UNIVERSAL HUMAN RIGHTS IN DISCOURSE AND PRACTICE:

THE CULTURE OF CIRCUMCISION IN U.S. FOREIGN AND DOMESTIC POLICY

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CITATIONS AND COMMENTS ENCOURAGED
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CONTENTS

ABSTRACT ....................................................................................................................... 1

INTRODUCTION ............................................................................................................. 1

WHY CIRCUMCISION? .................................................................................................. 3

US DISCOURSE ABROAD AND AT HOME .................................................................... 6

LOCATING CULTURE ..................................................................................................... 8

REGIONAL COMPARISONS .......................................................................................... 13

HISTORICAL EXCAVATION & MEDICAL EVIDENCE .................................................... 15

HYPOTHETICAL SURGERY ........................................................................................... 25

RATIONAL CHOICE? — A THOUGHT EXPERIMENT .................................................. 28

CONCLUSION ............................................................................................................... 30

APPENDIX A — HYPOTHETICAL SURGERY SURVEY ............................................... 31

APPENDIX B — COMPARING CIRCUMCISIONS SURVEY ........................................... 32
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ABSTRACT

A universal standard of human rights is fundamental to the assessment and enforcement of human rights internationally, yet its self-evident portrayal in US foreign policy rhetoric is made problematic when viewed in the context of US domestic policy. The adversary of universalism internationally is often a lightly constructed sense of culture that the US policy-makers and academics feel themselves immune to domestically and which is, therefore, unnecessary to explore thoroughly. Circumcision serves as a case to expose this inconsistency.

This paper presents the self-evidently cultural construction of female genital mutilation applied to US foreign policy and contrasts that with the self-evidently non-cultural construction of male infant circumcision applied to US domestic policy. This paper will then expose the cultural forces enabling male infant circumcision by contrasting geographic practices, excavating historical justifications, and presenting the results of two surveys on male infant circumcision as constructed in the United States. Thus it will expose how powerfully culture may blind even a nation that proclaims in official rhetoric and public opinion the necessity of universalism and the dangers of cultural relativism. In the end, this paper will demonstrate how difficult it is to construct and prescribe an objective universalist human rights policy at home and abroad, not that we should not attempt it, but that with an awareness of our own cultural blind spots we may attempt it more honestly.

INTRODUCTION

Improving the human rights of the world’s population is among our discipline’s most pressing issues, yet acting on these good intentions becomes profoundly complicated by, among other things, issues regarding the unbiased assessment of human rights violations and the uniform definition and enforcement of human rights standards. Each of these problems become even more acute when

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1 Special thanks to Paul M. Fleiss, N. Williams and L. Papita, the Circumcision Information Resources Pages, the National Organization for Circumcision Information Resource Centers, the Task force on Circumcision of the American Academy of Pediatrics, and the journal, Circumcision for making so many resources I cite so easily available.
considering religious-cultural practices which in public discourse constitute some of the most severe violations of human rights world-wide.

One such issue to receive considerable attention in the media recently is that of female genital mutilation (hereafter referred to as FGM). As FGM's horrific images reach our shores, scholars and policy makers are compelled to seek solutions. They discount the cultural relativism used to defend FGM, and they attempt to apply universal standards of human rights to combat it. Although these efforts to promote human rights are laudable, the logic underlying them is made problematic when viewed in light of the United States' culturally driven practice of routine infant male circumcision.

In the United States 3,000 male infants are routinely circumcised each day\(^2\) without personal consent, with great pain, dangerous medical risks, and as the medical community is now aware, practically no medical benefit. A flood of medical studies has dispelled or put in great doubt every past medical justification of routine circumcision. As the medical construction of circumcision is challenged (and indeed exposed to never have been sufficiently supported) we are left an uncomfortable yet undeniable awareness that our nation\(^3\) too perpetuates human rights abuses which are justified not by an objective, universal standard, but by the same contingent cultural foundations we so easily dismiss when employed abroad.

\(^2\) Routine infant male circumcision is the most common surgery performed in the United States.

\(^3\) To speak of nations as the unit of analysis when considering culturally based human rights issues may appear at first a shaky prospect. One might argue that circumcision in the US and abroad is neither practiced nor perpetuated by the state, but by people. This has not, however, shielded other states from criticism by the Department of State in its Human Rights Reports, nor should it shield the US. Viewing male circumcision as a human rights issue, one finds the US and state governments right at center stage; they either legally sanction or even fund its practice.
In a nutshell, this research probes the relationships between culture, human rights, and U.S. foreign policy and uses circumcision as the substantive case to explore these broader theoretical relationships.

**WHY CIRCUMCISION?**

Several characteristics of circumcision make its study fertile ground for exposing culture’s impact on the perception and practice of human rights. First, FGM (sometimes referred to by its euphemism, female circumcision) is an historically illuminating issue and a useful baseline to compare with both historical attitudes in the US and current attitudes toward male circumcision. The general population of the US now decries FGM, but historically this has not been the case. Well into the 1970s FGM was performed professionally in the United States at the rate of at least 3,000 per year, and was advocated in medical journals as late as 1973. In 1976 the World Health Organization declared that the US was the only medically advanced country in the world to continue its practice. Until 1977

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5 It shocks us now to know that reputable doctors were publishing articles like Wollman, L. 1973. Female Circumcision. *Journal of American Society of Psychosomatic Dentistry and Medicine* (20): 130-1; Benjamin E. Dawson A.M., M.D. 1935. Circumcision in the Female: Its Necessity and How to Perform It. *American Journal of Clinical Medicine* (22, no. 6): 520-523; and James C. Burt M.D. 1975. *Surgery of Love*, which advocated female circumcision. James Burt later fell into disrepute, not because he advocated and performed female circumcision, but because it was discovered much later that he was performing the surgery without the patients’ consent or knowledge.

FGM was covered by Blue Shield,\(^7\) and not until April of 1997 was it made illegal in the United States.\(^8\)

Now that the US has for the most part rid itself of FGM, it is turning its attention elsewhere and pressuring other nations to restrict or eliminate its practice. These attempts are constantly frustrated by claims of those practicing FGM that it is justified by cultural customs and a veneer of social and medical claims. Most Americans do not consider these cultural justifications acceptable, but culturally perpetuated blindness is a difficult thing to overcome as the US’s own history with FGM reveals.

Considering male circumcision in this context is of crucial theoretical significance. Male circumcision differs from FGM in several important ways--male circumcision is almost always less violently employed than FGM and it is not bound to the same structures of gender oppression. Yet once room is created beside FGM to consider male circumcision likewise a human rights issue, then numerous similarities become apparent. Both are imposed upon helpless victims; both surgeries are extremely painful, irreversible, and done without consent; neither provide substantial medical benefits although both often claim to do so; both are perpetuated by social custom; both may inflict life-long physical and emotional damage although the victims often deny such; and finally, both are often supported by their very victims.\(^9\)

\(^7\) Ibid.


\(^9\) One poll of Egyptian women documented that 80 percent of the female population supported the practice of FGM. Other studies document FGM’s support by a majority of Sudanese women (Lightfoot-Klein, H. 1989. Rights of Purification and Their Effects: Some Psychological Aspects of Female Genital Circumcision and Infibulation in an Afro-Arab Islamic Society” *Journal of Psychology and Human Sexuality* 2: 79-91) and yet another documents that a majority of Somali women support
This initial comparison demonstrates a second ground to consider circumcision in this theoretical context. Male and female ‘circumcision’ promises to be fruitfully considered because each of their practices has become constructed in such starkly contrasting spheres of meaning. Therefore, to the extent that we are able to transcend the discursive boundaries that separate them, we will be able to see both the profound power of these cultural constructs and the magnificent impact that culture exerts on the United States’ domestic and foreign policy.

Third, male infant circumcision is also an especially useful case in that it has donned an allegedly objective mask of scientific authority to hide its intersubjective nature. This is a crucial parting from many human rights abuses throughout the world which are justified overtly by culture or religion. The scientific claims that have evolved over time to justify male infant circumcision are, because of their claims of objectivity, vulnerable to objective evaluation. Other practices that are openly cultural cannot be so addressed. To suggest their ontological contingency will only elicit the response that of course they are, as are all practices, values, and rights. Any critique would soon be reduced to the difficult comparing and ranking of values, without the promise of offering a convincing standard that all sides of debate may agree upon.

Fourth, the case of infant male circumcision is an especially useful case because it is practiced most (in absolute numbers) by a culture that frequently criticizes cultural defenses of human rights

FGM’s practice and a desire to inflict it upon their daughters (Dirie, M.A. and G. Lindmark. 1991. Female Circumcision in Somalia and Women’s Motives. Acta Obstetricia Et Gynecologica Scandinavica 70: 581-5). When citizens of Sierra Leone felt pressure from the west to end FGM, tens of thousands of women marched through Freetown protesting that perceived infringement on their cultural rights. One might question the validity of these displays or polls, but a sense of Marx’s false consciousness or Gramsci’s hegemony seems much more likely at work.
abuses. It is important that the many sincere efforts of the United States government to promote human rights not be discounted as hypocrisy. Yet, if culture is blinding the United States to its own human rights violations than its citizens and leaders must become thus aware both to set their own house in order and to better understand and communicate with the cultures it criticizes.

**US DISCOURSE ABROAD AND AT HOME**

In its public rhetoric, the United States government has consistently proclaimed that human rights are essentially universal. US politicians rely on an unwavering sense of this universality in every accusation they make of foreign states’ practices. Secretary of State, Madeleine Albright, for example, recently declared that, “American . . . has no permanent enemies, only permanent principles . . . . The United States will not hesitate to address frankly the violation of internationally recognized human rights.”

It has become clear, however, that what qualifies as human rights changes over time. Only recently, especially with the great impact of the Beijing Women’s Conference of 1995, has the US government focused so acutely on the world-wide abuses of women so horrific in both their frequency and their often gruesome nature. In this spirit, President Bill Clinton recently stated that, “We cannot advance our ideals unless we focus more attention on the fundamental human rights and basic needs of women and girls. . . . We are putting our efforts to protect and advance women’s rights where they

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belong--in the mainstream of American foreign policy.”

Similarly, Secretary of State, Madeleine Albright similarly pronounced that, “Advancing the status of women is not only a moral imperative; it is being actively integrated into the foreign policy of the United States. It is our mission.”

FGM is among one of the many issues being integrated into the foreign policy of the United States. In practice, this integration takes the form of adjusting asylum policies, funding non-governmental efforts to minimize FGM’s health complications, and publishing in its annual *Human Rights Reports* the offending nations. In its most recent round of publications, the U.S. Department of State criticized Benin, Burkina Faso, Cameroon, Canada, Central African Republic, Chad, Comoros, Congo (Democratic Republic), Cote d’Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gabon, The Gambia, Guinea-Bissau, Indonesia, Kenya, Liberia, Libya, Malawi, Mali, Mauritania, New Zealand, Niger, Nigeria, Oman, Sierra Leone, Somalia, Sudan, Tanzania, Togo, and Yemen.

Some of these countries are congratulated for making progress in legal or educational campaigns to reduce or abolish incidents of FGM, but in every case the State Department clearly indicates that the practice continues. Why? The publications of Amnesty International, Human Rights Watch, and the US government all make it clear that culture is the driving force enabling and

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perpetuating this abhorrent practice. The cure to this cultural relativism they consistently prescribe requires that cultural relativism be superseded by a universal standard of human rights to be enforced universally.

Reflecting on the Universal Declaration of Human Rights, the UN document that represents the foundation for such universal standards, Madeline Albright stated that the “Universal Declaration reflects spiritual and moral values that are central to all cultures. . .” and that the protection of those rights is of “universal concern.” Finally, just before addressing abuses like FGM, she discloses the obstacle that most often frustrates these attempts stating that, “There are those who suggest that many of these abuses are cultural and there’s nothing we can do about them. I say they’re criminal and it’s the responsibility of each and every one of us to stop them.”

LOCATING CULTURE

If culture is the culprit, then culture must somehow be located. Viewed from afar, the cultural character of FGM seems obvious. Viewed up close, it is always more difficult to disclose one’s own culture (what is familiar is never known). The cultural construction of male infant circumcision will be exposed and explored with the following steps: first, a geographic comparison of circumcision rates; second, an historical assessment of its origins and perpetuation; third, a consideration of its supporting medical evidence; fourth, a look at survey results to isolate the rational process of a decision to circumcise without the cultural baggage; and finally, a brief thought experiment—an attempt to perceive

the practice and meaning of circumcision from outside our cultural perspective. Before any of that, however, let us explore how deeply the cultural element of circumcision is hidden. A survey (see Appendix A) comparing perceptions of and attitudes toward male and female ‘circumcision’ exposes how different each is perceived.

Figure 1 cuts right to the chase. When asked whether one, as a parent, would circumcise his/her daughter or son, the results were, not surprisingly, profoundly different. This despite that only 39 percent of respondents claimed they felt knowledgeable about female ‘circumcision’ and only 57 percent of respondents claimed they felt knowledgeable about male ‘circumcision.’ Of the three that either strongly agreed or agreed they would circumcise their daughter, two provided very contradictory statements later in the survey (ie checking a box “I oppose female

Figure 1. Response to “As a parent of a son, I would have his circumcised.” and “As a parent of a daughter, I would have her circumcised. N = 99.

15 The selection of accurate and meaningful terminology is rarely so difficult. Most literature uses the terms “FGM” to represent the various degrees of genital mutilation of females and “circumcision” to represent that of males. Sometimes the sanitized euphemism of “female circumcision” is employed but this does no justice to the senseless physical and psychological pain imposed by the surgery. On the other hand, opponents of male ‘circumcision’ have begun referring to “male genital mutilation” using similar logic.
circumcision”). Even given these few suspicious responses, the pattern is clear—in our culture, people are very much more willing to circumcise their sons than their daughters. As strong as this finding is, it is neither new nor surprising. Judging from actions alone, one might suspect this.

More interesting are the justifications given for this differing degree of support or opposition displayed in Table 1.

Table 1. Percent of Survey Respondents Indicating Support for or Opposition to Female and Male Circumcision (N=98, Respondents could check all that apply).

<table>
<thead>
<tr>
<th>Justification to Support or Oppose the Practice</th>
<th>Female Circumcision</th>
<th>Male Circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>4</td>
<td>42</td>
</tr>
<tr>
<td>Culture</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Hygiene</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>Medical Reasons</td>
<td>9</td>
<td>58</td>
</tr>
<tr>
<td>Religious Reasons</td>
<td>7</td>
<td>38</td>
</tr>
<tr>
<td>Social Reasons</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>Appearance (Oppose)</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>Culture (Oppose)</td>
<td>29</td>
<td>8</td>
</tr>
<tr>
<td>Human Rights (Oppose)</td>
<td>62</td>
<td>19</td>
</tr>
<tr>
<td>Medical Reasons (Oppose)</td>
<td>47</td>
<td>12</td>
</tr>
<tr>
<td>Religious Reasons (Oppose)</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Social Reasons (Oppose)</td>
<td>37</td>
<td>8</td>
</tr>
</tbody>
</table>

Although cultural, social, and aesthetic considerations all did play a role in support for and opposition to both practices, the most common responses were to support male circumcision for reasons of medicine and hygiene, while opposing female circumcision as a human rights offense. These
patterns suggest that the population surveyed made a clear distinction between male circumcision being
a medical issue, and FGM (even in its sanitized euphemism) as a human rights concern. Why is this so?
There are several possibilities.

The first possible explanation for the differing perceptions is that they differ in reality. One might,
a this point in reading, conclude that male circumcision is a medical issue and FGM is a human rights
issue, and isn’t it nice the survey respondents are smart enough to realize this. One the other hand, if
the reader were able to temporarily suspend his or her preconceptions, then a second possibility must
be considered. FGM and male circumcision are different, yet they are similar enough to be comparable. If this paper demonstrates sufficiently in its remaining space that routine male circumcision
cannot be justified medically, and that, like FGM, it is painful, unnecessary, and a violation of one’s
physical sovereignty and integrity, then one must consider that other cultural currents must explain the
differing perceptions, understandings, and practices of FGM and male circumcision in US domestic
and foreign policy.

Having thus far at least documented differing perceptions, the next step is to determine if these
perceptions translate into political action at home and abroad. To explore this link, the survey next
polled respondents on their attitudes on circumcision in US and international law. Do the attitudes only
apply toward their child or will their perceptions influence prescribed US domestic and foreign policy?
Figures 2 and 3 suggest that these attitudes do translate. Only two of 99 respondents indicated that they thought the United States should legally restrict male circumcision. Comparatively speaking, 42 respondents felt that FGM should be restricted or prohibited. Many did not know or have an opinion, but by far the most popular response was to indicate that the US should not legislate against male circumcision.

How this translates to prescriptions of US foreign policy are depicted in Figure 3. Only one respondent thought that the United States should encourage other nations to restrict male circumcision compared to 27 who advocated US foreign policy efforts to reduce FGM internationally. As in Figure 2, respondents were often uncertain. Many felt that the US should do nothing to protect

![Figure 2](image1.png) **Figure 2.** Response to “There should be laws restricting or prohibiting male circumcision in the United States.” and “There should be laws restricting or prohibiting female circumcision in the United States.” N = 99.

![Figure 3](image2.png) **Figure 3.** Response to “The United States should encourage other countries to adopt laws restricting or prohibiting female circumcision.” and “The United States should encourage other countries to adopt laws restricting or prohibiting female circumcision.” N = 99.
either sex, but many more (63 of 99) thought the US should not encourage other nations to restrict male circumcision.

**Regional Comparisons**

Now that these different perceptions and their accompanying policy prescriptions are apparent, we need to expose the culture nature of male circumcision. An initial attempt to isolate the cultural dimension of infant male circumcision requires a regional comparison. In the spirit of Ronald Inglehart, culture can be exposed in differing attitudes (perhaps even more so in differing actions) across geographical regions. Widely varying circumcision rates both within the United State and among western nations supports this point.

Within the United States, circumcision rates vary greatly from the mean of 60.2% nationally (all data from 1996). The Midwestern region exhibited a considerably higher rate of 81.0% whereas the Western region exhibited considerably lower rates of a mere 36.2%.

**Table 1: U.S. Circumcision Rates Across Time and Region**

<table>
<thead>
<tr>
<th>Year</th>
<th>Northeast Region</th>
<th>Midwest Region</th>
<th>Southern Region</th>
<th>Western Region</th>
<th>All Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>62.3%</td>
<td>78.1%</td>
<td>63.6%</td>
<td>40.5%</td>
<td>61.6%</td>
</tr>
<tr>
<td>1992</td>
<td>67.7%</td>
<td>78.1%</td>
<td>62.7%</td>
<td>37.6%</td>
<td>60.7%</td>
</tr>
<tr>
<td>1993</td>
<td>65.1%</td>
<td>74.4%</td>
<td>61.4%</td>
<td>35.5%</td>
<td>59.5%</td>
</tr>
<tr>
<td>1994</td>
<td>69.9%</td>
<td>80.1%</td>
<td>64.7%</td>
<td>34.2%</td>
<td>62.7%</td>
</tr>
<tr>
<td>1995</td>
<td>68.3%</td>
<td>79.8%</td>
<td>66.1%</td>
<td>42.6%</td>
<td>64.1%</td>
</tr>
<tr>
<td>1996</td>
<td>66.7%</td>
<td>81.0%</td>
<td>63.6%</td>
<td>36.2%</td>
<td>60.2%</td>
</tr>
</tbody>
</table>

Internationally, the disparity is even more remarkable. Compared with the United States’ 60 percent,\(^\text{17}\) no other Western industrialized nation even comes close. The only western industrial nations ever to widely adopt the practice for non-religious reasons were the Anglo nations of New Zealand, Australia, Canada, the United Kingdom, and the United States. Today just over 10 percent of Australia’s infant boys are circumcised varying by region from 5.4% in Victoria to 17.2% in Queensland.\(^\text{18}\) In Canada, current rates average about 25%, but they also vary widely from British Columbia 6.7% in 1996-97\(^\text{19}\) to as high as 70% in Essex County Ontario.\(^\text{20}\) At the low end, Great Britain experiences only about 0.5% circumcision rate of infants.\(^\text{21}\)

What would account for this great variance. Economic factors do not provide a very compelling explanation. Political consideration are certainly worthwhile; circumcision rates declined dramatically in the U.K., parts of Canada, and Australia after the government stopped covering the cost of what they considered an elective surgery. This, however, begs the question. With access to the same scientific


\(^{19}\) Or perhaps an even lower 2.7 percent in 1987 Quebec (from an uncited source at http://www.cirp.org/library/statistics/Canada/Quebec).


\(^{21}\) British Dept. of Health and Social Security, cited by Wallerstein in *Circumcision: An American Health Fallacy*. 


14
evidence as insurance companies and politicians in the United States, how could other Anglo nations conclude that circumcision was elective or primarily cosmetic, while the United States still feels it is so necessary. Furthermore, how could non-Anglo, continental European nations, who also possess reputable medical and scientific institutions, never realize circumcision’s ‘necessity’ in the first place?

**HISTORICAL EXCAVATION & MEDICAL EVIDENCE**

History provides still further insight into the cultural forces behind circumcision. Although male circumcision has been practiced in certain regions of the world for at least several thousand years, it was not practiced widely in the United States until the late 1870s. Springing out of the era’s prevalent Victorian culture, circumcision was introduced at first as a cure for masturbation. It was, unfortunately, soon viewed as such an effective ‘cure’ that by the early 1900s doctors also began to appreciate the potential of circumcision as preventive measure, so much so that by 1928 the editor of the medical field’s leading journal advocated routine male infant circumcision to prevent later masturbation.\(^\text{22}\)

At the risk of overkill, a number of quotes from prominent medical journals and opinion leaders at the time make the point quite convincingly that the earliest justifications for circumcision were much more grounded in a puritan culture than medical necessity.\(^\text{23}\) In 1887, for example, Angle Money in discussing how children’s diseases should be treated stated that,


There can be no doubt of [masturbation’s] injurious effect, and of the proneness to practice it on the part of children with defective brains. Circumcision should always be practiced. It may be necessary to make the genitals so sore by blistering fluids that pain results from attempts to rub the parts. 24

In 1891, Dr. Crossland adds hygiene to the list of benefits, but still focuses on the moral benefit of making the penis less sensitive and, therefore, the child less prone to masturbate.

In consequence of circumcision the epithelial covering of the glans becomes dry, hard, less liable to excoriation and inflammation, and less pervious to venereal viruses. The sensibility of the glans is diminished, but not sufficiently to interfere with the copulative function of the organ or to constitute an objection. . . It is well authenticated that the foreskin . . . is a fruitful cause of the habit of masturbation in children. . . I conclude that the foreskin is detrimental to health. . . . 25

Now a household name more for his Pop Tarts than his medicine, Dr. Kellogg was once an outspoken opponent of masturbation. In addition to prescribing his cereal as a cure, he suggests

A remedy [for masturbation] which is almost always successful in small boys is circumcision. . . . The operation should be performed by a surgeon without administering an anaesthetic, as the pain attending the operation will have a salutary effect upon the mind, especially if it be connected with the idea of punishment. . . . 26

In a similar spirit of applying medicine as punishment Dr. Bergman spoke of his patient in 1898,

Clarence B. was addicted to the secret vice practiced among boys. I performed an orificial operation, consisting of circumcision. . . He needed the rightful punishment of cutting pains after his illicit pleasures. 27


Such gruesome claims did not go unscrutinized, but the powerful cultural forces of Victorian fear of sexuality and general disregard for the rights of children won out. Repeatedly as the adoption of routine circumcision was being debated, doctors suggested in leading medical journals that curbing sexuality was their duty.

It has been urged as an argument against the universal adoption of circumcision that the removal of the protective covering of the glans tends to dull the sensibility of that exquisitely sensitive structure and thereby diminishes sexual appetite and the pleasurable effects of coitus. Granted that this be true, my answer is that, whatever may have been the case in days gone by, sensuality in our time needs neither whip nor spur, but would be all the better for a little more judicious use of curb and bearing-rein.  

Similarly, in opposition to the early arguments favoring the human right of natural physical integrity, Dr. Cockshut argues

I suggest that all male children should be circumcised. This is "against nature," but that is exactly the reason why it should be done. Nature intends that the adolescent male shall copulate as often and as promiscuously as possible, and to that end covers the sensitive glans so that it shall be ever ready to receive stimuli. Civilization, on the contrary, requires chastity, and the glans of the circumcised rapidly assumes a leathery texture less sensitive than skin. Thus the adolescent has his attention drawn to his penis much less often. I am convinced that masturbation is much less common in the circumcised. With these considerations in view it does not seem apt to argue that "God knows best how to make little boys."

What began as a moral crusade, soon adopted medical legitimacy. Over the years, medical journals adopted claims that “circumcision cured epilepsy, convulsions, paralysis, elephantiasis, tuberculosis, eczema, bed-wetting, hip-joint disease, fecal incontinence, rectal prolapse, wet dreams,

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hemia, headaches, nervousness, hysteria, poor eyesight, idiocy, mental retardation, and insanity.’”

One doctor recently observed that “no procedure in the history of medicine has been claimed to cure and prevent more diseases than circumcision.”

In the past two decades, doctors have been more modest in their claims, but in spirit they have continued to insist that circumcision prevents or cures a number of ills. The literature has focused especially on the risks of STD’s, urinary tract infections, and penile cancer.


31 Ibid. p. 38.

32 See, for example, the following articles:

33 See, for example, the following articles:
Recalling the results of the first survey presented in Table 1, it is clear that the medical justification have become broadly accepted in society. As was the case before, one might attribute these beliefs to either of the following contradictory arguments: either one believes that an accurate perception of the truth that circumcision has objective medical benefits, or one is compelled to admit that the decision is based on a culturally driven perception divorced from reality.

That medically objective ‘truth’ may be what compels routine infant male circumcision can be challenged two-fold. First, several studies demonstrate that even if there were strong medical basis for circumcision in practice, rational medical calculations are not central to parent’s decision making process regarding whether to circumcise a son. One study discovered that by far the strongest consideration was whether the father was circumcised (p < .0001). The study concluded that “the circumcision decision in the United States is emerging as a cultural ritual rather than the result of medial misunderstandings among parents.” Another study linked the father’s circumcised statue to the decision at p <.001 and discovered that parents’ perceptions of medical information was a secondary factor although still significant (p<.01). This study questioned, however, the quality of the information they

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See for example


received noting that physicians demonstrated an uniform bias; physicians most likely to favor

circumcising baby boys were older, male, and circumcised themselves.\textsuperscript{36}

The second challenge to the medical ‘truth’ defense, is that there has been a constant trend over
the past several decades wherein even ‘objective’ studies by advocates of circumcision are becoming
more modest in their claims of circumcision’s benefits, whereas numerous other studies have recently
emerged to counter even these few claims.

Regarding the objective medical calculations, literature has challenged the objective justifications
for circumcision on several fronts. First, it has raised great doubts concerning the potential benefits of
the surgery. For example, regarding risk of urinary tract infection,\textsuperscript{37} penile cancer,\textsuperscript{38} HIV and STDs\textsuperscript{39}

\textsuperscript{36} Stein, M.T. et al. 1982. Routine Neonatal Circumcision: The Gap Between Contemporary

\textsuperscript{37} See, for example, the following articles:
studies and prophylactic therapy. J Perinatology. 1997;17:305-308
Mitchell CK, Franco SM, Vogel RL. Incidence of urinary tract infection in an inner-city outpatient
Wiswell TE, Tencer HL, Welch CA, Chamberlain JL. Circumcision in children beyond the neonatal
1992;120:87-89
1965;36:132-134
Pryles CV. Percutaneous bladder aspiration and other methods of urine collection for bacteriologic
Schlager TA, Hendley JO, Dudley SM, et al. Explanation for false-positive urine cultures obtained by
See, for example, the following articles:


See, for example, the following articles:


Smith, Gregory L; Robert Greenup; Ernest T. Takafuji. Circumcision As a Risk Factor For Urethritis In Racial Groups American Journal of Public Health (Washington) 77 no. 4


Bassett Ingrid; Basil Donovan; Neil J Bodsworth; Peter R Field; Davie W T Ho; Stig Jeansson; Anthony L Cunningham. Herpes Simplex Virus Type 2 Infection of Heterosexual Men Attending a Sexual Health Centre Medical Journal of Australia vol. 160 no. 11, June 6, 1994 pp. 697-700.

Donovan B; Bassett I; Bodsworth NJ. Male Circumcision and Common Sexually Transmissible Diseases in a Developed Nation Setting Genitourinary Medicine vol. 70 no. 5, October 1994 pp. 317-320.
current literature suggest that much of the earlier claims overestimated the benefits of circumcision. Others were full of bias, and still others were inadequate methodologically,

A common strategy in almost all of these criticisms is that they expose serious procedural or logical weakness in previous research. Either the procedures to collect data are suspect, or more commonly, the simple correlations used to ‘prove’ a relationship between circumcision status and propensity for problems (STDs, UTIs, or Penile Cancer) fail to account for rather obvious spurious relationships or intervening variables. For example, published studies ‘concluded’ that because rates of AIDS are higher in Africa where fewer men are circumcised than in the United States, circumcision must minimize the spread of aids. Similarly, a study of circumcision and urinary tract infections ‘concluded’ that circumcision greatly reduced the likelihood of infection, but failed to account for a biased sample; most of the uncircumcised pool in this study where infants who could not be circumcised for medical reasons such as premature birth or genital birth defects. After reviewing several dozen such studies, it becomes clear that a medical researcher that understands multivariate analysis is worth her weight in gold. Interestingly, it is only now that most of these logical holes are being filled. When the results of previous studies supported so conveniently the preconceived notions, the researchers felt no need to look to additional intervening variables. As additional social, behavioral, and medical variables are added to the causal story, the claims supporting circumcision are invariably weakened.
Second, there has been substantial commentary and documentation of the risks and side effects of circumcision not the least of which is pain. Other documented complications include bleeding.

40 See for example the following articles:
Australian College of Paediatrics Position Statement: Routine Circumcision of Normal Male Infants and Boys May 27, 1996

41 See for example the following articles:
Williams, N; L. Kapila. Complications of Circumcision British Journal of Surgery vol. 80 no. 10 October 1993 pp. 1231-1236.

42 It is especially revealing to note that in the earliest literature on circumcision (like the exerts quoted above) pain was an acknowledged and preferred consequence of circumcision. Later, when medically inflicted pain became less culturally acceptable, numerous medical studies argued that infants feel little or no pain during circumcision. The tide has now turned again, and the following literature demonstrates quite well that infants feel a great amount of pain from the surgery. Currently, less than half of the subjects receive any anesthesia.
Gunnar, Megan R., Robert O. Fisch, Sherry Korsvik, John M. Donhowe The Effects of Circumcision on Serum Cortisol and Behavior Psychoneuroendocrinology vol. 6 no. 3 1981 pp. 269-275.
Gunnar, Megan R., Robert O. Fisch, Steve Malone The Effects of a Pacifying Stimulus on Behavioral and Adrenocortical Responses to Circumcision in the Newborn Journal of the American
infection, phimosis, wound separation, concealed penis, skin bridges, urinary retention, inclusion cysts, scalded skin syndrome, urethral fistula, amputation of the glans or whole penis, and death. Some commentators even take the position that because the patient loses the foreskin, a healthy and necessary part of his body, that the actual surgical complication rate is 100%.

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43 See the following
The culmination of this medical history reached a major landmark in March 1999 with the American Academy of Pediatrics’ publication of their newest policy statement on newborn male circumcision. A task force consisting of seven of the field’s top experts on male circumcision considered almost four decades of medical literature during 1998 and early 1999. As a result, they advocated the most cautious official approach toward circumcision to date. The AAP does suggest that some literature demonstrates there are potential medical benefits, but they continued to scrutinize those studies supporting the benefits and often suggested the further research was needed. In the end, the task force concludes that “these data are not sufficient to recommend routine neonatal circumcision.”

**HYPOTHETICAL SURGERY**

A third approach to locate culture is to isolate the rational element of a decision and then contrast that with what appears to be its nonrational remainder. Contemplating the perpetuation of the practice of male circumcision on perceived medical grounds, I wondered how many people who claimed they would circumcise their sons, would themselves elect to have a similar, hypothetical surgery cloaked in a way as to remove the potential influence of cultural baggage. In other words, would a parent who on

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44 With the same sense of the field’s inconclusiveness an expert and practitioner of circumcision in summing up the recent literature concluded that “We are dealing with the art of medicine rather than science. (Grossman, E.A. and N.A. Posner. 1984. The Circumcision Controversy: An Update. *Obstetrics and Gynecology Annual* (13): 181-95.)

one hand supported circumcision of his or her son, also elect themselves to have an unnamed surgery\textsuperscript{46} which had all of the medical risks and benefits of circumcision. Responses to the survey (see Appendix B for the survey) indicated that for the most part they would not.

When offered a list of possible benefits and risks\textsuperscript{47} of the surgery each with its accompanying probability, only 28 percent of the respondents indicated they would have the surgery. When the additional information was added—the non-surgical alternatives could achieve similar benefits—the number electing to have the surgery fell to 15 percent (or eight respondents).\textsuperscript{48} Additional information had no further effect.

\textsuperscript{46} To determine whether the ruse was convincing, I asked the respondents whether they had imagined that the hypothetical surgery represented an actual surgery, and if so, which had they imagined. Only nine of the 54 respondents indicated that they imagined a real surgery, and only one of the nine responded “removal of the foreskin.” That the other eight gave such disparate responses as “brain surgery,” “removal of appendix,” “hysterectomy,” and “liposuction” suggests that the responses were not biased by the survey’s inability to hide the actual surgery.

\textsuperscript{47} I choose to use the probabilities of risks and benefits offered by the American Academy of Pediatrics in their March 1999 publication of their most recent policy statement on male infant circumcision (American Academy of Pediatrics. 1999. Circumcision Policy Statement (RE9850) \textit{Pediatrics} vol. 103, no. 3). I chose these figures because the AAP represents the most authoritative account of the whole field’s literature on the topic. They are often criticized for being overly optimistic regarding circumcisions’ benefits or risks, and I might have instead used studies documenting much smaller benefits or substantially greater risks. Using these conservative estimates, however, my results are all the stronger; even AAP’s conservative figures solicited the responses I expected.

\textsuperscript{48} Follow-up questions suggested that the percentage might have been still lower except that miscellaneous cultural baggage had crept into the decision process. Three of the eight had imagined real surgeries (compared with only five of the other 43). They imagined a hysterectomy, liposuction, and a vasectomy. Another, responding to what factor most affected his decision responded “If its surgery, it must be good.”
This pattern of personal choice contrasts sharply with the data if Figure 1 indicating that most parents would choose to have sons circumcised. Of 45 respondents to this second survey only two claimed they would not circumcise their son, contrasted with the 38 of the 45 who claimed they would not themselves have the hypothetical surgery. Bivariate correlations indicated that there was no significant relationship between the respondents’ choice to circumcise their sons and their desire for the hypothetical surgery themselves at any step of the decision-making process.

I suggest that this suggests yet again that culture is the driving mechanism for the perpetuation of infant male circumcision. Once the cultural baggage is removed from the calculus. Once parents are not primed to consider aesthetic, social, or cultural factors, they rationally decide not to have the surgery. That so many parents still do inflict the surgery on their sons, is evidence of how powerful the aesthetic, social, are cultural motives are. These are those same primal forces that work throughout the world to perpetuate FGM, the forces we so little understand in our human rights foreign policies.

49 See Appendix B for the full account of the information provided.
RATIONAL CHOICE? — A THOUGHT EXPERIMENT

A final, brief strategy to expose the power of culture in US domestic practice is to consider a thought experiment. I suggest that one can locate culture in a society’s unquestioned habits and customs, in a feeling of momentum or Gramscian hegemony that places the burden of proof for all changes on the new. Consider then that you inhabit a culture that has never practiced and knows nothing of circumcision.

As often happens, some inquisitive soul might someday wonder what that foreskin is for. Scientists might study its purpose, and might even wonder what the consequences would be without it. Of course they could never study that contrast because it would be absolutely unethical to create an experimental group and cut people’s foreskins off just to compare to a natural control group.

If, however, this hypothetical society were fortunate enough to encounter another population who were already circumcised, than the comparisons could progress. They would likely place the burden of proving a benefit on the circumcised state—you wouldn’t cut off a foreskin without a good enough reason—and if there were any bias to the science it would likely be against changing the organ as our society has always know it. Even without bias, one might expect that our doctors and scientists would

50 I imagine that even this step may be too far fetched. I wonder how many reputable scientist have ever wondered what it would be like without earlobes, toenails, bellybuttons, or other natural but not obviously necessary parts.

51 Such an experiment echos suspiciously the Nazi and Japanese WWII era experiments when the “what if” questions could be resolved without regard for the victims.

52 Probably after some initial shock just as many initially react to other cultures’ bodily markings (plates in lips, necks extended by rings, intentional body scarring, or even FGM) . Or as a Swedish friend once commented to me in a discussion of circumcision, “You American’s are a bunch of freaks. Why would you ever want to cut that thing?”
eventually conclude what the AAP has now concluded, 1) it hurts, and 2) there is no compelling medical reason to circumcise routinely. Without the cultural, social, or aesthetic powers at play, it is easy to image that the practice would never be adopted.

If by some chance it were somehow adopted, how long would it be before a parent found himself in court trying to justify the cutting of his son’s genitals without objective medical cause? Who would be willing to pay $100-$250 for the procedure? How quickly would doctors lose their licences without proof of substantial benefit to their patient? How durable would this practice be; how long would it last after the first child died from its complications?

It is not too hard to imagine how differently this hypothetical society would view circumcision, and even how differently it would view other cultures who practiced it. It might very well describe the United State’s current reactions toward images of FGM from abroad. Might an outsider, however, also look at the United States with similar accusations of human rights abuses.

This will forever remain a thought experiment because we know it is impossible, and perhaps not even desirable to begin a society with such a clean slate. All cultures carry millennia of baggage into the present day. Culture’s presence and power is certain, but its content and expression is malleable. The crucial question is how do we, as a culture, proceed from our current state, and how to we exercise a healthy influence on other cultures to do the same.

**CONCLUSION**

This paper disclosed the force of culture and its intricate and often hidden relationship with international and domestic policies of human rights. It challenged the United States’ claims of
objectivity and its policies as a reliable standard of universal human rights by revealing that routine male infant circumcision could be considered a human rights violation not unlike FGM.

This paper exposed the cultural forces enabling male infant circumcision by contrasting geographic practices, excavating historical justifications, and presenting the results of two surveys on male infant circumcision as constructed in the United States. Thus it exposed how powerfully culture may blind even a nation that proclaims in official rhetoric and public opinion the necessity of universalism and the dangers of cultural relativism. In the end, this paper demonstrated how difficult it is to construct and prescribe an objective universalist human rights policy at home and abroad, not that we should not attempt it, but that with an awareness of our own cultural blind spots we may attempt it more honestly.
Please read each statement carefully and check the box below that best describes your personal feelings. Thank you.

1. I feel knowledgeable about the topic of male circumcision.
   - Strongly Agree  - Agree  - Neither agree nor disagree  - Disagree  - Strongly Disagree

2. As a parent of a son, I would have him circumcised.
   - Strongly Agree  - Agree  - Neither agree nor disagree  - Disagree  - Strongly Disagree

3. There should be laws restricting or prohibiting male circumcision in the United States.
   - Strongly Agree  - Agree  - Neither agree nor disagree  - Disagree  - Strongly Disagree

4. The United States should encourage other countries to adopt laws restricting or prohibiting male circumcision.
   - Strongly Agree  - Agree  - Neither agree nor disagree  - Disagree  - Strongly Disagree

5. I support male circumcision for the following reasons: (Check all that apply.)
   - Medical reasons
   - Religious reasons
   - Social reasons
   - Cultural customs
   - Appearance
   - Hygiene
   - Other ____________________
   - None of the above; I oppose it.

6. I oppose male circumcision for the following reasons: (Check all that apply.)
   - Medical reasons
   - Religious reasons
   - Social reasons
   - Cultural customs
   - Appearance
   - Human rights considerations
   - Other ____________________
   - None of the above; I support it.

7. I feel knowledgeable about the topic of female circumcision.
   - Strongly Agree  - Agree  - Neither agree nor disagree  - Disagree  - Strongly Disagree

8. As a parent of a daughter, I would have her circumcised.
   - Strongly Agree  - Agree  - Neither agree nor disagree  - Disagree  - Strongly Disagree

9. There should be laws restricting or prohibiting female circumcision in the United States.
   - Strongly Agree  - Agree  - Neither agree nor disagree  - Disagree  - Strongly Disagree

10. The United States should encourage other countries to adopt laws restricting or prohibiting female circumcision.
    - Strongly Agree  - Agree  - Neither agree nor disagree  - Disagree  - Strongly Disagree

11. I support female circumcision for the following reasons: (Check all that apply.)
    - Medical reasons
    - Religious reasons
    - Social reasons
    - Cultural customs
    - Appearance
    - Hygiene
    - Other ____________________
    - None of the above; I oppose it.

12. I oppose female circumcision for the following reasons: (Check all that apply.)
    - Medical reasons
    - Religious reasons
    - Social reasons
    - Cultural customs
    - Appearance
    - Human rights considerations
    - Other ____________________
    - None of the above; I support it.

13. What is your gender?  - Female  - Male

14. Were you circumcised?  - Yes  - No

Definitions:
Female circumcision is the surgical removal of clitoris and sometimes the labia.
Male circumcision is the surgical removal of foreskin.
Given the current medical climate, many patients are weighing carefully the potential risks and benefits of medical procedures. Although doctors can provide a list of benefits and risks of a given procedure, ultimately the patient must decide whether to have a procedure done. Given the following hypothetical surgery and the information provided, indicate whether you would elect to have the this surgery performed on you.

**The hypotheticalotomy:**

This procedure is categorized as outpatient surgery. It can be performed in about 15 to 30 minutes, and you are free to leave soon thereafter. Only a local anesthetic is required, although you will still likely feel moderate pain at the time of the surgery and some discomfort during the week or so thereafter. The surgery is irreversible. The benefits that lead some patients to desire the surgery and the risks that lead others to reject it are as follows.

**With the surgery**

- Your future chances of developing a certain type of serious but curable infection will be lower, about 1 in 1,000.
- Your chances of developing a certain type of rare cancer in your old age are lower, about 3 in 1 million.
- You future chances of contracting STDs (including HIV) through unprotected sexual contact may be slightly lower.
- Your chances of suffering an immediate side effect of surgery are about 4 in 1,000 including bleeding (1 in 1,000) and infection (1 in 1,000). Other extreme but very rare immediate side effects include death (about 1 in 1 million) or loss of a sexual organ (about 1 in 2 million).

**Without the surgery**

- Your future chances of developing a certain type of serious but curable infection will be higher, about 10 in 1,000.
- Your chances of developing a certain type of rare cancer in your old age are higher, about 9 in 1 million.
- Your future chances of contracting STDs (including HIV) through unprotected sexual contact may be slightly higher.
- There are no side effects without the surgery.

**Do you choose to have the surgery?** (Circle one)

- I would have the surgery.
- I would not have the surgery.
Given some additional information, would you elect to have this surgery?

There is an alternative to the surgery which would allow you to receive the same or greater benefits without the side effects. By not smoking, bathing regularly, and having fewer sexual partners and/or protected sex, you will lower your risk of getting the cancer, infections, and STDs even more so than by only having the surgery.

**Now do you choose to have the surgery?** (Circle one)

I would have the surgery.  
I would not have the surgery.

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Given some additional information, would you elect to have this surgery?

The American Medical Association, after considering hundreds of studies regarding the benefits and risks of the surgery states that “existing scientific evidence demonstrates potential medical benefits of the hypotheticalotomy, however these data are not sufficient to recommend routine hypotheticalotomies. There are potential benefits and risks, yet the procedure is not essential to the patient’s current well-being.”

**Now do you choose to have the surgery?** (Circle one)

I would have the surgery.  
I would not have the surgery.

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Given some additional information, would you elect to have this surgery?

Your medical insurance does not cover the procedure which costs between $100 and $250.

**Now do you choose to have the surgery?** (Circle one)

I would have the surgery.  
I would not have the surgery.

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**Follow up:**

C Please indicate what factors were most influential in making your decision to have or not to have the surgery.________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

C As you answered these questions, did you imagine a particular real surgery instead of the suggested hypothetical surgery? (Circle one)  
Yes  
No

C If so, what surgery did you imagine?  
________________________________________________________