Sex and Circumcision
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Published online: 12 Feb 2015.
On infant circumcision.

The effects of circumcision 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 so on, on a series of makeshift pen-and-paper scales, drawing some conclusions about the ongoing debate regarding this controversial practice (for overviews, see Earp under review) on the back of data that do not apply to the practice they seek to defend.

Consider the trial by Krieger and colleagues, 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 make-shift 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 2013) 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 onto neonates. In other words, the data the authors appeal to in support of infant circumcision have almost nothing to do with infant circumcision.

The Ethics 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 onto neonates. In other words, the data the authors appeal to in support of infant circumcision have almost nothing to do with infant circumcision.

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questions. Having obtained the questionnaires from 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 indi-
cators of sexual dysfunction. [We also] did not use vali-
dated instruments” (see Earp and Darby 2014 for the
citations and further discussion).
Jacobs and Arora decline to mention any of these cav-
eats, and instead blandly refer to the studies as being of
“high quality” (presumably because of their randomized
design). 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 ero-
egnous 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 centi-
meters 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 other-
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questions. 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 diffi-
culties. Several questions were too vague to capture possible dif-
fferences 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 out-
comes in these African trials probably favoured the null hypothe-
sis 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’ exam-
ple), 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 noth-
ing the matter with having larger than average labia. The labia,
just like the foreskin, are highly sensitive to touch, and are impor-
tant 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 inva-
sive 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 ster-
ilized 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 fur-
ther discussion.

A GENDERED PERSPECTIVE
Jacobs and Arora (2015) claim that the “use of rights rheto-
ric 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
alterations—no matter how slight—of the external genitalia
of healthy girls. Indeed, those who advance such arguments
are often the very same people who are critical of infant
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 psycho-sexual significance compared to other parts of the body, which could make their unconscionably altered 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. 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.

REFERENCES


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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.