Moral Hypocrisy or Intellectual Inconsistency?: A Historical Perspective on Our Habit of Placing Male and Female Genital Cutting in Separate Ethical Boxes

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Moral Hypocrisy or Intellectual Inconsistency? A Historical Perspective on Our Habit of Placing Male and Female Genital Cutting in Separate Ethical Boxes

In his detailed and comprehensive analysis, Brian D. Earp shows clearly that prevailing discourses on female genital cutting (FGC) have sought to quarantine the practice from male genital cutting (MGC), and further demonstrates that none of the various features that are supposed to fully distinguish one set of procedures from the other can logically hold water. The fundamental problem seems to be that the voluntary and official bodies campaigning against FGC, and especially the United Nations and the World Health Organization (WHO), show unjustified discrimination and hence inconsistency with respect to gender and culture, but fail to make justified and morally relevant discriminations with respect to age and degrees of harm.

On the first point, they treat males and females unequally by giving less favorable treatment to males (females having total protection from nontherapeutic genital cutting, however slight, while males have close to zero, however severe). On the second point, they judge FGC entirely on the basis of Western liberal feminist norms, without a nuanced appreciation of the significance of these practices in their cultures of origin. The result is a gender bias favoring females over males, and a cultural bias favoring modern Western culture over "Other" cultures.

The opposite problem is found with respect to age. Anti-FGC campaigners fail to make necessary discriminations on the basis of age, and thus between procedures imposed on children without consent, and those elected by competent adults, or agreed to by older children capable of having a reasonable understanding of the implications of these surgeries. In many countries, including Australia, the law makes FGC illegal even when sought and agreed to by the woman.[1] By contrast, no law anywhere[2] gives male minors meaningful protection against circumcision.

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A further failure of discrimination is in relation to the degree of harm. Both FGC and MGC involve a wide range of surgical outcomes, with differing degrees of harm, both physical and psychological—the latter strongly influenced by whether the surgery was elected or coerced. Although campaigners acknowledge the various forms of FGC, all are rejected as morally unacceptable, no matter how slight the bodily damage; at the same time, however, they fail to distinguish among the different degrees of harm involved in male circumcision and regard them all as equally unproblematic and acceptable.

Like the various forms of FGC, however, the impact (physiological, anatomical, aesthetic and psychological) of circumcision can vary considerably, depending on how much of the foreskin tissue is removed, the instruments and method used, the skill of the operator, and the age of the subject. In order to reflect this variability, Darby and Svoboda (2007) and Svoboda and Darby (2008) have proposed a typology of male circumcision to complement the classifications of female genital mutilation devised by WHO. The 7-point scale is based primarily on the quantity of foreskin tissue removed, and ranges from mild injury without loss of tissue to partial or complete denudation of the penis.

The age at which circumcision is performed can also have a significant impact on both the physiological and anatomical outcome—physiologically (functionally) because nerve pathways from the penis to the brain are not fully developed in infancy or childhood (Immerman and Mackey 1998); and anatomically because at birth the foreskin is normally fused to the glans by a thin layer of tissue and is not mobile or retractable until some point in later childhood. Circumcision of infants and young boys normally requires tearing the foreskin forcibly from the glans, thus adding a dimension of risk and damage that can be avoided if the surgery is performed after natural separation of foreskin and glans has taken place.[3]

Questions provoked by Earp's analysis are why these biological realities have been ignored by the authorities, and why the unacceptability of FGC tends to be cast in terms of and by contrast with the acceptability or even the desirability of MGC, usually meaning circumcision of male infants and other minors. The broad answer has three elements. The first is the Christian world's familiarity with Jewish circumcision practices and contrasting ignorance of female circumcision; the discovery of such practices during the eighteenth century was met with a combination of incredulity, fascination, and horror (Bruce 1790, 670–80). Secondly, there is the premodern concept of children as the property of their parents and

tribe. Thirdly, there are the anxieties about juvenile sexuality and venereal disease that led, during the nineteenth century, to the demonization of foreskin as a source of physical and moral decay (Miller 2002). More specific causes can be traced to a debate on the propriety of clitoridectomy as a medical treatment in 1860s Britain; and the characterisation of FGC as a public health emergency (rather than solely as a human rights issue) in recent times.

To take this last point first, the success of anti-FGC activists in having the issue framed as a public health problem has enabled bodies such as WHO to campaign against FGC using funds allocated for health promotion. (It would seem that funding for health is more readily and more generously available than funding for human rights promotion; and no mainstream agency has ever devoted its resources to combatting MGC.)[4] The basis for this policy was a landmark paper in the *New England Journal of Medicine* by Nadia Toubia (1994) based on the premise that "From the perspective of public health, female circumcision is much more damaging than male circumcision. The mildest form, clitoridectomy, is anatomically equivalent to amputation of the penis. Under the conditions in which most procedures take place, female circumcision constitutes a health hazard with short and long term physical complications and psychological effects." Although "Female circumcision has particularly strong cultural meanings because it is closely linked to women's sexuality and their reproductive role in society," Toubia went on to argue that "No ethical defence can be made for preserving a cultural practice that damages women's health and interferes with their sexuality." Key recommendations were to prevent medicalization of any form of the operation (where surgically trained personnel perform the procedure);[5] and for more research to examine the full range of physical, sexual, and psychological consequences of the various procedures.

This is exactly what has happened. Official bodies working against FGC have condemned medicalization of the procedure and funded massive research programs into the harm of the surgery.

The irony here is that WHO also frames male circumcision as a public health issue—but from the opposite starting point. Instead of a research program to study the possible harms of circumcision, it funds research into the benefits and advantages of the operation. In neither case, however, is the research open-ended: in relation to women the search is for damage, in relation to men it is for benefit; and since the initial assumptions influence the outcomes, these results are duly found. As Earp points out, since it

is impossible to run controlled trials to learn whether various forms of FGC might lower the risk of this or that disease, such knowledge can never be acquired. It is equally true that since no official body is interested in researching the harm and long term adverse consequences of MGC, definitive knowledge in this area remains elusive.

Toubia's paper elicited a revealing response from one of America's most prominent circumcision advocates, Edgar Schoen (1995), who agreed that female genital mutilation was "a form of child abuse" with no redeeming features, but warned that use of the term female circumcision "could have unforeseen political repercussions" by giving ammunition to opponents of male circumcision: "The problem with describing female genital mutilation as female circumcision is that the latter can be confused with the circumcision of newborn boys, a low-risk procedure with medical benefits," including reduced risk of HIV infection. He added that there was the danger that "Use of the term 'female circumcision' to describe female genital mutilation helps the organizations that oppose circumcision, which now demand the prohibition of all circumcision."

Schoen's anxiety to prevent opposition to FGC spilling over into opposition to MGC is notable in that it reprises the debate over the medical validity and ethical legitimacy of clitoridectomy that occurred in Britain in the early 1860s. Although the obstetricians involved ended up rejecting and effectively prohibiting the operation, they did so in terms that enshrined the acceptability of male circumcision. A detailed account of this episode is in Darby (2005, Ch. 7), and a summary of the relevant points is given here. Inspired by reports that circumcision was proving effective in discouraging and even preventing masturbation in boys, as well as recent advances in the nerve force theory of disease, the London gynecologist Isaac Baker Brown developed the idea that a similar operation in women might be efficacious in treating nervous diseases such as masturbation, hysteria, mania, and frigidity. A clinic that he established for this purpose attracted much interest among the profession, and also sufficient customers to make it a paying proposition, all of whom (according to his own report) were cured of the problem that brought them to his door. It was not long, however, before his activities attracted hostile scrutiny from the mainstream medical profession, which probably resented his entrepreneurship as much as his surgery. Brown was strongly criticized in the medical journals of the day, and at a stormy meeting in 1866 he was expelled from the Obstetrical Society and stripped of his license.

Among the most interesting features of this affair are the similarities between the debate then and the debate now, particularly over the proper analogies between the male and female genitals and the similarities/differences between male and female circumcision. Brown himself always insisted that clitoridectomy was nothing more than female circumcision and no more damaging than circumcision of boys or men, thus making assessment of the harm/benefit of male circumcision central to the debate, and forcing his critics to argue, in sharp contrast, that female circumcision was far more harmful and entirely without benefits. They often finished up, implicitly if not explicitly, concluding that male circumcision was not injurious at all: despite a wide range of opinions, none of Brown's critics disputed his contention that "no man who has been circumcised has been injured in his natural functions." There was a widespread (though far from universal) view that the male equivalent of clitoridectomy was amputation of the entire penis (though nobody went as far as Schoen in stating that it would involve removal of the scrotum as well). Since it was known that boys used their foreskin and girls their clitoris for masturbation, the foreskin–clitoris analogy was not without plausibility.

Denying that circumcision caused harm was a particular imperative for committed circumcision advocates such as Jonathan Hutchinson, who was as anxious as Schoen to ensure that the moral and medical critique of clitoridectomy remained quarantined from circumcision of boys, in whom it was seen desirable as a means of preventing masturbation, phimosis, and (later) syphilis and various cancers. Editorialising in the *Medical Times and Gazette*, he phrased his condemnation of clitoridectomy in terms that required the acceptance of "mere circumcision": "Instead of taking away a loose fold of skin it removes a rudimentary organ of exquisite sensitiveness, well supplied with blood vessels and nerves, and the operation is . . . occasionally attended with serious bleeding; in these respects it differs widely from circumcision." No critic at the time replied that the foreskin was also highly sensitive and well supplied with blood vessels and nerves; nor that circumcision (as Hutchinson himself later acknowledged) was sometimes attended with serious bleeding. The same editorial further attacked clitoridectomy as unethical because it was wrong to amputate a body part showing no signs of disease and contrary to medical science to amputate something merely because it was subject to irritation: "Intense itching is a common malady, but . . . to cut off part of the body because it itches is monstrous." Yet the *Medical Times and Gazette* is on record as recommending the excision of normal foreskins

"showing no signs of disease" as a precautionary measure, and it had even endorsed the contention that itching certainly was a sufficient reason for circumcising boys who were in "perfect health" (Darby 2005, Ch. 7).

Thus it came about that Brown's unwitting attempt to legitimize clitoridectomy by comparing it to male circumcision gave the champions of the latter the opening they needed, allowing them to promote the (familiar) surgery they favored at the same time as they condemned the exotic, barbaric operation they wished to reject. The clitoridectomy controversy of the 1860s was the closest Victorian England came to a debate on circumcision, the effect of which was to crystallize male circumcision as the standard of harmlessness by which the infamy of clitoridectomy was measured. The outcome was a double standard on genital mutilation that, as Earp so clearly demonstrates, has persisted to our own times. The difference today is that an ethically consistent position can be heard—not from official and semigovernment circles, whose agencies continue to reproduce the same inconsistency exhibited by Brown's critics, but from the community-based anticircumcision groups from whom Schoen was so concerned to withhold ammunition. In the same issue of the *NEJM*, pediatrician Paul Fleiss (1995) applauded proposals for action against FGC, but asked whether circumcision of baby boys was any less barbaric merely because it had the sanction of the American medical community:

> The genital mutilation of boys and girls must be opposed . . . [because] The amputation of healthy genital tissue is a violation of the person's right to an intact body. No one asks to have his or her genitals removed. Indeed, the infant's shrieks of pain are an obvious indication of protest against the procedure. We as adults must do our part to prevent those screams by upholding the basic human right to an intact body, to which all people, whatever their age or sex, are entitled.

It should also be noted that Toubia herself was by no means a supporter of male circumcision. In a reply to the correspondence in response to her paper she wrote that:

> There is no universal consensus that routine circumcision of male children is an acceptable medical procedure for preventive care. It remains a religious practice for some and a selective nonreligious practice for others, with or without medical consent. Whether male circumcision is medically harmless or even beneficial remains a matter of debate and study. (1995, 189)

In other words, she did not agree with advocates that circumcision had proven "medical benefits"; the difference between circumcision and FGC

is only that the former is less damaging. Indeed, Toubia subsequently associated herself with the very forces that Schoen condemned, and has expressed equally strong opposition to medically unnecessary circumcision of boys. The first of four principles that should govern attitudes to both male and female circumcision, she writes, is that: "Cutting any healthy part of a child's body, including the genitals, is wrong. The female clitoris and the male foreskin should be guaranteed the same protections as the nose, the hand, or any other body part" (1999, 2).

The ethical consistency of Toubia's position represents an advance on the position of those who argue against FGC on universally valid bioethical and human rights grounds yet ignore or condone circumcision of boys. As Earp points out, for most such critics, FGC is such a serious violation of personal rights and autonomy that (unlike male circumcision) it cannot be justified by the claims of culture, religion, or tradition. To take one striking example, a paper by Stephen James (1994) makes a powerful case that prohibition of FGC is consistent with respect for cultural diversity and other multicultural principles, and does not represent an instance of Western do-gooders imposing their norms on other cultures. He lists numerous objections to FGC, the most significant of which are that it is a violation of the rights of the child and of a woman's right to autonomy and bodily integrity:

> International human rights law recognizes the illegitimacy of any coercion being used against a person, designed to compel her to adopt, modify, or reject a cultural practice for the sake of saving, maintaining or strengthening a (typically) dominant culture (International Covenant on Civil and Poltical Rights, Art. 18.2). The international human right of individual autonomy protects the decision of a woman to reject, at least in relation to herself, that aspect of her culture which would compel female circumcision. (1994, 22)

It is easy to overlook the shift from "person" to "woman." What James evidently fails to appreciate is that every one of his objections to FGC applies just as strongly to circumcision of male minors (and indeed to circumcision of adult men in the absence of fully informed consent and a free choice). The illogic of this position is pretty clear: if the principles of bioethics and human rights are universal, applying to all persons irrespective of sex, race, religion, age, nationality, etc., then they must apply to boys and men as well as to girls and women. If, on the other hand, such principles are not universal, but culture-specific, and applicable only to modern liberal societies, then women are no more protected than men

from traditions that prescribe genital cutting and other forms of marking and domination.

NOTES

1. In Australia, women desiring cosmetic genital surgery can get around this if their doctor certifies that the operation is medically necessary, thereby attracting a rebate under Medicare.
2. With the partial and inadequate exception of South Africa, where the relevant law (Children's Act 2005), ostensibly prohibiting circumcision below the age of 16 "except for religious or medical reasons," has had little effect in practice, and has not stopped the annual death toll among Xhosa teenagers. See http://www.circinfo.org/South_Africa_Childrens_Act.html
3. The original Judaic form of circumcision recognized this by requiring only the tip of the foreskin extending beyond the glans to be "snipped" and did not require any retraction (see Glick 2005, esp. Ch. 1; Lang 2013).
4. For an excellent analysis of why nontherapeutic circumcision of male minors has failed to fire the international human rights community see Carpenter (2014).
5. This would of course make the operation far safer, but at the cost of entrenching it more deeply (as has happened with circumcision of boys).

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