the sorcerer's apprentice: why can't we stop circumcising boys?

Almost alone in the wealthy world, the United States still circumcises most newborn boys. Elsewhere this practice is disappearing, except when it is done for religious reasons. Why not here? Another failure of the medical establishment?

People have always eaten people,
What else is there to eat?
If the Juju had meant us not to eat people
He wouldn't have made us of meat.
—Flanders and Swan, "The Reluctant Cannibal"

The pediatrician spent hours resuscitating and assessing the injuries of a boy who had been born unable to breathe, without a pulse, and with a broken humerus and depressed skull fracture resulting from a difficult forceps delivery. He then visited the mother, whose first question was "When can he be circumcised?" Such a sense of priorities indicates the privileged place of male circumcision in modern America and highlights the difficulties in explaining what Edward Wallerstein has called "the uniquely American medical enigma." Why does routine circumcision persist in the United States long after it has been abandoned in the other English-speaking countries that originally took it up? Despite critical statements from the American Academy of Pediatrics and the College of Obstetricians and Gynecologists in 1971, 1975, 1978, 1983, 1989, and 1999, the operation is still performed on well over half of all newborn boys.

The U.S. experience contrasts with that of the other countries in which routine circumcision had once been common. In Britain, the procedure was widely recommended in the 1890s, reached its peak of popularity in the 1920s (at a rate of about 35 percent), declined in the 1950s, and all but disappeared by the 1960s. In Australia, the incidence of circumcision peaked at over 80 percent in the 1950s, but it declined rapidly in the 1980s after statements by pediatric authorities. Today it stands at about 12 percent. The Canadian pattern is broadly similar, though the decline was slower until the late 1990s, when rates fell sharply. In New Zealand, the procedure was nearly universal between the wars, but fell so precipitately in the 1960s that now fewer than 2 percent of boys are circumcised. We thus face a classic puzzle of comparative sociology: Why did routine circumcision arise in the first place? Why only in Anglophone countries? Why did it decline and all but vanish in Britain and its dominions? Why does it survive in the United States?

Nobody has firm answers to these questions. The rise of circumcision was associated with the "great fear" of masturbation and anxiety about juvenile sexuality; the misidentification of infantile phimosis (the naturally non-retractile state of the juvenile foreskin) as a congenital abnormality; the puritan moralities of the nineteenth century; dread of many incurable diseases, especially syphilis; and the rising prestige of the medical profession, particularly surgeons, leading to excessive faith in surgical approaches to disease control and prevention. Most of these features were common to all European countries, however, and the factors which provoked the Anglophone *Sonderweg* remain obscure. (Perhaps language itself is the key.) The fall of circumcision in Britain was associated with other medical advances, especially the discovery of antibiotics, the decline of anxiety about masturbation, concern about complications and deaths, and the development of a more positive attitude toward sexual pleasure. In 1979, an editorial in the *British Medical Journal* attributed much of the trend to a better understanding of normal anatomical development and the consequent disappearance of fears about childhood phimosis.

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The same editorial contrasted the British case with the situation in the United States, where the majority of boys were still circumcised, and many doctors (despite the AAP state-

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ment) defended the procedure with some vehemence. It offered no suggestions as to why the experience of the two leading Anglophone powers diverged so sharply after the 1940s, but clues may be found in the relatively low incidence of circumcision in Britain, its concentration among the upper classes, and the fact that even at the height of its popularity it was a minority practice that lasted scarcely more than two generations. In the United States, generous medical insurance policies after World War II allowed more families to take advantage of surgical procedures, and the introduction of Medicaid in the 1960s permitted even the poor to enjoy many of the same services as the rich. The practice thus came to affect the vast majority of U.S. males and to endure for more than two generations, with the result that there were soon few doctors and parents who were familiar with the normal (uncircumcised) penis and thus knew how little management it needed. In Britain, there were always doctors and relatives who had not lost touch with the way things used to be. In my research on Britain and Australia, I found that routine circumcision began as a doctor-driven innovation, became established in the medical repertoire, spread rapidly, and then declined slowly as doctors ceased to recommend it. Since parents had absorbed the advice of the generation before and many fathers had been circumcised themselves, they continued to ask for it. The fundamental reason for the circumcision of boys is a population of circumcised adults.

The American situation remains puzzling: Why has a custom initiated by our Victorian forebears prospered so mightily in the age of medical miracles? Some doctors blame parents for demanding circumcision, while parents accuse physicians of suggesting and even urging the operation, and of not warning them about risks and possible adverse effects. Critically minded doctors call for "the organized advocacy of lay groups . . . rather than the efforts of the medical profession," while others object to the interference of "outsiders" in what they insist is a strictly clinical matter. Wallerstein felt that the practice continued because "medical and popular literature abounds in serious errors of scientific judgment," with the result that the medical profession is reluctant to take a firm or united stand. Although few think there is any real value in circumcision, and many regard it as cruel and harmful, doctors seem mesmerized by the force of parental demand and social expectation. Like the sorcerer's apprentice in *Fantasia*, they watch helplessly as the waters mount, waiting for the master magician to return and restore normality.

There has been remarkably little research into this problem. Circumcision is a highly controversial subject, but most of the debate is over whether it should be done, not on why the practice continues; those who defend it regard it as an unproblematic hygiene precaution or at least a parent's right to choose, and often become annoyed when critics ask them to justify it. Discussion of the issue is hampered by uncertainty as to the incidence of routine circumcision, its social distribution, and the reasons parents want it or agree to have it done. There has certainly been a significant decline in the incidence of circumcision in the United States since the 1970s, but it has been neither steady nor uniform across the country. The rate fell from 85 percent of newborns in the 1970s to 60 percent in 1988, rose again to 67 percent in 1995, then fell slightly to 65 percent in 1999—the last year for which authoritative figures are available. But given the AAP's critical statement in 1999, another substantial reduction might be coming. The incidence of circumcision varies significantly by region, and nearly all the observed reduction has occurred in the West, particularly in California, where the rate fell from 63 percent in 1979 to 36 percent in 1999. In the Northeast, the rate remained constant at about 65 percent over the same period, while in the Midwest and South it actually increased—from 74 to 81 percent and 55 to 64 percent, respectively.

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Other variations are found on the basis of ethnic origin and education level. When Edward Laumann and colleagues analyzed data from the National Health and Social Life Survey (covering men aged 18–59) they found that while 81 percent of whites were circumcised, the figure was only 65 percent for blacks and 54 percent for Hispanics. Whereas 87 percent of men whose mothers were college graduates were circumcised, the figure for those whose mothers did not complete high school was only 62 percent. Laumann also found that circumcision was less common among conservative Protestants, but noted that all these differences shrank as the sample got younger, suggesting a trend toward homogeneity. We can thus say that circumcision is rarer among blacks and Hispanics (though more common than it was), and that the same is probably true among non-Muslim Asians, among the less educated, and in the western states. But we cannot know which of these is the decisive variable; it may be that blacks,

Photo courtesy of www.StopInfantCircumcision.org

Hispanics, and Asians tend to be less educated than whites and also to be concentrated in the South and West.

Preventive circumcision has always been an experimental and controversial surgery, never endorsed by the medical profession as a whole. Given the uncertainty of its benefits, the high risk of harm, and the significance of the organ being so dramatically altered, you might expect a few ultranervous adults would elect to have it done to themselves but not for millions to inflict it on their babies. These days only a few diehards seriously believe that circumcision in infancy confers compelling health benefits, and nobody suggests that the practice continues because the inhabitants of Indiana are healthier than those of California or because Americans in general are healthier than the populations of countries where the practice is rare. Indeed, readily available statistics suggest the opposite. Although per capita health spending is vastly greater in the United States than anywhere else, health outcomes on such key indicators as infant mortality, life expectancy, and the incidence of Sexually Transmitted Diseases (STDs) are significantly worse in the United States than in comparably developed countries where most men retain their foreskins. Far from circumcision being a protection against STDs, as often claimed, Laumann found that circumcised men had more STDs, both bacterial and viral, than the uncut, and the United States has the highest incidence of HIV infection of any country in the developed world except Portugal.

If American health outcomes are no better than those of noncircumcising countries, why does this "health precaution" survive on a mass scale? Robert Van Howe suggests seven lines of inquiry: (1) the foreskin is the focus of myths, misconceptions, and irrationality affecting the medical profession and public alike; (2) a lack of respect for the rights and individuality of children; (3) a contrasting exaggerated respect for the presumed sensibilities of religious minorities who practice circumcision for cultural reasons; (4) the reluctance of physicians to take a firm stand against circumcision and to refuse parental requests; (5) a bias in American medical journals, which tend to favor articles with a pro-circumcision tendency; (6) a failure to subject circumcision to the normal protocols for surgery, such as the need for informed consent, evidence of pathology, and proof of prophylactic benefit; and (7) strong financial incentives to perform the operation, which is generally covered by medical insurance.

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To these suggestions might be added the role of the armed forces. During the two world wars, the U.S. military made a

concerted effort to circumcise servicemen because it believed this would make them less susceptible to venereal disease. Military discipline forced men to submit to a procedure they would not otherwise have agreed to, and thousands of men were circumcised in their late teens and early 20s. When they returned home and became fathers, doctors began asking whether they wanted their sons circumcised. Remembering the ordeal that they or their buddies had endured from the operation as adults, many said yes, thinking it would avoid the need to do it later when the pain was thought to be worse than in infancy. With two generations circumcised, the foreskinned penis became rare, and few men had the personal experience to refute the rumors told about it.

The importance of financial incentives has been stressed by a number of critics. In their analysis of Medicaid funding, Amber Craig and colleagues found that low and declining rates of circumcision correspond to regions where the procedure is not funded, notably in California, which dropped coverage in 1982. Even more striking is their finding that the higher the rebate, the higher the incidence of circumcision—vivid proof of the power of market signals. Nor do the advantages of circumcision—for doctors—end there. Despite optimistic claims that the rates of injury and death are low, there has never been an adequate assessment of long-term complications, and they are certainly more frequent than most people think. The dirty little secret in pediatric surgery is that badly performed circumcisions, causing discomfort or poor cosmetic outcomes, often necessitating repeat operations and repair jobs, are common; one attorney who specializes in medical malpractice reports that some urologists see at least one such case each week. In this way the division of professional labor ensures that the benefits of circumcision are spread far beyond the original doctors: their mistakes provide work for many colleagues and the disasters add lawyers to the equation.

The most common justifications turn out to be the supposed need to look like the father or peers and not to be teased in the proverbial locker room. If "health benefits" are mentioned at all, they enter as an afterthought or when other arguments fail.

Yet physicians may not be the major beneficiaries. In the age of biotechnology and tissue engineering, human body parts have a high market value, and baby foreskins are prized as the raw material for many biomedical products, from skin grafts to antiwrinkle cream. The strongest pressure for the continuation of circumcision may not be from doctors or parents at all, but from the hospitals that harvest the foreskins and sell them to commercial partners.

Lack of unanimity and conviction among the medical profession has been stressed by Lawrence Dritsas, who attempts to deconstruct the AAP's unwillingness to make a firm recommendation and its corresponding tactic of throwing the burden of decision onto parents. He quotes an article that offered this explanation:

> "We are reluctant to assume the role of active advocacy (one way or the other) because . . . the decision is not usually a medical one. Rather, it is based on the parents' perceptions of hygiene, their lack of understanding of the surgical risks, or their desire to conform to the pattern established by the infant's father and their own societal structure."

He translates this to mean that circumcision is irrational but that, contrary to the usual protocol, "parental wishes become sufficient, while medical necessity, normally a guiding rule for the surgeon's knife, takes a back seat." Dritsas contrasts this hands-off approach with the AAP's ethically based rejection of female genital mutilation (where the possibility of a health benefit is not even entertained). In its position statement on informed consent the AAP says, "Providers have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses. . . . The pediatrician's responsibility to his or her patient exists independently of parental desires or proxy consent." Except, it seems, when it comes to male circumcision.

Dritsas is genuinely puzzled by the glaring contradictions in AAP policy and explains them in terms of medical culture and the apprenticeship model of professional training, which does not encourage students to question authority. "For a physician to cease performing circumcisions represents a condemnation of past practice and an admission of error," he writes, and nobody holding the power of life and death wants to be seen as doing that. The doctors are thus in much the same position as the parents themselves, whose unconsidered assumption that the baby will be circumcised is an expression of the authority of their grandparents' physicians who convinced prior generations that it was the thing to do. Dritsas criticizes the stance of the AAP as reminiscent of the response of Pontius Pilate when confronted with the problem of what to do with Jesus. In his view, what they are really saying is that, "as scientific doctors, we find ourselves unable to

recommend or deny this procedure; therefore, you will decide, and we shall be your scalpels." This sort of abdication of responsibility contrasts with the proactive stances of pediatric bodies in Britain, Australia, New Zealand, and, most forcefully, Canada, which have seen it as their duty not only to discourage parents from seeking circumcision but, in the end, to refuse to perform the operation.

There must be an explanation for these national differences. The medical profession is not an independent force; its members are subject to the same social pressures that shape the beliefs and condition the actions of everybody else. Several recent commentators have thus argued that circumcision should not be seen as a medical issue at all but as an expression of social norms. At a superficial level this has long been known. In the 1950s Dr. Spock urged circumcision because it would help a boy to feel "regular," and pediatricians since then have noted that "entrenched tradition of custom is probably the greatest obstacle faced by those who would decrease the number of circumcisions done in this country." But it is only recently that the sociological aspect of the question has received serious attention. In a comprehensive survey of the history of modern circumcision and the debate over its "advantages," published in 2002, Geoffrey Miller shows in brilliant detail how late Victorian physicians succeeded in demonizing the foreskin as a source of moral and physical decay. Acting as "norm entrepreneurs" they "reconfigured the phallus," transforming the foreskin from a feature regarded as healthy, natural, and good into one feared as polluted, chaotic, and bad. The incessant quest for novel associations between the foreskin (often expressed as "lack of circumcision") and nasty diseases is a tribute to the lasting success of their enterprise.

Cartoon by Steve Breen. Courtesy of Copley News Service.

As a legal scholar, Miller is surprised at the law's indifferent or often supportive attitude toward what one might expect it to regard as an assault, or at least a mutilation, but he points out that the law is an expression of the surrounding culture and cannot be expected to be too far ahead of prevailing norms. Even so, he considers routine circumcision in the mainstream community to be on the way out. Although still normative, it is in decline and edging toward the critical halfway mark, or "tipping point," where the incidence can be expected to fall precipitously as parents come to believe that their children will now face stigma if they are circumcised. Like foot-binding in China or wife-beating in nineteenth-century Britain, a widely accepted social convention is "likely to collapse as the culture reaches a 'tipping point' and turns against the practice." The increasingly desperate search for new health reasons to circumcise—urinary tract infections (1985), HIV-AIDS (1989), and cervical cancer in potential future partners (revived in 2002)—may delay the process, but cannot permanently halt it.

Sarah Waldeck offers a subtle analysis of how norms contribute to a person's behavioral cost-benefit calculations, how the desire to have a child circumcised fits into this assessment, and thus why parents continue to seek it. She is particularly interested in the "stigma" supposedly attached to the uncircumcised penis in a society where most males are cut, and she considers the role of the popular media in perpetuating a stereotype of the foreskin as somehow disagreeable. She also notes that few parents have any clear reasons for wanting their sons circumcised and produce them only when challenged. The most common justifications turn out to be the supposed need to look like the father or peers and not to be teased in the proverbial locker room. If "health benefits" are mentioned at all, they enter as an afterthought or when other arguments fail. Waldeck still subjects the medical case to scientific, legal, and ethical scrutiny, and finds it inadequate to justify the removal of healthy body parts from nonconsenting minors. She concludes with a thoughtful discussion of how the American norm might be changed and suggests three specific strategies: requiring parents to pay for the procedure; requiring doctors who perform the operation to use effective pain control; and tightening the informed-consent process.

As a celebrated German-Jewish philosopher once observed, "The tradition of all the dead generations weighs like a nightmare on the brains of the living." When preventive circumcision was introduced in the late nineteenth century, concepts of medical ethics, informed consent, therapeutic evidence, and the cost-benefit trade-off were rudimentary. Neither the morality nor the efficacy of the procedure was seriously debated, nor was there any study of its long-term consequences; it became estab-

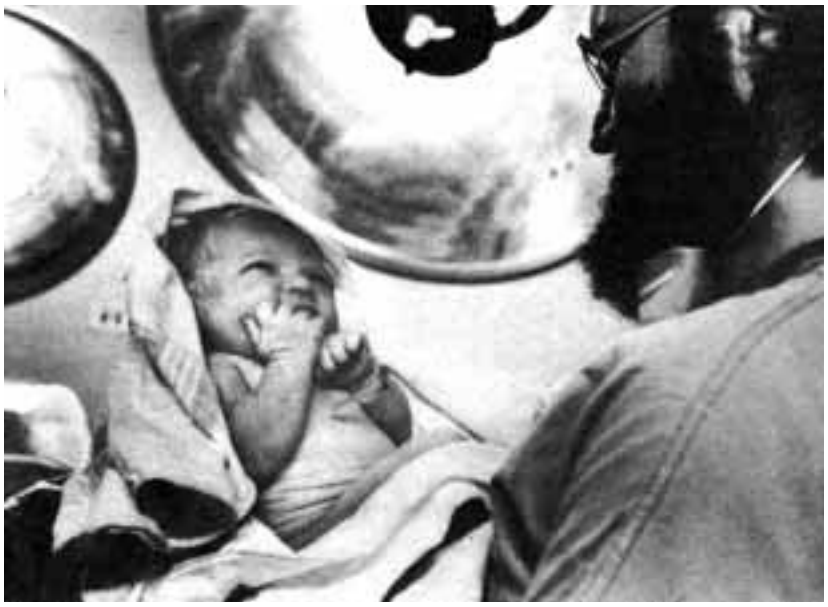

Photo by Suzanne Arms

lished in the medical culture of Anglophone countries by virtue of the authority of its early promoters. No matter how many statistics-laden articles get published in medical journals, circumcision cannot shake off the traces of its Victorian origins. It remains the last surviving example of the once respectable proposition that disease could be prevented by the preemptive removal of body parts, which, though healthy, are thought to be a weak link in the body's defenses. In its heyday, this medical breakthrough, described by Ann Dally as "fantasy surgery," enjoyed wide esteem and included excisions of other supposed foci or portals of infection, such as the adenoids, tonsils, teeth, appendix, and large intestine. Few doubted that if the doctor thought you were better off without any of these, it was your duty to follow his orders.

Because there was no real debate about the propriety or efficacy of preemptive amputation as a disease-control strategy when it was first introduced, those who wanted to remove healthy body parts from children were able to throw the burden of proof onto their opponents. Instead of the advocates having to demonstrate that the gain outweighed the loss, it was up to the doubters to prove that the loss outweighed the gain. The consequence is that what should have been a debate about the introduction of preventive circumcision in the 1890s has turned into a debate about its abolition a century later. Miller and Waldeck are probably right to argue that circumcision will not die out until the uncut penis becomes an acceptable—perhaps the preferred—option. But the transformation of attitudes will not seem so improbable, nor is the task of effecting it so daunting, if we remember that there is no need to invent a new norm, merely to restore the sensibility that governed the Western world before the late nineteenth century. In the 1870s, when Richard Burton remarked that Christendom "practically holds circumcision in horror," the observation was ceasing to be true, but it was certainly the case before Victorian doctors reconfigured the phallus and bequeathed a thorny problem to their successors.

[*Note on terminology*: In this article "circumcision" or "routine circumcision" means circumcision of normal male minors in the absence of any medical indication or valid religious requirement, on the decision of adults, and without the consent of the child.]

Robert Darby is an independent historian living in Canberra, Australia. His study of the rise and fall of routine circumcision in Britain, A Surgical Temptation*, has just been published by the University of Chicago Press. Further information is available on his website: www.historyofcircumcision.net.*

recommended resources

* Lawrence Dritsas. "Below the Belt: Doctors, Debate and the Ongoing American Discussion of Routine Neonatal Male Circumcision." *Bulletin of Science and Technology* 21 (2001): 297–311. A brief analysis of the uncertainties, contradictions, and disagreements among American medical professionals.

* Geoffrey Miller. "Circumcision: Cultural-Legal Analysis." *Virginia Journal of Social Policy and the Law* 9 (2002): 497–585. Miller shows how Victorian medical men transformed popular images of the penis and set routine circumcision in motion.

Robert Van Howe. "Why Does Neonatal Circumcision Persist in the United States?" In *Sexual Mutilations: A Human Tragedy*, ed. Marylin Milos and George Denniston (Plenum, 1997). A discussion of the main factors behind American exceptionalism.

* Sarah Waldeck. "Using Circumcision to Understand Social Norms as Multipliers." *University of Cincinnati Law Review* 72 (2003): 455–526. A searching analysis of routine circumcision as a cultural phenomenon.

* Edward Wallerstein. "Circumcision: The Uniquely American Medical Enigma." *Urologic Clinics of North America* 12 (1985): 123–32. Why doctors and parents prefer health faddism to biological evidence.

** Items marked with an asterisk are available online at the Circumcision Information and Resource Pages website: http://www.cirp.org/library.*