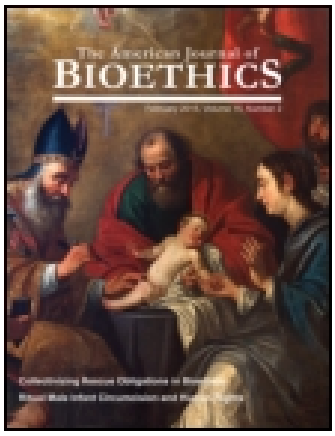

The American Journal of Bioethics
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/uajb20

Sex and Circumcision

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Published online: 12 Feb 2015.

To cite this article: Brian D. Earp (2015) Sex and Circumcision, The American Journal of Bioethics, 15:2, 43-45, DOI: 10.1080/15265161.2014.991000

To link to this article: http://dx.doi.org/10.1080/15265161.2014.991000

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Sex and Circumcision

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What are the effects of circumcision[1] on sexual function and experience? And what does sex—in the sense related to gender—have to do with the ethics of circumcision? Jacobs and Arora (2015) give short shrift to the first of these questions, and they do not seem to have considered the second. In this commentary, I explore the relationship between sex (in both senses) and infant male circumcision, and draw some conclusions about the ongoing debate regarding this controversial practice (for overviews, see Earp 2013; Earp and Darby 2014).[2]

THE EFFECTS OF CIRCUMCISION ON SEXUALITY

According to Jacobs and Arora (2015), circumcision has "little or no effect . . . on sexuality" (34). Since this is a cornerstone assumption of their argument, it is worth considering in some detail. Problematically, the authors rely (chiefly) on a pair of clinical trials that were carried out not on infants but on adult men who had volunteered to be circumcised. This conflation is unjustified for two reasons. First, it obscures the very distinction that opponents of involuntary circumcision typically invoke as being morally decisive (namely, the presence or absence of informed consent by the individual to be affected by the surgery); second, it is inaccurate on medical grounds. The effects of adult circumcision, whatever they are, cannot be simply mapped on to neonates. In other words, the data the authors appeal to in support of infant circumcision have almost nothing to do with infant circumcision.

Consider the trial by Krieger and colleagues,[3] cited by Jacobs and Arora. Participants in this trial, aged 18–24 years, were asked about their sexual desire, satisfaction, and so on, on a series of makeshift pen-and-paper scales, up to 24 months after the surgery. But if circumcision has a desensitizing effect on the penile glans (due to long-term exposure to irritation from the environment; see Frisch

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1. Jacobs and Arora (2015) purport to have written an article about "ritual infant male circumcision." However, they limit their discussion to circumcision performed "in a hospital or outpatient setting hygienically and with adequate analgesia" (30), which is not how "ritual infant male circumcision" is traditionally performed. Indeed, the authors build the bulk of their case about "benefits versus risks" (see Earp under review) on the back of data that do not apply to the practice they seek to defend.

2. Some sentences in the following sections have been adapted from Earp and Darby (2014).

3. For the full citation, see Jacobs and Arora (2015).

2012), this is unlikely to be detectable after only 24 months. In infant circumcision, by contrast, the unprotected head of the penis has to rub against clothing (etc.) for over a decade before sexual debut. In this latter case, however, the affected individual has no point of comparison by which to assess his sexual sensation or satisfaction—his foreskin was removed before he could acquire the relevant frame of reference—and thus he will be unable to record any differences.

There are further problems with these kinds of studies. The most significant is that the target of investigation—namely, human sexual experience—is both subjective and complex. It cannot be reduced to a set of items on a survey without sacrificing morally relevant information. As the authors of one of the trials cited by Jacobs and Arora reported: "The questionnaire [we used] did not ascertain more subjective aspects of sexual satisfaction such as changes in time to ejaculation, subjective intensity of orgasm or the partner's satisfaction with intercourse." The authors of the other trial stated: "This [trial] has several limitations. We did not have direct observation of sexual function, partner reports, or physiologic or laboratory indicators of sexual dysfunction. [We also] did not use validated instruments" (see Earp and Darby 2014 for the citations and further discussion).

Jacobs and Arora decline to mention any of these caveats, and instead blandly refer to the studies as being of "high quality" (presumably because of their randomized design).[4] At the same time, however, the authors ignore several blatant effects of circumcision on sexuality that can be directly inferred from penile anatomy. First, any erogenous sensation *in the foreskin itself* is necessarily eliminated by circumcision. This is not a trivial concern: In the adult male, the foreskin constitutes roughly 30–50 square centimeters of densely innervated, vascularized, elastic genital tissue (see Earp and Darby 2014). This tissue can be stretched, rolled back and forth over the glans, and otherwise manipulated during sex and foreplay, which allows for a range of sexual functions—along with their concomitant sensations—that are physiologically impossible if this tissue is removed. To say that circumcision has "little or no effect" on sexual experience, therefore, is to adopt an extremely narrow conception of that term.

This is not to say that circumcised men either do not or cannot enjoy sex; that is clearly not the case (as circumcised men will generally attest). However, it does negate the premise that circumcision does not *affect* sexual experience—and in a way that some would regard as being detrimental.

In light of these considerations, a great many men—including Jewish and Muslim men—do in fact "rue their circumcisions." This is evidenced by the well-known "foreskin restoration" community (not acknowledged by Jacobs and Arora), in which thousands of men, to speak of the known cases, attempt to "restore" a pseudo-prepuce through surgical or other means. One common strategy is to attach weights, tapes, and other devices to the remaining tissue on the penile shaft, so that it might be stretched out over the course of several years (see Earp 2014). Given that this is a rather extreme expression of "ruefulness," it seems reasonable to conjecture that there may be manifold more men who are seriously resentful about having been circumcised, but who do not go to such lengths to try to rectify their situation (or who may simply feel uncomfortable talking about such personal matters in public).

A GENDERED PERSPECTIVE

Jacobs and Arora (2015) claim that the "use of rights rhetoric often is applied selectively to circumcision, ignoring the various other elective procedures performed on minors that are at least as invasive and permanent as circumcision [including] sex-assignment operations [and] labioplasty for large labia majora" (32). Perhaps the authors are unaware of the sizable and growing ethical literature that does in fact advocate the deferral of medically unnecessary intersex surgeries, as well as *all* nontherapeutic[5] alterations—no matter how slight—of the external genitalia of healthy girls.[6] Indeed, those who advance such arguments are often the very same people who are critical of infant

4. As Frisch (2012) notes: "Rather than blindly accepting such findings as any more trustworthy than other findings in the literature, it should be recalled that a strong study design, such as a randomized controlled trial, does not offset the need for high-quality questionnaires. Having obtained the questionnaires from the authors … I am not surprised that these studies provided little evidence of a link between circumcision and various sexual difficulties. Several questions were too vague to capture possible differences between circumcised and not-yet circumcised participants (e.g. lack of a clear distinction between intercourse and masturbation-related sexual problems and no distinction between premature ejaculation and trouble or inability to reach orgasm). Thus, non-differential misclassification of sexual outcomes in these African trials probably favoured the null hypothesis of no difference, whether an association was truly present or not " (313).

5. If a girl's "large labia" cause her pain (as in the authors' example), then their surgical reduction would not, arguably, qualify as "nontherapeutic": instead, she would most likely be diagnosed with a condition called labial hypertrophy. Of course, absent this specific problem, or some other functional difficulty, there is nothing the matter with having larger than average labia. The labia, just like the foreskin, are highly sensitive to touch, and are important for normal sexual response (Schober et al. 2010).

6. Such alterations are defined as "female genital mutilation" by the World Health Organization, including forms that are less invasive than male circumcision. One way in which such alterations are often contrasted with male circumcision, however, is that they are said to have "no health benefits." Yet this is not actually known. Removing the labia (for example) in infancy—with a sterilized surgical tool—might very well reduce the risk of certain infections, yet it would be illegal (and in my view, unethical) to conduct a study to find this out. See Earp (2014; in press) for further discussion.

male circumcision, and for similar, if not identical, reasons (Earp under review; Earp 2014; Svoboda 2013; Svoboda and Darby 2008).

For example, as I have argued elsewhere: "Children of *whatever* gender should not have healthy parts of their most intimate sexual organs removed, before such a time as they can understand what is at stake in such a surgery and agree to it themselves" (Earp 2014, 12, emphasis added). One reason for this view is that the genitals (in particular) might plausibly be seen as having a special, even unique psychosexual significance compared to other parts of the body, which could make their unconsented alteration more likely to be experienced (later on) as a harm (see, e.g., Watson 2014). Presumably, this is as true for boys as it is for girls, as well as for children of indeterminate sex. Indeed, such a profoundly felt experience of having been personally harmed by having had one's genitals involuntarily altered may help to explain why there is an active "genital autonomy" movement in the United States, Europe, and elsewhere—fueled by women, men, and intersex people who are extremely resentful about their childhood genital surgeries—but not an anti-orthodontics movement or an anti-mole-removal movement.[7] Moreover, since these latter interventions do not remove functional tissue, the potential for them to be regarded as being an impairment of some kind, or even a "mutilation" (see Johnson 2010), would seem to be significantly reduced.

CONCLUSION

Removing healthy, functional, and erotogenic tissue from a child's genitals (whether the child happens to be female, intersex, or male) is not an unremarkable affair. Given the controversial nature of such an intervention, including the inevitable uncertainty regarding whether it will be experienced, later on, as an enhancement as opposed to a diminishment (see Maslen et al. 2014; Earp, 2014), it seems reasonable to argue that the decision about whether to have it performed in the first place should be left to the individual who must live with the consequences. ■

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7. These are two further examples raised by Jacobs and Arora of practices that, they claim, opponents of infant male circumcision should condemn with equal force and vigor if they wish to be morally consistent. Note that, apart from their lack of psychosexual significance, both of these interventions are typically done with the age-appropriate consent of the affected individual (and often at his or her request). Likewise for ice hockey, etc., among the other strained analogies offered by the authors.