his career Sayre urged physicians always to examine a boy's prepuce in all cases of disease. Whenever phimosis, as defined by reflex theory, was found, Sayre advised immediate amputation of the foreskin. Because of his professional reputation and impeccable credentials, major American medical schools steadily incorporated Sayre's theories and therapies into their curricula.

During the late 1860s and throughout the next decade epilepsy was increasingly the focus of medical interest, as indicated by the growing number of articles on the subject published in medico-scientific journals. Capitalising on the new anxiety, Sayre reported to the New York Pathological Society in 1870 that phimosis was also the cause of epilepsy [34]. A few English physicians had been experimenting with circumcision as a treatment for epilepsy since 1865 [35], but they attributed the problem to the tendency of the foreskin to encourage masturbation, and thus cited prevention of masturbation as the key to curing the condition. Sayre maintained that a long foreskin alone had the power to induce violent epileptic convulsions, and that circumcision had cured every case of epilepsy that he had encountered. As with paralysis, hundreds of case reports were published over the next 75 years, all validating Sayre's advocacy of circumcision as a cure for epilepsy.

At the annual meeting of the AMA in 1875 Sayre delivered another important lecture on phimosis. Here he informed his audience that he had discovered that a long and adherent foreskin could cut off the circulation of blood to the spinal column, thereby causing lameness, curvature of the spine, paralysis of the bladder and club foot. [36] Miraculously, he reported, circumcision brought an immediate cure to all these patients, including the patient with the club foot. In the same lecture he also described several cases in which clitoridectomy brought instant relief to paralytic girls.

3.2 Masturbation hysteria and circumcision

Alarm amounting to hysteria about masturbation reached a climax in the last decades of the nineteenth century. From 1800 to the early 1870s there was an astounding 750 per cent increase in the number of articles in medical journals on masturbation. From the 1870s to the 1880s the number of papers on masturbation increased by 25 per cent, and from the 1880s until 1900 by a further 30 per cent. Among the more influential American physicians who noticed this obsession, and who contributed to it, were Abraham Jacobi (1830-1919) and M.J. Moses. Jacobi was the founder and first president of the American Pediatric Society, the first chairman of the Section on Diseases of Children of the AMA, and president of the New York State Medical Society, the New York Academy of Medicine and the Association of American Physicians. Both Jacobi and Moses asserted that Jewish boys were immune to masturbation because they were circumcised, and that non-Jews were especially prone to masturbation, and all the terrible diseases that resulted form it, simply because they retained their foreskin. Moses and Jacobi's studies acquired canonical authority, and their claims that the foreskin was the prime risk factor for epilepsy, paralysis, malnutrition, hysteria and other nervous diseases, were regularly cited by medical writers for the next few decades. [37]

In 1871 Moses published a very influential and widely-cited article, "The value of circumcision as a hygienic and therapeutic measure", in the New York Medical Journal. In a key passage he cited his experience "as an Israelite" as giving him the authority to speak on the value of circumcision as a health, and specifically as an anti-masturbation, measure:

As an Israelite I desire to ventilate the subject, and as a physician have chosen the medium of a medical journal, that I may not be trammelled in my expressions … I refer to masturbation as one of the effects of a long prepuce; not that this vice is entirely absent in those who have undergone circumcision, though I never saw an instance in a Jewish child of very tender years, except as the result of association with children whose covered glans have naturally impelled them to the habit. [38]

It is quite clear from the context that the title word "hygienic" has a different meaning from today. At that time circumcision advocates used words such as hygiene to denote moral hygiene, not personal cleanliness. Moses' paper had a big impact on American physicians, who now argued that castration should be abandoned in favour of circumcision, since circumcision cured all the same diseases, but did so without affecting the power to procreate. An article in the Medical Record in 1895 explained the power of circumcision to stop masturbation thus:

In all cases [of masturbation] … circumcision is undoubtedly the physician's closest friend and ally. … To obtain the best results one must cut away enough skin and mucous membrane to

rather put it on a stretch when erections come later. There must be no play in the skin after the wound has thoroughly healed, but it must fit tightly over the penis, for should there be any play the patient will be found readily to resume his practice, not begrudging the time and extra energy needed to produce the orgasm. It is true, however, that the longer it takes to have an orgasm, the less frequently it will be attempted, and consequently the greater the benefit gained. [39]

3.3 More miracle cures

The list of previously incurable diseases that orthodox physicians now claimed to be able to cure or prevent by means of circumcision continued to grow. A textbook from 1895 declared:

Only within recent years, since the physiology of nervous reflexes has become better understood, has [circumcision] become a generally accepted operation with thinking surgeons. Not alone for local conditions is the operation demanded. In all cases in which male children are suffering nervous tension, confirmed derangement of the digestive organs, restlessness, irritability and other disturbances of the nervous system, even to chorea, convulsions and paralysis, or where through nerve waste the nutritive facilities of the general system are below par and structural diseases are occurring, it should be considered as among the lines of treatment. [40]

Thousands of such reports and opinions were published in reputable American medical journals. In 1890 Dr William D. Gentry (1836-1922) produced a typical example, “Nervous derangements produced by sexual irregularities in boys”, which detailed the frightening and varied consequences of phimosis, as well as the miracle cure offered by circumcision:

Whilst I was physician to the children’s home at Kansas City in 1884-85, there was brought to the home from some similar institution in Chicago a child of two and half years, who was blind, deaf and dumb. It was nervous, fretful, and caused the matron a great deal of trouble. It was dwarfed and presented the peculiar general appearance which nearly every boy will present who is afflicted with sexual derangement. As soon as I saw the child the thought came into my mind that his trouble had some connection with such derangement, and on making an examination I found that he had phimosis. With the consent of the father of the boy I operated and removed the derangement. In two months the child could see and make sounds as if trying to speak. In six months he could hear, see and speak. [41]

Where today do we hear this gushing tone?

3.4 Anti-sexual nature of circumcision

The early promoters of circumcision fully acknowledged the sexual functions of the foreskin and advocated circumcision as the intentional destruction of those functions. One of many such acknowledgements was published in an issue of the Medical News in November 1900:

Finally, circumcision probably tends to increase the power of sexual control. The only physiological advantage which the prepuce can be supposed to confer is that of maintaining the penis in a condition susceptible of more acute sensation than would otherwise exist. It may be supposed to increase the pleasure of the act and the impulse to it. These are advantages, however, which in the present state of society can well be spared, and if in their loss some degree of increased sexual control should result, one should be thankful. [42]

In 1902 an editorial in the American Practitioner and News made clear the anti-sexual motivation behind the doctrine of circumcision as a hygienic measure:

Another advantage of circumcision is … the lessened liability to masturbation. A long foreskin is irritating per se, as it necessitates more manipulation of the parts in bathing. … This leads the child to handle the parts, and as a rule pleasurable sensations are elicited from the extremely sensitive mucous membrane, with resultant manipulation and masturbation. The exposure of the glans penis following circumcision … lessens the sensitiveness of the organ. It therefore lies with the physicians, the family adviser in affairs hygienic and medical, to urge its acceptance. [43]

4. Early twentieth century

After the germ theory of disease had become widely accepted and vitamins had been identified, most bacterial diseases, such as tuberculosis, were silently removed from the list of diseases caused by phimosis. Even so, most American physicians tenaciously clung to the belief that phimosis was pathogenic and the cause of diseases, such as epilepsy, in ways not yet understood. Year by year the list of diseases blamed on phimosis continued to grow. Doctors even attributed suspicions deaths to phimosis. [44]

4.1 Abraham Wolbarst and the cancer scare

Abraham Wolbarst (1872-1952) was a urologist practising, among other places, at the Beth Israel Hospital and the Jewish Memorial Hospital in New York. In January 1914 he published, in the Journal of the American Medical Association, the first of series of papers indicting the foreskin as the culprit in the diseases that were to haunt the imagination of the twentieth century. Wolbarst was a prominent and influential member of both the AMA and the notorious American Society of Sanitary and Moral Prophylaxis, a reform organisation dedicated to the abolition of childhood and extra-marital sexuality. His views on sexuality were characteristically extreme. In the 1930s he argued that adult masturbators should be sterilized and forbidden to marry, and in 1914, in his influential paper, “Universal circumcision as a sanitary measure”, he added his own statistics to those of Hutchinson in order to prove that circumcision conferred immunity to syphilis, and to argue that it should be made compulsory as a means of reducing the incidence of masturbation and many other problems as well. He stated that it was “generally understood that irritation derived form a tight prepuce may be followed by nervous phenomena, among these being convulsions and outbreaks resembling epilepsy. It is therefore not at all improbable that in many infants who die in convulsions, the real cause of death is a long or tight prepuce”. He added that it was “the moral duty of every physician to encourage circumcision in the young” [46, 47].

In this paper it is clear that the title word “sanitary” denotes moral restraint rather than the absence of germs or dirt.

It is important to note that until this time circumcision was primarily imposed as a therapy for children and adults, but not as prophylaxis for infants. As a result of Wolbarsts’s ceaseless lobbying and agitation, however, the radical notion of universal, non-therapeutic, involuntary circumcision of young babies slowly gained acceptance among American physicians. (The procedure was non-therapeutic because it was performed on normal, healthy children showing no

signs of deformation or disease.) Medical textbooks were rewritten to instruct obstetricians and pediatricians to examine the penis of every newborn boy to determine whether the foreskin was retractable. If not)as was usually the case), the advice was that it be removed immediately.

By the mid-1930s, when most of the medical profession had converted to the theory that epilepsy was a problem of the brain, Wolbarst clung to his conviction that the most likely cause was a tight foreskin. [48]. While he never abandoned this idea, he must have sensed the need to reformulate his arguments against the foreskin in order to tailor them to appeal to the changing interests and fears of the public. In the early decades of the twentieth century the number of articles on cancer in popular magazines rose dramatically, indicating a shift in the national focus. The Readers Guide to Periodical Literature listed thirteen articles on cancer between 1900 and 1904, but by 1909 the number had doubled, and by 1928 it had increased by 569 per cent. At the peak of this surge in popular anxiety about cancer in 1932, Wolbarst published what was long regarded as the definitive paper on circumcision as the most reliable preventive of cancer of the penis. Based on his "observation" (read contention) that Jewish men never got penile cancer, Wolbarst theorised that the disease was caused by "the accumulation of pathogenic products in the preputial cavity". [49] Wolbarst offered no scientific validation in support of this notion, yet, based on this paper, the proposition that smegma was carcinogenic became widely accepted as a proven fact in the United States.

4.2 Advances in understanding the anatomy and development of the foreskin

In 1932 a research team at the University of Pennsylvania led by Dr H.C. Bazett published a detailed anatomical description of the innervation of the foreskin. They observed that the foreskin was richly networked with nerves and nerve endings and capable of detecting fine distinctions of touch and temperature. [50] The following year Dr Glenn A. Deibert, of the Daniel Baugh Institute of Anatomy at Jefferson Medical College, made a careful investigation of the development of the foreskin in utero and the process by which it separated from the glans after birth. [51] Deibert demonstrated that the adherence of the foreskin to the glans was neither phimosis nor a birth defect, but a normal stage of penile development. In 1935 the British anatomist Richard Hunter at Queen's University, Belfast, published a similarly detailed description of the embryological development of the foreskin. No doubt because these findings did not support the prevailing orthodoxy that the foreskin was a useless, pathological defect, all three studies were completely ignored by the medical establishment. [52]

4.3 The Gomco clamp

The profit margin for circumcision procedures rose with the mass manufacture and wide distribution of the now ubiquitous Gomco clamp, invented in 1934 by Aaron Goldstein and Dr Hiram S. Yellen. Gomco is an acronym for the GOldstein Manufacturing COmpany, which later changed its name to the Gomco Surgical Manufacturing Corporation of Buffalo, New York. This cruel stainless steel device is still widely used today to crush the foreskin and isolate it so that it can be excised by scalpel. The standardization of its surgical technique facilitated the rapid institutionalisation of neonatal circumcision as a routine hospital procedure and led to the acceptance of the "high and tight look" (since the clamp usually produced a maximum loss of tissue) that came to be regarded as the normal appearance of the penis.

4.4 Popular perceptions

The September 1941 issue of Parents Magazine included the first published article on the advisability of routine circumcision that had ever appeared in a popular magazine with such a wide readership. The author was Dr Ian F. Guttmacher, an obstetrician at Johns Hopkins University Medical School, and he fed the public with many of the same myths and scare stories that had been in circulation since the nineteenth century. Like his predecessors, he admitted that circumcision "causes blunting of male sexual sensitivity", but (like Hutchinson) argued that this was an advantage. As well as citing Wolbarst's discoveries about penile cancer, Guttmacher reiterated the Edwardian myth about the necessity for daily scrubbing of the glans. Although this had been a cliché of British Empire baby care guides from the 1890s until the 1930s, in Britain it had just been exposed as a myth by Douglas Gairdner. The idea was new to American medical literature, however, and just as a better understanding of normal infant anatomy triumphed in Britain, old myths became consolidated in the United States; with all the authority conferred by his professional title and institutional connections, Guttmacher told the public:

Present-day hygiene require that the prepuce, the hoodlike fold of skin which covers the end of the penis (glans) be drawn back daily and the uncovered glans thoroughly washed. Trouble occurs if this is neglected, for the secretion from the multiple glands lining the inside of the hood becomes caked, and within a few days the material may set up an inflammation. Such inflammation may lead to the growth of slender, strandlike bands of tissue between the inside of the prepuce and the glans, gluing the two together, thus forming an adherent foreskin.

Thus we see the Victorian myth of acquired phimosis taking on a new lease of life in the New World of space travel. To avert this frightening scenario, Guttmacher advised parents to have their boys circumcised at birth because doing so "makes care of the infant's genitals easier for the mother", and because "it does not necessitate handling of the penis by the infant's mother, or the child himself in later years, and therefore does not focus the male's attention on his own genitals. Masturbation is considered less likely". Guttmacher succeeded in validating the perceived associations between the foreskin, difficult hygiene, inevitable masturbation, genital defects and the fear of touching the baby's penis. It also served to legitimise the increasingly common practice on the part of large urban hospitals of instituting programs of automatic circumcision of the newborn, irrespective even of parental wishes [53-55].

4.5 Abraham Ravich and the myth of cancer of the prostate

Abraham Ravich was a urologist at Israel Zion Hospital, Brooklyn, from which position he became one of the most rabid crusaders for mass involuntary circumcision since Jonathan Hutchinson and Peter Charles Remondino. In 1942, expanding upon Wolbarst's theory of smegma as a carcinogen, and repeating the myth of Jewish men's immunity to such disease, he postulated a causal link between the foreskin and cancer of the prostate. He also restated the obscure theory (first suggested, without much evidence in 1926 [56]), that cervical cancer in the female was caused by smegma from the male [57]. The popular magazine Newsweek gave sympathetic coverage to Ravich's claims and quoted his demand that there be "an even more universal practice of circumcising male infants" [58]. Among the many achievements that he listed for his entry in Who's Who in America, Ravich credited himself with being the first to report on the value of neonatal circumcision as a preventive of genital cancers. [59].

5. World War II

Mass recruitment and conscription during World War II put a lot of men under the power of military doctors with the authority to institute a campaign of near-routine circumcision of servicemen in all branches of the armed forces. Even at the height of the war, Navy physician Lt Marvin L. Gerber confidently stated in he pages of the United States Naval Medical Bulletin that circumcision was one of the most commonly performed surgical operations in the navy, even more common than trauma surgery [60]. Military doctors alleged that epidemics of phimosis and paraphimosis among soldiers justified the mass circumcision campaign. Men were regularly humiliated by unannounced examinations of their penises (called short arm inspections), and many who had not been circumcised were declared to be suffering from phimosis and sent off to get cut; court martials were threatened if they showed reluctance.

5.1 Sexually transmitted diseases and the scapegoating of Blacks

Military records reveal that Black Americans were blamed for spreading venereal disease in the military and were thus made particular targets of circumcision campaigns. Military doctors such as Eugene A. Hand (1909-c.1972), a dermatologist (VD expert) at the naval hospital, St Albans, New York, were responsible for the military's adoption of the view that Blacks were dangerous carriers of disease, and that the low rate of circumcision among them was the main reason for this. Capt Leonard Heimoff, US Army Medical Corps, declared that Negro troops were "causing 70 per cent of all new cases of venereal disease", and he organised covert military police units to monitor the sexual life of civilian Black communities. [61] Heimoff's report, like that of Hand and others, concluded that Blacks could not be taught to practise personal hygiene nor trusted to take precautions against contracting STDs – presumably a euphemism for claiming that they were too stupid and/or sex crazed to use condoms.

Where else today do we find this assumption guiding health policy?

The war coincided with an increased national obsession with the danger of VD. From 1930 to 1940 the number of articles on VD in popular magazines increased by 192 per cent, and at an annual rate of 17 per cent from 1940 to 1947, after which interest trailed of – presumably in response to the discovery of an effective cure for syphilis in the form of penicillin. At the height of this hysteria Hand delivered a paper called "Circumcision and venereal disease" at the annual meeting of the AMA in June 1947. Comparing the incidence of VD among Jews, gentiles and Blacks, and reporting that it was rare among Jewish men, Hand theorised that circumcision had a major protective effect:

Circumcision is not common among Negroes. … Many Negroes are promiscuous. In Negroes there is little circumcision, little knowledge or fear of venereal disease, and promiscuity in almost a hornets nest of infection. Thus the venereal rate in Negroes has remained high. Between these two extremes there is the gentile, with a venereal disease rate higher than that of Jews, but much lower than that of Negroes. [62]

In the same study Hand reported that cancer of the tongue was more common among men with foreskins than among Jews. Newsweek gave generous coverage to these sensational findings, thereby fuelling the popular perception that a policy of mass circumcision was both scientifically valid and of critical importance to the future security of the nation. [63]

5.2 Douglas Gairdner saves the British foreskin

In December 1949 the British Medical Journal published "The fate of the foreskin", a landmark study by Cambridge pediatrician Douglas Gairdner (1910-1992). Drawing on the research of Deibert ad Hunter, and presenting his own meticulous observations on preputial development, adhesion and retractability, Gairdner debunked the phimosis myth and demonstrated that non-retractability, adhesion and length were the normal conditions of the infant foreskin, and that separation occurred gradually as the boy got older. His paper also reviewed the standard list of the benefits of circumcision (cancer, syphilis) and rejected them as spurious. Circumcision rates in Britain had been declining since the 1930s, when doctors had become concerned at the high incidence of injury and death, and Gairdner's paper gave it the death blow. [64] Under the new National Health Service established in 1948, parents who asked to have their boy circumcised were told that it was not an approved procedure and that if they wanted it they would have to pay to get it done privately. As you would expect, when a price was put on the operation most parents decided that it was not really necessary after all, and the incidence of circumcision declined rapidly.

A short history of circumcision in the United States: Part 2 Print

6. Corporate institutionalisation of circumcision in the Cold War era

In the United States, however, Gairdner's paper was ignored, and the old myths repackaged by doctors such as Guttmacher held sway instead. Medical textbooks became even more insistent that obstetricians should examine every newborn boy to check whether his foreskin was adherent, unretractible or too long , and to perform an immediate circumcision if such symptoms of "phimosis" were present – as they nearly always were. In 1953 obstetricians Richard L. Miller and Donald C. Snyder published an influential paper in the American Journal of Obstetrics and Gynecology, calling for the immediate circumcision of all males straight after birth. Ignoring Gairdner and relying heavily on the writings of Wolbarst, they insisted that "phimosis" required immediate surgical correction, and asserted that circumcision would "reduce the incidence of onanism", heighten male libido and "increase longevity and immunity to nearly all physical and mental illness." They also stated that circumcision immediately after birth was convenient for the doctor and in the financial best interests of the hospital. Leading obstetrical textbooks were soon rewritten to include Miller and Snyder's recommendations. [65, 66]

6.1 The new cancer scare

During the 1950s, with syphilis under control thanks to penicillin, cancer regained its position as the most feared disease. Between 1943 and 1951 the number of articles on cancer in popular magazines increased by 182 per cent, a further 32 per cent between 1951 and 1955, and another 72 per cent from 1955 to 1957. In keeping with this renewed and increased alarm, Ravich published a new paper, "Prophylaxis of cancer of the prostate, penis and cervix by circumcision", in which he alleged that 25,000 deaths annually from cancer were really caused by the foreskin, and that between 3 and 8 million American men then living had contracted prostate cancer through the influence of their foreskin. Ravich concluded that a program of mass compulsory circumcision was necessary as an "important public health measure". [67] Ravich's theory of cervical cancer was taken up by Dr Ernest Wynder at the Manhattan Memorial Centre for Cancer and Allied Diseases, and in 1954 he published a lengthy paper that purported

to show that universal neonatal circumcision of males could eliminate cervical cancer in women. [68} Again, a popular news magazine (in this case, Time) gave warm coverage to Wynder's claims, thus giving them both publicity and credibility, and encouraging public support for the burgeoning circumcision industry. [69]

Meanwhile, there were also a few calls for circumcision of girls and women. During the 1950s some American physicians stepped up their efforts to popularise circumcision of adult females – here meaning excision of the clitoral hood as a hygiene measure. In 1959 Dr W.G. Rathmann published an article in which he promoted the idea of female circumcision as a cure for psychosomatic illness and marital problems. He also took the opportunity to tout his newly-patented female circumcision clamp. [70]

6.2 Kaiser, Gomco and Europe

In the 1950s an increasing number of corporation-managed hospitals and insurance companies entered the now profitable business of routine neonatal circumcision. Private hospitals instituted policies of immediate and automatic circumcision of all male neonates, often in the delivery room. At the Kaiser Foundation Hospital in 1950, out of 889 live male births, 812 (92 per cent) were circumcised immediately after birth. [71] Likewise, many urban hospitals adopted the policy of circumcising any boys who missed out at birth when they were brought in for other common procedures, such as having their tonsils removed.

In the late 1950s the American circumcision industry sought to spread the practice to Europe, with a particular focus in east and west Germany, the latter under extensive American influence as a result of the post-war occupation. Around 1957 the Gomco corporation established a distribution network in Ulm [72], and in the same year Kaiser worked with Otto Dietz, a minor official in the East Berlin secret police, to introduce circumcision in east Germany [73]. In 1959 150 babies born in a state-run clinic in Darmstadt, west Germany, were experimentally circumcised without anaesthesia a publicity stunt for the Gomco clamp [74], and in1963 Dr H. Koester arranged for the maternity clinic at the University of Giessen to adopt a policy of automatically circumcising all boys born there, again using the Gomco clamp. In 1968 a further demonstration of its speed and efficiency was arranged in east Germany [76].

By the early 1970s, however, the experiments had aroused the disfavour of both east and west German authorities, and the experiments came to an end. Gomco promptly turned its attention to Denmark and in 1973 arranged for 18 Danish newborns to be cut. [77]. Along with publicity photos of the clamp, the results were praised by the Danish medical press. The Danish public, however, were less impressed and strenuously resisted the idea of allowing their children's sexual organs to be surgically altered for any reason, and the campaign faded away.

It is easy to see that Gomco's attempted push into Europe had nothing to do with health, but was entirely a commercial venture.

6.3 Professional opposition to circumcision

There was some opposition to forcible circumcision. In 1956 and 1959 Dr Richard K. Winkelmann, a fellow in dermatology at the Mayo Clinic, published two studies which documented the intense innervation of the foreskin and identified it as specific erogenous zone.

[78, 79] In a period that was intensely hostile to sexual enjoyment, however, his studies were ignored. In 1954 Ravich's theory that the foreskin caused cancer of the prostate was disproved [80], and in 1962 the hypothesis that it caused cervical cancer in women was falsified [81]. In 1963 a further study invalidated Wolbarst's contention that smegma was carcinogenic. [82] In 1965 the trend towards scepticism was boosted when the Journal of the American Medical Association published Dr William Morgan's provocatively titled paper, "The rape of the phallus". In this article Morgan debunked all the then current arguments used by hospitals to justify involuntary circumcision and initiated a controversy within the American medical profession that continues to this day. [83]

An even more significant article, on the nature of the juvenile foreskin, was published in 1968. The British pediatric journal, Archives of Diseases of Childhood, carried an account of the exhaustive research of the Danish pediatrician Jakob Oster, who had examined the incidence of preputial adhesions in 9,545 Danish schoolboys aged 6 to 17 years. [84] Like Gairdner, Oster's findings disproved the phimosis myth and demonstrated that adhesions between the foreskin and glans were not a birth defect, but a perfectly normal stage of penis development. He further showed that separation between glans and foreskin was a gradual biological process that often took ten years or more to complete. His research revealed that no interventions were needed in normal cases and, more importantly, that inappropriate attempts to hasten development (e.g. by tearing the foreskin from the glans) could damage both structures and actually bring about the phimosis it was supposed to fix. Oster's study significantly advanced scientific understanding of the foreskin was widely read by the British and European medical community; in the United States it was pretty much ignored.

In 1970, however, the spark ignited by Morgan was fanned into flame in an article by Noel Preston, "Whither the foreskin?", in JAMA. [85] The paper debunked all the reigning circumcision myths and influenced the American Academy of Pediatrics to publish the following revolutionary statement in the fifth edition (1971) of its Standards and Recommendations for Hospital Care of Newborn Infants: "There is no valid medical indications for circumcision in the neonatal period." [86]

In the late 1970s, as Americans became increasingly aware of the abuses of power rampant in the nation's social institutions, grass roots movements against the forced circumcision of American children began to emerge. In the face of ridicule and hostility from health care professionals, many American parents began to refused to allow their sons to be circumcised. At the same time, developments in medical ethics that brought the concept of informed consent into the surgical arena required doctors to explain the probable outcome of any surgery, state the known risks, offer alternative treatments for the problem and obtain written consent from the patient. Circumcision, too, now required a consent form, but since the person being operated on was not capable of giving informed consent, spokesmen for the circumcision industry claimed that parents could give consent by proxy. By presenting involuntary circumcision the parents' choice, circumcision advocates obscured the vital fact that the person who ran the risks and had to bear the lifelong consequences of the surgery was still not permitted a choice in the matter. Critics countered that doctors had no legal power to concede control of the baby's genitals to the parents because doctors had no legal power over his genitals in the first place.

6.4 Backlash from the circumcision industry

The high-water mark of involuntary circumcision was reached in the 1970s. With or without parental consent, hospital practice raised the incidence of neonatal circumcision to 90 per cent in the late 1970s and early 1980s. Circumcision advocates from urban areas took positions in small rural hospitals in America's heartlands and instituted new circumcision programs in regions of the country where it had not been known.

At the same time, baby care guides, popular medical magazines and health texts circulated myths to the effect that a boy not circumcised in infancy would suffer terrible psychological damage if he ever saw that his father's circumcised penis differed from his own. [87-89] (Oddly enough, this had not been raised as a problem when the father was uncircumcised and the boy cut, though you would think that a person would be more upset at lacking something his father possessed than possessing something his father lacked.) Another myth that was particularly effective in exploiting middle class anxieties about conformity and social status was that an uncut boy would be made to feel weird and inferior to his circumcised classmates in school locker-rooms. [90]

Accurate information on the anatomy and physiology of the foreskin was omitted from American textbooks and replaced with the pseudo-science of the circumcision lobby. [91, 92] Even anatomical representations of the penis in standard urology texts silently omitted the foreskin and showed the penis as circumcised, as though it were that way by nature [93]. The few drawings of the anatomy of the natural penis that could be found generally represented the foreskin incorrectly. The normal human penis became a strange and alien anomaly to the new generation of Americans – physicians and laymen alike – most of whom had never seen one. As an example of the outdated information being given to American medical students, here is a quote from the 1970 edition of Campbell's Urology, the standard urology textbook:

Phimotic stenosis causes extreme difficulty of urination, with straining and crying; hernia or rectal prolapse may be secondary end results. Urinary infection is a frequent complication, and is often directly predisposed to by the preputial obstruction. Malnutrition, epistaxis, convulsions, night terrors, chorea and epilepsy have all been reflexly attributed to phimosis.

Consistent with these Edwardian notions, it also advised circumcision as a precaution against masturbation:

Parents readily recognise the importance of local cleanliness and genital hygiene in their children and are usually ready to adopt measures which may avert masturbation. Circumcision is usually advised on these grounds. [94, 95]

The Victorian masturbation hysteria was apparently still alive and well in American medical textbooks in the scientific seventies.

In October 1972 the American Academy of Pediatrics appointed a committee to discuss circumcision in order to provide guidance to health insurers who had been asking whether neonatal circumcision should be covered in their insurance policies. The outcome was never officially released, but the conclusion was unofficially presented by Dr Thomas Guthrie to an

AMA conference in June 1973. He argued for even more widespread neonatal circumcision and the continuation of insurance coverage. [96]

Female circumcision had not entirely disappeared from American medical practice. In 1973 Dr Leo Wollman, a gynaecological surgeon at Maimonides Hospital, Brooklyn, published an article in which he argued for female circumcision (meaning excision of the clitoral hood) as a cure for frigidity. [97] Wollman's appeal was geared to the ethos of the sexual revolution of the 1970s, when sexual pleasure was at last becoming recognised as a legitimate part of life and even the responsibility of the medical profession. Surgical modifications of the male and female genitalia, it was argued, would improve the quality of orgasm. This was the exact opposite of the message communicated a century before, when one of the chief virtues of circumcision was (correctly) held to be its effect in reducing sexual sensation. The sudden reversal of argument convinced critics that American circumcision advocates were willing to say anything in order to push circumcision onto a gullible but increasingly suspicious public.

To make matters worse for the circumcision lobby, in 1975 the American Academy of Pediatrics issued a further policy on circumcision that concluded:

There is no absolute medical indication for routine circumcision of the newborn. … A program of education leading to continuing good personal hygiene would offer all the advantages of circumcision without the attendant surgical risk. Therefore, circumcision of the male neonate cannot be considered an essential component of adequate total health care. [98]

6.5 Legal action for children's rights

In the 1980s men finally began to wake up to what had been done to them as infants, and several lawsuits against doctors and hospitals in California were filed, charging that hey had violated the constitutional rights of the plaintiffs by circumcising them without consent. [99, 100] The cases were filed in order to establish that parents do not have the right to consent by proxy to medically unnecessary surgery on their children, basing their claim on the 1975 AAP policy that circumcision was not medically necessary. The acknowledged lack of medical justification for circumcision put circumcisers at risk of litigation, but more importantly the constitutional challenge to the legality of subjecting children to involuntary circumcision threatened to dismantle a lucrative medical sideline – which in 1986 was estimated to generate some $200 million annually. [101] If neonatal circumcision were to survive, new medical excuses would have to be found.

6.6 The urinary tract infection scare

In the mid-1980s the new excuse was provided by urinary tract infections (UTIs). Although nothing on this rare condition had ever appeared in a popular magazine, the medical literature reflected a surge of research interest. A search of Medline uncovered only four publications on UTIs for the period 1966 to 1974; 65 from 1975 to 1979; and 350 from 1980 to 1984. While the national incidence of UTIs had not altered from 1966 to 1989, the astounding 8,650 per cent increase increase in the number of published studies showed clearly that UTIs were the next big thing, and it was not long before the foreskin was being blamed as a risk factor. In 1982 Drs Charles Ginsburg and George McCracken published a report of a study of 100 infants with acute UTIs. Because only 3 of the 62 males were circumcised, the authors speculated that lack of

circumcision might increase susceptibility, though they admitted that “perineal hygiene was inadequate in many patients”. [102]

In 1985, evidently intrigued by this lead, Dr Thomas Wiswell, then a neonatologist at Brooke Army Medical Centre, Texas, sought to verify it with his own studies, and soon published in Pediatrics the first of many studies promoting the theory that the foreskin increased the risk of UTIs and that circumcision was therefore a valuable prophylactic. [103] Wiswell’s first review of hospital charts implied a UTI incidence of 1.4 per cent in uncircumcised boys and 0.14 per cent in circumcised boys, though he did not take into account such relevant factors as whether the babies were breast-fed (breast milk carries powerful antibodies) or the fact that many of the uncircumcised boys had been subjected to premature retraction of their foreskin, thus making it likely that the infection had been communicated by the doctor or nurse. Such questions were simply not asked. Although the difference between the two groups was very small (1.2 percentage points), it was made to appear much larger by being described as a 10 per cent increase. Circumcision enthusiasts hailed the results of Wiswell’s research as a new indication for circumcision and just what they needed to defeat the emerging legal and human rights challenges.

Indeed, a letter in response to Wiswell’s study addressed the lawsuits directly. The author, Dr Aaron Fink (1926-1994) was a urologist in the mould of Wolbarst and Ravich and a long-time agitator for universal neonatal circumcision. He was clearly disturbed at the possibility that circumcisers might face the risk of legal action from their victims and ridiculed the idea that circumcision required the consent of the person on whom it was performed. [104] In his reply, Wiswell agreed that the medical indication he had discovered removed the need to obtain consent before operating. [105] McCracken was less convinced, however, and commented that “because the long-term outcome of UTI in uncircumcised male infants is unknown, it is inappropriate at this time to recommend circumcision as a routine medically indicated procedure.” [106]

Nonetheless, medical texts and popular magazines quickly incorporated UTIs into their list of why the baby should be circumcised [107-109]. Magazines such as Newsweek and US News and World Report ran feature stories on Wiswell’s discoveries and hailed them as the answer to those who were trying to stop circumcision. [110, 111] Since few males ever experience a UTI the UTI myth had little power to influence fathers, but research had shown that it was the mother, more often than the father, who signed the circumcision consent form. [112-114] Among girls, however, unpleasant and painful bouts of UTI are relatively common [115, 116], and the new UTI scare proved quite effective in frightening young mothers into agreeing to the circumcision of their sons. Unlike STDs and cancer, which did not affect men until they were sexually active adults and old men, UTIs could affect infants. Wiswell’s warning that the foreskin posed a serious threat to the baby’s health, and even his life, in the first few weeks, and that it could increase the risk of complications such as kidney failure, meningitis and death, naturally alarmed many parents and convinced them that they had better get the baby done “just to be on the safe side”. [117-118]

At this point Wiswell tried to turn the legal tables by suggesting that if insurers did not cover circumcision they might be held legally liable if a baby contracted UTIs. “If ten years from now

there are uncircumcised children on dialysis with kidney damage associated with UTI , insurers who would not pay for circumcision might be held liable," he wrote [119]. At the same time, oddly enough, he stated that "I tell them [parents] that I personally don't like the procedure and don't recommend it, but if they want it performed I will do it."

A further effect of the UTI scare was to persuade pro-circumcision forces in the AAP to agitate for a new circumcision policy. In 1989 a new task force was established under the chairmanship of Dr Edgar Schoen (b. 1925), a pediatrician at the Kaiser Foundation Hospital, Oakland, since 1954, and a fanatical advocate of universal circumcision. (Kaiser, it will be recalled, was the commercial medical services company that tried to sell Gomco circumcision clamps to Germany and Denmark in the 1960s.) After intense debate the Task Force produced a new and highly equivocal statement that took Wiswell's UTI hypothesis into account but stopped short of recommending a return to routine circumcision:

Newborn circumcision has potential medical benefits and advantages as well as disadvantages and risks. When circumcision is being considered, the benefits and risks should be explained to the parents and informed consent obtained. [120]

By closing the legal loophole in the 1975 statement, the new policy protected circumcisers from legal action while avoiding any overtly unscientific or unverifiable claims. Sensitive to the awkward fact that European countries had steadfastly rejected American attempt to export circumcision, Schoen (from his office in the Kaiser Permanente Medical Centre) made another attempt to badger northern European countries into adopting programs of routine circumcision on the United States model. [121] The terse reply to his overtures, written by two of Sweden's most eminent physicians and published in a leading Swedish medical journal, invoked a number of critical issues that he had never considered: fairness, human rights and medical ethics. Pointing out that it was a violation of a person's human rights to be subjected to such a procedure without informed consent, the authors observed that it was only fair to postpone a decision on the matter until the boy was old enough to make his own decision. The authors explained that since an ethics committee on experimental animals would never accept clinical trials involving circumcision without anaesthetic on laboratory animals, Europe could hardly justify subjecting its own children to such pain and suffering. [122]

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NOTE
In relation to the following two sections it should be noted that this study was written in 1995-96 when the notion that the foreskin was a major risk factor for HIV-AIDS, and that circumcision was therefore an important part of any anti-HIV strategy, was no more than the speculation of cranks. At that time there was no predicting that the idea would be seized upon by the international AIDS industry, given massive funding, and presented to the world as the definitive solution to the AIDS problem in Africa, and probably in other underdeveloped regions as well. What we can observe is the consistency of the historical pattern: as soon as a new disease leaps to the forefront of public anxiety, circumcision enthusiasts suggest that the foreskin has something to do with it and yet more circumcision is the answer. In fact, the claim that mass circumcision is necessary to control AIDS is largely a re-run of the nineteenth century conviction

that mass circumcision was necessary to control syphilis; in each case, an incurable disease had so terrified the public that they were ready to accept almost anything if it offered the possibility of increasing their safety without the need to change their habits.

What gets forgotten is that AIDS is not a particularly contagious disease and that you have to go to some trouble to contract it; apart from blood transfusions, tattoos, surgery and intravenous drug use (where circumcision would obviously make no difference), the only way you can get AIDS is through unprotected intercourse with an infected partner. The simplest way to run no risk of HIV infection, therefore, is not to be promiscuous and to practise safe sex. This policy has successfully kept HIV infection at a low level in countries such as Australia, Germany and Britain, but western health agencies seem to have much the same attitude towards Africans as Eugene Hand exhibited towards American Blacks: because they are too stupid to use condoms and too sex crazed not to be promiscuous, the only thing that can be done is to circumcise them in the hope of slightly reducing the risk. The foreskin is targeted not because it is a particularly useful point of intervention, but because it is an easy target for surgical removal and a once-off procedure, after which the agencies can congratulate themselves that they have done all they can.

It should also be remembered that there are strong cultural pressures to use the AIDS scare as the latest means of preserving circumcision as a routine procedure among the cultures that traditionally practise it. The billions poured into the World Health Organisation and UNAIDS represent a bizarre alliance between American medical research money, African tribalism and Muslim religiosity, all of which forces have an emotional commitment to finding new and "scientific" justifications for continuing their traditional practices.

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6.7 The HIV scare

In the early 1980s the arrival of a new and terrifying infection in the form of HIV-AIDS (as it later became known) gave the circumcision lobby a juicy new opportunity to incriminate the foreskin in the generation of disease. First to capitalise on the opportunity, as early as 1986, was the egregious Aaron Fink, who was able to persuade the New England Journal of Medicine to publish his speculation that the presence of the foreskin made men more susceptible to infection. [123] On the basis of this theory, throughout 1987 and 1988 Fink lobbied the California Medical Association to adopt a resolution endorsing routine neonatal circumcision as "an effective public health measure". His efforts were rejected by the Scientific Committee of the CMA in 1987, but in 1988 he managed to get his resolution passed on the voices at a CMA meeting. This attracted some national attention, unlike his other new reasons for circumcision – group B-streptococcal disease and "sand balanitis" [124, 125] These connections were evidently too far out even for the gullible American media.

Fink's theory about the foreskin and AIDS, however, was eagerly taken up by other American circumcisionists, such as Francis Plummer and Stephen Moses, who have campaigned tirelessly for new programs of neonatal circumcision as a precaution against HIV acquisition in later life.

6.8 The future of involuntary circumcision

Since the 1980s private hospitals have been in the business of supplying the foreskins they

harvest to private biological research laboratories and pharmaceutical companies that require human tissue as raw research material, as well as manufacturers of cosmetics and artificial skin. They have also supplied foreskins to transnational corporations such as Advances Tissue Sciences (San Diego), Organogenesis and BioSurface Technology, companies that have recently emerged to reap profits from the sale of products made form harvested human tissues. [126-129]

Despite the efforts of Schoen, Fink, Wiswell etc, the incidence of circumcision in the United States began to fall in the early 1980s, and the downward trend accelerated in the 1990s. The fall was not due so much to the policies of the AAP, which most doctors ignored, but to the educational efforts of popular and professional anti-circumcision groups. Official figures show that the incidence of neonatal circumcision in the western states, where such groups were most active, fell from 64 per cent in 1979 to 34 per cent in 1994. As a result of an increase in the rate in the Midwest, however, the national figures fell much less – from 64 per cent to 62 per cent over the same period.

In February 1996 a research team at the University of Manitoba led by Dr John Taylor published the results of the most significant investigation of the anatomy and physiology of the foreskin since Winkelmann. Their paper, "The prepuce: Specialized mucosa of the penis and its loss to circumcision", described the structural and functional components of the foreskin and established its rich innervation and vascularisation, clearly evolved to constitute an erogenous zone and to enhance erotic experience. Since circumcision had originally been instituted precisely for the purpose of destroying these very features, it is not surprising that the medical establishment was reluctant to acknowledge Taylor's work, let alone face the obvious implications. Other bodies, however, have paid attention, including the Australian College of Paediatrics and the Canadian Pediatric Society, both of which published policies on circumcision in 1996. Each recommended that circumcision of newborns be not performed, and pointed out that circumcision without informed consent was a violation of accepted principles of both medical ethics and human rights. [131, 132]

Around this time, too, prominent figures from the world medical community condemned the American practice of routine circumcision of infants as both medically unnecessary and morally wrong. The consensus among critics was that irrespective of the validity of the health arguments for circumcision, the fact that it was done without consent made it an unacceptable intrusion into the personal lives of individuals and an unwarranted deprivation of their private property. [133-138] The constitutional conflict between human rights and the American medical establishment's assumption that it knows best what's good for boys may be settled in the courts.

7. Conclusion

The historical record makes it clear that in the late nineteenth century American physicians sought to institutionalise genital mutilation of both boys and girls as a means of eliminating childhood sexuality, and that their efforts were successful in the case of boys, unsuccessful in the case of girls. Doctors circumcised boys to denude, desensitise and disable the penis to such an extent as to make masturbation impossible, or at least not worth the effort. Clitoridectomy of girls was introduced for the same reason. While the medical establishment's use of popular fears about masturbation to justify mass circumcision has remained pretty constant since Victorian times, the subsequent supplementary excuses offered to justify circumcision follow a clearly

defined pattern: whatever incurable disease happens to be the focus of national attention at any given time will be the disease that circumcision advocates will cite as a reason for circumcision. In the 1870s, when epilepsy was the disease of the moment, circumcision advocates claimed that circumcision could cure and prevent epilepsy. In the 1940s, when STDs were the focus of national health fears, they claimed that circumcision could prevent the spread of STDs. In the 1950s, when everybody was obsessed with cancer, circumcision advocates claimed that circumcision could prevent all sorts of cancers – of the penis, of the tongue of the prostate and of the cervix. Since the late 1980s, when HIV-AIDS became the greatest health scare since the Black Death, circumcision advocates have predictably claimed that circumcision is the answer to AIDS control.

Ironically, and despite these claims, the United States, for all that most of the men are circumcised, does not have a particularly good health record, and on most indicators is well behind places such as Japan and Scandinavia, where circumcision is practically unknown. Today the USA has both the highest percentage of sexually active, circumcised men and one of the highest rates of genital cancers and STDs in the western world. The paradox implicit in this history is that even though mass circumcision has been ineffective as a public health measure, and has done little to control either cancers or STDs, the American medical establishment has clung to its faith in circumcision and consistently sought to find new justifications for it. Their priority does not seem to have been maximising public health, but maximising their foreskin harvest. Such unscientific allegiance to an ineffective and harmful surgical procedure, when good sense would suggest the adoption of more conservative and more effective strategies, suggests that there may be a deeper, non-rational dynamic behind circumcision advocacy, and that it is not just matter of simply applying, as they so often claim, the discoveries of medical science to public health policy. [139]

The history of the institutionalisation of involuntary circumcision in the United States demonstrates that American society has been willing to apply what it takes to be scientific measures at the expense of personal liberty. It is tempting to dismiss circumcision as merely a quaint example of medical quackery pursued by a handful of zealous doctors. We would do better to remember that in the name of scientific progress, millions of American citizens have been subjected to genital mutilation and deprived of an integral, functional and beautiful part of their body. In the face of increasing international criticism and constitutional challenges we must wonder how much longer the medical establishment will be able to continue to indulge in the kinds of illogical thinking and disregard for human rights that underpin their commitment to circumcision as prophylaxis and therapy.

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