

# Circumcision and the socially imagined sexual body

## ABSTRACT

### KEY WORDS

circumcision,  
sexuality,  
masculinity,  
sexual  
dimorphism,  
social  
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sociology

*In a generation, Australia has changed from a country where most boys are circumcised in infancy to one where circumcision is the minority experience. Proponents argue that routine circumcision is desirable because it protects against a number of conditions. Yet circumcision can be seen rather as a sociocultural intervention with post hoc medical justification. As a form of body modification, it serves to exaggerate the visual difference between male and female. Reducing the ambiguity and untidiness of the penis turns it into a neat phallus more specifically fitted for what is seen as its purpose in a gendered sexual culture focused on coitus. Does circumcision reduce penile sensitivity? Applying the methods of evidence-based medicine to this question has problems, centrally that of how 'sensitivity' is to be measured. The nature of the loss is in a sense 'unspeakable' and for many people unimaginable, because the reception of delicate sensation is not part of their notion of masculine sexuality.*

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Circumcision is the removal of the male foreskin. It has been traditionally practised by some cultures especially in Africa and the Middle East. In the English-speaking world the procedure has been medicalised and is carried out by surgeons or other doctors, usually on newborn babies, and is popularly regarded as a healthy or medically protective procedure, probably to a greater degree than it is seen as a mark of belonging to a certain religious or ethnic group. In Australia neonatal circumcision became routine after hospital birth during the 20th century.

In recent decades medical opinion has turned against routine circumcision for a range of

reasons including the rare surgical accidents, issues about pain experienced by the child during and after the procedure, and the difficulties with giving general anaesthesia to newborns. New babies cannot give informed consent, yet it is questionable whether a parent's consent to the procedure made in the absence of expert consensus that it was medically necessary would be legally valid if challenged. Because of such doubts and difficulties, circumcision has not been routine in the United Kingdom and has declined in frequency since the 1970s in Australia (though it remains common in the United States). Circumcision is no longer covered by Medicare except where there are medical indications. This has apparently led to a dramatic rise in the reported incidence of such indications (Spilsbury et al. 2003a). An analysis of who gets circumcised under this system suggests that people at the top and bottom of the socioeconomic scale are less likely to have their sons circumcised than those in the middle (Spilsbury et al. 2003b).

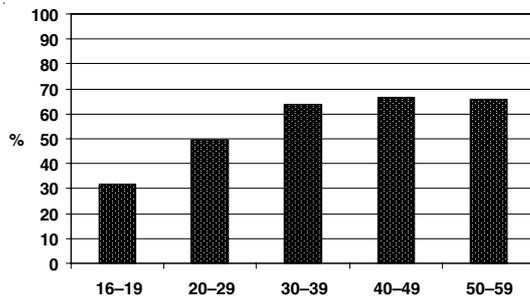


Figure 1 Prevalence of male circumcision by age group, Australia, 2001-02  
(Data source: Richters et al. in press)

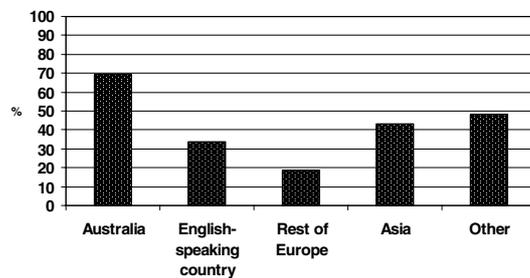


Figure 2 Distribution of male circumcision by country of birth, Australia, 2001-02  
(Data source: Richters et al. in press)

Figure 1 shows the prevalence of circumcision by age among Australian men in 2001-02, as recorded in the Australian Study of Health and Relationships (Smith et al. 2003, Richters et al. in press). Figure 2 shows the distribution of circumcised men by country of birth. These strong associations with age and country of birth, and thus with culture and behaviour, confound any attempts to disentangle long-term health or sexual effects directly attributable to the procedure itself from social and cultural effects on the same outcomes.

Involving as it does the improvement or mutilation (depending on your point of view) of that intensely meaningful cultural object the penis, circumcision is a contentious and emotive topic. Websites for and against make extravagant claims for the beneficial and deleterious effects of circumcision (e.g. Circinfo.net, Circinfo.org, Thornby 1999). Despite this, it is not much debated in the public arena, compared with say censorship of sex in the movies, drink driving,

private school funding, abortion or immigration policy. The only time circumcision becomes an issue for most people is probably when parents are asked (by health services or by their families and friends) whether they are having their newborn boy circumcised.

Modern Western neonatal circumcision is not accompanied by intensely symbolic ceremonies and is not part of a rite of passage into manhood, as peripubertal circumcision is in many traditional cultures (Silverman 2004). It is seen as a medical procedure. Pro-circumcisionists believe their arguments to be logical and health-based. This belief is reflected in the 'pro' reasons given in the brochure for parents produced by the Paediatrics and Child Health Division of the Royal Australasian College of Physicians (n.d.; based on a review, RACP 2004), which are all medical, i.e. that circumcised boys and men have a lower risk of contracting minor infections, penile cancer, human immunodeficiency virus (HIV) and other sexually transmissible infections (STIs).<sup>1</sup> The reasons advanced against circumcision, however, invoke a broader range of discourses or frames of reference: pain for the child; that it is 'natural' to avoid surgery; the risks of surgery; and 'some people believe' loss of penile sensitivity and perhaps sexual pleasure.

How would we set these disparate arguments from different discursive frames against one another to come to a conclusion about the desirability or otherwise of infant circumcision? The arguments about short-term pain and surgical risk can more or less be set against the health benefits. This form of population-level risk-benefit analysis is common in the evaluation of other procedures such as vaccination and Pap smear screening (NHMRC 2003, National Cervical Screening Program 1998). Public health authorities are aware that most preventive technologies carry some risk for the individual: vaccination injections hurt babies, some get feverish and a very few may have serious reactions, yet the benefit in illness prevented and lives saved for the huge majority is overwhelming (NHMRC 2003). So that the preventive health dollar can be allocated rationally, to programs that do the most good, techniques have been developed for

comparing different interventions in terms of years of life lost or (more contentiously) 'quality-adjusted' years of life lost (Hall 1998). Results from several studies in different settings can be combined according to the techniques of meta-analysis to produce rigorous balanced reviews of the effectiveness of a certain technique in preventing or curing a certain condition (Irwig 1998, Taylor and Berry 1998).

One problem with evaluating circumcision is that it is recommended not to prevent a single outcome but to prevent many outcomes of varying seriousness and rarity, from childhood urinary tract infections to late-life penile cancer leading to amputation. I am not going to pursue the public health pro- and anti-circumcision debate further here. Nor am I going to pursue the question of whether neonatal circumcision would be ethically or legally justifiable (because of consent issues) even if its benefits were accepted as exceeding its 'costs' on the balance of probabilities. Rather I have raised the issue because I believe that in Australia, and presumably in other similar societies (more in the United States and less in Britain), circumcision is widely believed by laypeople to be 'cleaner' or 'nicer' or 'better for you' in a way that is not clearly based on a rational health benefit assessment in terms of definable possible disease outcomes. But why? What social or symbolic role does circumcision play in Australia?

The second question I want to explore is one of the elements of the 'cost' side of the calculation of health benefits and costs. How are we to understand the effect of circumcision on the sexual sensitivity of the penis? Exploring this question leads me to ask whether it is even possible for this question to be answered within the conceptual framework of mainstream medical research.

### **What is circumcision for?**

Even if circumcision can be demonstrated to have a measurable net health benefit, is that the reason for most pro-circumcisionists' advocacy for it?

It has often been argued that the cultures that traditionally practised circumcision did so because it had demonstrable hygienic advantages in hot dry dusty climates. If you imagine getting sand

under your foreskin or between your labia, and not being able to wash, this seems intuitively reasonable—though surely even in windy desert climates the penis, well covered by clothes, would be far less at risk from irritating sand than the ears, mouth or nose, which were not traditionally subject to corrective surgery. In any case, traditionally circumcising societies do not all come from sandy desert regions, and some inhabit areas that have suffered desertification in recent historical times. Perhaps this explanation for circumcision is a 'just so' story.<sup>2</sup>

Anthropologist, Mary Douglas, in her influential *Purity and Danger* (1984[1966]), argues that 'it is one thing to point out the side benefits of ritual actions, and another thing to be content with using the by-products as a sufficient explanation' (p. 30). In other words, even if some traditional ritual action has a beneficial result in health terms, that is not an adequate explanation of how the ritual arose in the first place or why it has persisted. Douglas instead explores what could be called the social-cognitive frameworks within which things are pronounced clean or dirty, good or bad, high or low in a culture and within which ritual actions are prescribed. 'In chasing dirt', she argues, 'we are not governed by anxiety to escape disease, but are positively re-ordering our environment; making it conform to an idea ... [dirt-avoidance] is an attempt to relate form to function to make unity of experience' (p. 2). This is not to deny that a modern person tidying and cleaning his or her house may genuinely (though unsoundly) believe that this is necessary for hygienic reasons.

I want to make use of the second part of Douglas's contention, that ritual actions serve to re-order our environment to make it 'conform to an idea' and that in so doing we are attempting 'to relate form to function to make unity of experience'. Although she does not explicitly mention circumcision, this idea seems to me to be productive in the attempt to understand why a practice that appears intuitively to be mutilating and *prima facie* undesirable is regarded by many people as right and proper—or, on the other hand, why an obviously beneficial minor surgical procedure is so distressing to its opponents.

*Circumcision as a gender dimorphic body modification practice*

Humans indulge in a huge range of practices of body modification and decoration that are not functional, from ear piercing to foot binding. One category of modificatory or decorative practices is those that enhance (socially desirable) gender dimorphism. Clothing and other equipment may serve to emphasise or externally symbolise the sexual organs: penis gourds, codpieces, Robert Plant's tight jeans, skirts for women. Secondary sexual characteristics may be emphasised by the wearing of beards or mutton-chop whiskers, by breast augmentation or uplift bras. Other physical sexual differences that figure in a society's gender code may be emphasised: women shave their legs and under their arms, or wear small shoes or large bustles; men wear shoulder pads.

In the same way the differences between male and female genitals may be emphasised or exaggerated. The foreskin can be seen as a 'feminine' attribute in the male because it is soft, moist and receptive rather than firm, dry and insertive. Likewise the clitoris has been seen as a 'masculine' element in the female. Although Western culture does not practise routine clitoridectomy, 'over-large' clitorises are surgically reduced, particularly in people with intersex conditions (Crouch and Creighton 2004).

The need to reduce gender ambiguity of the genitals is explicit in some cultures, which may practise both male circumcision and clitoridectomy. The Dogon of Niger believe children to be androgynous and that both procedures are needed to assist children to become adult men and women (or so it is reported in Bishop et al. 2001, pp. 172–3; I do not know whether the Dogon still hold this view nowadays). To put it another way, progress to reproductively functional male or female adulthood is not seen by the Dogon as biologically automatic or developmentally inevitable; culture must intervene to help the process along, giving knowledge and altering the body, much as we believe both training and practice are necessary to make a child into a musician or professional tennis player. The Dogon are not alone in this: as Silverman (2004) puts it, 'For traditional Judaism, no less

than for many Melanesian and African cosmologies, male and female bodies require postpartum adjustment to attain proper wholeness.'

Thus I suggest that routine male circumcision fulfils (in the Western cultures that practise it) an analogous role: it 'perfects' the penis, makes it more unambiguously phallic, which is to say smooth, firm, dry and suitable to what is seen as its key task of insertion, rather than irregular, soft, moist and mutable. Circumcision removes the foreskin and its awkward ambiguity, its feminine capacity to function as a receptive space (for objects such as the partner's tongue) and as a receiver of sensory stimulation. After circumcision the skin of the glans penis becomes toughened and keratinised, more like ordinary body skin, instead of remaining moist and vulnerable like the vulva. (Whether this perceptibly reduces the sensitivity of the glans penis is the topic of heated argument, to which I will return below.) It could also be argued that the circumcised penis resembles an erect penis even when flaccid, as the difference between a circumcised and an uncircumcised penis is less apparent when they are erect and the foreskin is retracted behind the coronal sulcus. This effect too makes the circumcised penis more 'phallic', more symbolically expressive of its purpose.

In suggesting this I am not claiming that circumcisers consciously desire to remove a 'feminine' element from baby boys in the way that women who find it necessary to depilate their upper lips are conscious that they are removing a socially undesirable 'masculine' moustache. Indeed, I suspect that surgeons who perform circumcision and others who advocate it would resent the suggestion that they are recommending a procedure analogous to leg-waxing (gender-specific, fashion-driven, socially and historically contingent) rather than to vaccination (gender-neutral, scientific and necessary wherever particular pathogens are present). The very fact that a custom is embedded in culture means that rationalisations of its purpose in terms of health outcomes are believed. Circumcision just seems 'right', 'nice' and 'clean' (Bishop and Hobden 2001, p. 38). The circumcised penis is simply

seen as better, and men and women prefer its appearance (Fink, Carson and DeVellis 2002, Williamson and Williamson 1988).

One problem with an argument of this form is that we cannot test the hypothesis by appeal to an empirical study of people's attitudes: unlike the Dogon, modern Westerners do not consciously hold a world view that consistently explains their social practice in this domain. I therefore cannot propose an opinion survey that would confirm or disprove my hypothesis. What I can do, however, is: (1) show how it fits into a broader theoretical schema; (2) produce internal evidence from pro-circumcision arguments that the motivation is not rationally based on public health arguments; and (3) wait for the hypothesis to show its 'fitness' by outlasting other explanations of what is going on in the circumcision debates.

#### *The role of the penis in sexual discourse*

That the medical conception of human sexuality is reductively reproductive has been argued at length by others (including, from different points of view, Koutroulis 1990, Laqueur 1990, Foucault 1990, FFWHC 1991). Despite the ascendancy of social constructionist views of sexuality—often now accepted or at least given lip service even in the medical literature—much work on sexuality clings to a discursive framework based around reproductive function which is thus implicitly heterosexual and coital (e.g. Basson 2005). Ross Morrow (1994a, 1994b, 2003) has argued that the construction of Western sexual practice expressed in the discipline of sexology (i.e. the theory and practice of sexual counselling and therapy) requires an insertive penis. Sexual function equals coital adequacy. Inability or unwillingness to perform coitus is seen as a 'dysfunction'—not, say, as a difference in personal taste, or as rudeness, laziness or bloody-mindedness. Social norms about appropriate sexual practice are expressed in medicalised terms as if failure to perform according to them were a physiological problem (analogous to indigestion or constipation) rather than a cultural and interpersonal one (analogous to bad cooking or table manners).

In this naturalised and biologised picture of good sex shared by sexologists, the media and

lay people (Lancaster 2003), the key role of the penis is to be erect and to be inserted (into the vagina or perhaps the mouth or anus) of the partner. The central role of coitus as 'the' (hetero)sexual practice has persisted into the early 21st century despite the disruption of earlier values supported in the Judaeo-Christian tradition that opposed all non-reproductive sex. Even though most people now accept contraception, extramarital sex and former 'perversions' such as fellatio, the centrality of coitus as a core practice has barely diminished (Laumann et al. 1994, Johnson et al. 1994, 2001, Messiah et al. 1995, de Visser et al. 2003). It may even be that the emphasis on condom use in post-1980s sex education has increased it (Richters 1994). For many people, coitus is still what is meant by the word 'sex': sex workers offer 'French and sex' (i.e. fellatio and vaginal intercourse) and younger people often don't count oral sex as really 'having sex' (Sanders and Reinisch 1999, Remez 2000, Richters and Song 1999, Rissel et al. 2003, Pitts and Rahman 2001).

In this story of what sex is, there is no place for the foreskin. The penis is an instrument, not a sensitive receiver of delicate stimulation. Men see their own penises as imperforate, and perceive themselves as not at risk of infection as long as they only take the insertive role. Men are genuinely puzzled that anything could get into the penis, which emits fluid but does not receive it (Waldby 1995, Richters, Hendry et al. 2003, Richters, Grulich et al. 2003). Only the gay male body is 'leaky' and vulnerable, because it is penetrated. Distaste at the lack of hygiene of the uncircumcised penis retaining sexual fluids if not washed after intercourse is apparent in the [www.circinfo.net](http://www.circinfo.net) website, whose author is a professor of molecular medical sciences. He quotes a colleague writing in a medical newspaper:

*Furthermore, Dr Terry Russell, an Australian medical practitioner and circumcision expert states 'What man after a night of passion is going to perform penile hygiene before rolling over and snoring the night away (with pathogenic organisms multiplying in the warm moist environment under the prepuce)'.*

Somehow or other women are expected to survive the regrettable fact that their genitals are always warm and moist, and presumably host to untold numbers of multiplying organisms, but this is seen as unacceptable for men.

In the next section I will discuss one of the arguments between pro- and anti-circumcision camps: the question of whether circumcision reduces the sensitivity of the glans penis. We will see that there too the argument turns on the true nature and purpose of the penis in a coital economy.

### **Does circumcision reduce penile sensitivity?**

The fact that circumcision results in a change in the texture of the epithelium of the glans penis is not contested. The question is whether this results in a significant diminution of sexual sensation for circumcised men. At first sight, this is a scientific question that could be resolved by scientific investigation.

In their 1966 book *Human Sexual Response*, Masters and Johnson state that in laboratory tests they found 'no clinically significant difference' between 35 intact and 35 circumcised men in 'routine neurologic testing for both exteroceptive and light tactile discrimination ... on the ventral and dorsal surfaces of the penile body, [particularly] the glans' (p. 190). No further details of the study method are given. Nor is there any information on whether statistical but non-clinical differences were observed. No reference is given in the book to any peer-reviewed published report of this experiment. Despite the lack of scientific evidence, Masters and Johnson's conclusion that circumcision makes no difference to sensation has been widely quoted and believed.<sup>3</sup>

After a gap of over 30 years during which the topic was much argued but no further evidence produced, two recent studies have attempted to address the question of sexual effects of circumcision by studying men who underwent circumcision as adults for medical indications. Collins et al.'s (2002) paper concludes that circumcision 'should not significantly alter sexual functioning'. The study has been criticised (Casella 2002) because its failure to find a statistically significant change can be attributed

to its small sample of only 15 respondents. But the difficulty with the study is not that the differences found are not statistically significant, but that the measure of sexual 'function' is inadequate. The researchers used the Brief Male Sexual Function Inventory (BMSFI, O'Leary et al. 1995) on the grounds that it had been validated in several languages and was 'the simplest questionnaire for our patient population to answer'. The questionnaire asks about: sexual drive (feeling like having sex); frequency of erection on awakening and in response to stimulation; firmness of erection; difficulty in ejaculating after stimulation; amount of semen ejaculated; whether the above things were problems; and satisfaction with sex life.

In short, the BMSFI could be said to be a urologist's summary of the reproductive necessities: Do you feel randy? Can you get it up? Can you ejaculate? It does *not* ask about: discomfort on erection (e.g. 'tethering' that might be caused by too little penile skin left after circumcision); penile response to light touch or firm pressure; discomfort or stimulation of the uncovered glans; premature ejaculation; any difference in required or desired stimulation to reach orgasm, or change in preference for or sensation of sexual practices (e.g. fellatio, coitus); or sensation derived from the foreskin itself (before the procedure).

In the same issue of the *Journal of Urology* the immediately following article, by Fink et al. (2002), also examined satisfaction after adult circumcision but came to less confident conclusions despite having 43 respondents from a survey of 123 men undergoing adult circumcision. The researchers compiled a questionnaire using items from various indexes and scales, as they found none specifically designed to evaluate the outcomes they sought to study: erectile function, penile sensitivity, sexual activity and overall satisfaction. Open-ended questions were also included.

On average their respondents reported reduced erectile function, decreased penile sensitivity (borderline statistical significance), no change in sexual activity, and improved satisfaction, but none of the differences was huge. Men's views of penile sensitivity differed. One

man said that 'Somewhat less sensitivity helps prolong intercourse' (p. 2114). Another felt that despite a warning he had not been fully informed of the loss of sensitivity. For men who were happier with the procedure, higher satisfaction represented being happy with the appearance of the penis, or having less pain (remember that these men mostly had medical conditions, most commonly phimosis, that led to the need for circumcision). The authors concluded that 'sexual pleasure means different things to different men and should be more specifically defined ...'.

### **Can evidence-based medicine understand sexual pleasure?**

A key difference illuminated here is between a view of the pleasure of sex, especially for men, as primarily deriving from the satisfaction of coital performance, and a view of the pleasure of sex as receiving erotic sensation. One man can be happy if he feels that a certain degree of penile anaesthesia makes it easier for him to control the timing of his orgasm while thrusting. Another is dismayed to find that he can no longer feel sexual sensations he once enjoyed. For most people, such issues are rarely articulated verbally. Although sociologists and anthropologists view it otherwise, people experience their own sexual sensation as natural and given by physiology (Tiefer 2004, Lancaster 2003). For a man circumcised at birth to understand what it feels like to have a foreskin is perhaps impossible. This may make it easier for scientists to claim that they have discovered that it makes no difference. But it may also be unthinkable for a man to imagine himself as a receiver of delicate stimulation when his whole sexual persona as a normal member of his culture is that of a coital tool or instrument. When sex is conceptualised entirely as reproductively adequate coitus, there is no cognitive framework within which to understand arguments about sensuality.

The lack of research evidence to answer the questions about the sexual effects of circumcision raised in the debates highlights some of the limitations of evidence-based medicine. Large population-based studies and meta-analyses can tell us how many neonatal circumcisions are

necessary to prevent one case of each condition such as urinary tract infection or penile cancer ('number needed to treat' analysis), and on average how many circumcisions are carried out for each adverse event attributable to the procedure ('number needed to harm' analysis; see Christakis et al. 2000). Attempts at conventional evidence-based decision-making stumble when faced with complex multiple outcomes of different levels of seriousness. Christakis et al. remark that people's views of outcomes are affected by whether they are caused by actions or omissions, and whether the outcomes are preventable. Weighing of multiple benefits against harms is therefore an unavoidably subjective process.

This is nowhere more true than in consideration of the question of the sexual effects of circumcision. Traditional public health discourse cannot engage with the imaginary sexual body. If an experience is not part of culturally shared sexual narrative, there are no words to describe it. For many men (and women) whose sexuality is focused on gender and role adequacy, on the performance of coitus, the argument against circumcision on the grounds of sexual sensitivity is tantamount to saying that you shouldn't have your son circumcised in case he wants to be a pervert.

### **Directions for future research**

Despite the fervent discussion of the pros and cons of circumcision, we lack empirical data. The topic is not included in attitude surveys – unlike, say, abortion or school sex education. Studies of men who have undergone adult circumcision are few; there have been none in Australia. We need to know about both their motivations and the effects of the procedure, particularly as news of the successful HIV-prevention studies in Africa may affect demand for it. Better studies could be designed to find out whether circumcision does reduce the sensitivity of the glans penis. At the interpretive cultural level, we know little of how the circumcised (or indeed 'uncut') penis figures as an image in pornography or as a personal attribute in the (cyber)sexual market. Does the export of sexual imagery from the United States – the one rich Western country with high circumcision rates – affect the views of

circumcision held in other countries? Most importantly we need careful meta-analyses to inform the debates about medical benefit (Morris et al. 2006, Richters 2006), so that epidemiologists can reach agreement on responsible advice to give parents.

## Endnotes

- 1 Recent evidence from Africa and India confirms that circumcised men are much less likely to contract HIV in vaginal intercourse (though not fully protected) (Weiss et al. 2000). As a result, US-funded programs are performing randomised clinical trials of adult circumcision for HIV prevention in two locations in east Africa (see [www.clinicaltrials.gov/ct/show/NCT00059371](http://www.clinicaltrials.gov/ct/show/NCT00059371)). A French study in South Africa was halted early because evidence of effectiveness was so strong it was considered unethical to continue (Auvert et al. 2005).
- 2 From the *Just So Stories*, Rudyard Kipling's collection of whimsical Lamarckian fables explaining how the camel got his hump, the elephant his long trunk, the leopard his spots and so on.
- 3 Masters and Johnson remark on the fact that only 35 of their 312 male study subjects were uncircumcised, and they were disproportionately found in the over-40 group, because of the 'medical trend toward urging routine circumcision of the newborn male infant' (p. 189). Interestingly, they state that circumcised and uncircumcised men alike believed 'as biologic fact' that *circumcised* men were likely to have difficulty with ejaculatory control and a greater tendency toward impotence (p. 190), because the glans penis was not protected by the foreskin. This is the reverse of what is believed today, when it is accepted that the foreskin usually retracts to expose the glans penis, if not on erection then during intromission.

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