Circumcision and the Oppression of the Medical Colonizer: A Critical Reflection

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Abstract

This article provides a critical reflection of medical circumcision on baby boys in western society. Employing a critical deconstruction of the circumcision practice, this writer explores his own circumcision as an experience of personal, cultural, and structural oppression. Included is an analysis of the history of circumcision, the vulnerability of infants, politics in medical practice and implications at all levels of ecological practice for the social work practitioner. Finally, several solutions are suggested to control and obliterate the oppressive practice of medical circumcision in western and global society.

Keywords: male circumcision, oppression, medical colonization
Introduction

Dear foreskin, it has been 27 years since you were taken from me...

In the following pages the authorunpacks and deconstructs what they have come to understand as one of the most unacknowledged oppressions that has been committed on one of the most vulnerable populations known to humankind. Through oppression at the personal, cultural, and structural levels, circumcision is an oppressive practice set on infant boys. Infants exist as a vulnerable population through their lack of voice, undeveloped immunity, and lack of mobility. Structured in the circumcision procedure is a history of patriarchy, masculine branding and hegemonic masculinity, which has perpetuated this violent practice on boys for thousands of years. With the illumination of circumcision as a violent and unnecessary practice, the author presents the opportunities that social work affords when confronting the complexities of this problem. Ultimately, circumcision is an oppressive practice beset on a vulnerable population and this paper serves as a call to social workers to respond to this injustice.

The Colonization of My Body

Writings of the colonization of the western world label the colonial experience as a brutal exchange of power and corruption between Europeans and First Nations people (Dickason, 2002; Frideres & Gadacz, 2001). The experience featured the unannounced intrusion of white men who penetrated the western continent in an exploitative raping of the natural resources and systematic annihilation of the First Nations peoples bodies, culture and essence. Commonly identified as savages, the First Nations people were dehumanized into subhuman classifications and once it was determined that their usefulness did not complement European ways, people were either killed or assimilated and sliced from their history. This pillaging of the western world left the continent numb and unfeeling and impacted a permanent mark on the land that signified European supremacy and control.

Post-colonial work takes the metaphor of colonial practices and applies it to modern day interaction. Edwards (2008) interprets the colonization of Habermas’ theory into the contemporary lifeworld of systemic and organic inputs and outputs. Edwards suggests that colonization replaces communicative forms of interaction with actions mediated by money and power. It is the authors’ intent to take circumcision and place it as a lifeworld colonization committed by men in the western medical institution on male babies in the interest of money and power. To illustrate this point, the author presents their construction of being circumcised as a colonial conquering of their body, then outlines various arguments for and against circumcision followed by the efforts they have made to live their life as a conquered person.

Using my first-person voice, I will relay my appreciation of what happened with respect to my initial circumcision. I was born in a hospital in Toronto, Ontario, Canada and it’s likely that a day or two after I was born, my parents agreed to have me circumcised. I do not know whether anaesthetic or analgesia was used, and I do not know the qualifications of the person who cut my skin. It was likely that I was laid out on a table, covered in a cloth with only my penis exposed and then the foreskin of my penis was cut off. In my discussions with parents around their experience with their son’s circumcisions, some say that their babies scream in agony as their skin is cut off and others say that there is no sound or identifiable response from
the baby until the day after, when bandages must be removed from the exposed wound or through painful urination.

I was kept in silence and darkness about my circumcision until I turned 18 years old and started looking around at other young men. I realized first that I was circumcised and that I could not retract my penis into a foreskin as a few other men could. Secondly, I realized I was even different from other circumcised boys as there was a strange piece of skin attached from the corona of my penis to the shaft of it. With some courage and support from friends I went to a urologist to be diagnosed as having what the doctor described as a botched circumcision. He told me that when I was circumcised, some of the exposed wound attached to the corona and healed to be fastened together. I was offered no emotional support or apology for this experience of malpractice; rather I was offered an operation to have the circumcision revised.

Knowing that such a personal and private part of my body was grounds for this mutilation left me feeling both enraged and isolated. I wondered how my parents did not see this when I was young, I wondered who on earth could have circumcised me and let this happen to my body. I decided to do the entire procedure alone and booked my surgery with the hospital without telling my parents or my friends.

The night before the surgery the hospital phoned my home and my mother picked up. The hospital said that they were sending a reminder that I would go in for surgery the next day. My mother sat down with me and demanded that I tell her what the surgery was about. After much deliberation, I asked her if she ever noticed anything wrong with me and she replied no. I told her that I had been circumcised improperly and that I was going to get it fixed. She responded that she thought that was strange and we quickly ended the conversation. I remember going to bed that night enveloped in rage over how neglected I felt. I wondered, how could my mother be so insensitive to my distress over the most intimate part of my body and the rage I felt around being mutilated?

I remember lying in the cold, sterile room before I was given the anaesthesia. I laid in the bed naked and watched as the doctor prepared his tools to cut me. I wondered what it was like 18 years ago when I was voiceless and powerless in this state. It felt humiliating to know that my only access to a partially normal penis was through the painful blade of a scalpel. I then remember darkness.

I think about that cut and that pain and I think about the experience of the western world as colonialists came and cut into it. As my foreskin was removed brutally and barbarically to leave me with a viciously scarred, mutilated penis, I could only image the harsh scarring of the landscape of the western shoreline as unknowing men raped and clear cut much of the forests of the Americas. Like that knife that cut into my body with vague intentions of normalcy and which led to an iatrogenic overflowing of emotional disturbance and medical complication, I imagine the barbaric practices of Europeans left cultures, families, individuals and entire histories mutilated. So here I stand, colonized by the western medical system, as a conquered body, oppressed into the medicalized skin I wear.

It has been a deep process of anger and despair as I have come to terms with what has happened to me. I look down at my penis that has been numbed and branded by scars and bruises
and I cringe in humiliation. Speaking to other men who have experienced foreskins and then been circumcised in later life, the foreskin is described as a crucial part of sex that allows a much smoother gliding action for intercourse. These men have described sex with a foreskin as the experience of seeing in colour and sex as circumcised like only seeing in black and white. So here I am, stripped of my sensitivity, and forced by the medical system to a life of sex that is about invading my partner’s body with this numbed probe. I imagine the surviving First Nations people numbed by their experience, as their culture, history and language were cut from them and I imagine the feelings of disenfranchisement and isolation as this population tries to encounter a numbed recovery.

I must be explicit and state that the trauma, humiliation and oppression of circumcision is nowhere near what has happened to the First Nations people of the west and throughout the world. What I can say is that the act of circumcising a penis has strikingly similar patterns to a colonial oppression. Physically, the scar and the unnaturally exposed top of the penis exist like a clear-cut forest, or a village that has been mutilated to an unfeeling existence through assimilation and murder. This removal of the foreskin marks the obtrusive cutting away of the most sensitive part of the body, just as the swords and rifles of the colonists cut away deep social and spiritual rights of the First Nations people. What is left is a numbed body part, forever incapable of feeling, working or existing like it once did.

**History of Circumcision**

The history of circumcision on infants and men dates back thousands of years. Renshaw (2006) articulates the history of circumcision and states that the depictions of Pharaohs on tombs in Egypt which date back to 4000 and 2000 B.C.E. present circumcision illustrations. An analysis of the Old Testament finds circumcision references in Genesis 17, 10-11 (King James Version), where it is presented that the circumcision of boys is a token of the connection between God and man. In Victorian England, the medical profession took note of Jewish customs and began using circumcision as a cure for several diseases including alcoholism, rheumatism, and masturbation (Spilsbury, Semmens, Wisniewski, & Holman, 2003). It is suggested too that as spiritual and cultural forces butted heads for reign over the male body, medical traditions came out ahead as the foreskin was constructed as a trap for dirt and a source for inappropriate sexual urges. At this point in the 19th century it is suggested that the foreskin removal operation was utilized in western medicine and administered to 30% of the upper class. The medical practice of circumcision peaked in the 1930’s in Britain and the United States where it was reported that more than 80% of boys were circumcised.

In recent history there have been several developments revolving around circumcision. The eighteenth century religious and political pressure advocated for moral restraint and anti-sensuality, and it was not until the 1950’s that the western world saw these established medical norms begin to be questioned (Renshaw, 2006). Renshaw states that questions emerged around the neonatal pain, surgical risks, value of tissue loss, and the suffering of infants who were mutilated without adequate informed consent, anaesthesia or any evidence of medical necessity. It is suggested further that what fuelled these questions was the lack of scientific evidence around the benefits of circumcision. Much of the population that was uncircumcised was just as healthy as the circumcised population and sexual dysfunctions such as erectile dysfunction or premature ejaculation were found to be no more prevalent in either population.
Spilsbury et al.’s (2003) work on circumcision prevalence finds that globally, it is estimated that one sixth of the world’s men are circumcised. Spilsbury et al. state that in 1994 Ontarians reported a 44% circumcision rate, which had declined from 53% in 1979. In the USA it is estimated that approximately 80% of newborns were circumcised in 1980, compared with 61% in 1992. Spilsbury et al.’s study, in Australia, finds that only 8% of boys were being circumcised as of 1999. This low rate is attributed to recent movements of the Australian Association of Paediatric Surgeons against supporting the routine circumcision of newborn boys in Australia. Although Australia seems to be paving the way in lowering circumcision rates through policy change, the USA and Canada still have lengths to go.

A study by Xu and Goldman (2008) may shed some light on the reasons parents still choose circumcision for their infant boys. The most common reasons for newborn circumcision were as follows: hygiene (77.9%), family tradition (57.4%) and medical reasons (36%). Furthermore, the authors found that the most common perceived benefit was hygiene (95.6%) and the most common concern was pain (79.4%). The authors also found that 41.2% of parents wished for further information to help them better make the decision before or at the time of childbirth. The authors indicated that 76.5% of these parents would recommend circumcision to other parents, 19.1% were unsure and 4.4% would not recommend newborn circumcision by an experienced practitioner to other parents.

Infants and Circumcision

Only in the last two decades have major bodies such as the American Academy of Pediatrics and the Canadian Paediatric Society acknowledged that newborns feel pain (Simpson, 2006; Cramer-Berness, 2007). Simpson states that newborn pain receptors are sufficiently developed to allow the transmission of painful stimuli in both preterm and term newborns. Rasmussen (2001) presents a study on the relationship between acute procedural pain and the immune status in newborn infants. It is presented that as ability of infants to perceive pain through behavioural, cardiorespiratory and hormonal response have been documented; the response of the newborn’s immune system to pain is also an indication of pain committed on the body. Furthermore, Rasmussen states that infants are prone to infection through the cutting in circumcision because of the immaturity and naiveté of their immune systems. Cramer-Berness states that an infant’s memory of the pain of circumcision can last months after the surgery. The study found that infants who were circumcised without any topical anaesthetic experienced significantly more behavioural stress than infants who received the anaesthetic. Ultimately, there is no question that infants perceive pain. Putman (2008) acknowledges that the concept of tradition has become a common justification for limiting our judgment about practices with which we personally may or may not agree; Putman also implies the necessary question regarding male circumcision: how can we allow tradition to form limitations against our ethical judgement?

Speaking toward the use of anaesthesia in circumcision, research suggests that in current medical practice, the use of anaesthesia or analgesia is completely optional (Simpson, 2006). Simpson states that common reasons for not using anaesthesia or analgesia include the belief that newborns do not feel or will not remember pain, lack of physician knowledge for how to perform the procedure, inconvenience, and practitioner ability to perform the procedure with minimal notice to the parents of the baby. Simpson then goes on to ask, what would an adult say to having
part of their body removed, or mutilated, without anaesthesia? Rasmussen (2001) states that circumcision is an acute procedure, meaning that it is performed in a relatively brief time frame as opposed to a full-fledged surgery, yet she goes on to state that it is one of the most painful procedures that an infant can go through. The lack of control around use of anaesthesia with newborns and circumcision is significant.

**Medical Issues Around Circumcision**

Medical evidence exists both for and against the use of circumcision as a protective and preventative procedure. Starting first with arguments for circumcision, there has been a strong move to circumcise adult males in the interest of preventing HIV infection. Krotz (2006) describes the work of two doctors, Dr. Stephen Moses and Dr. Robert Bailey, who conducted research on 2800 young men, aged 18-24, in Nairobi. Their work involved testing a control group of circumcised men and an experimental group of uncircumcised men over a two-year period and assessing which group experienced the higher rates of HIV incidence. It was found that out of more than 300 couples studied where the man infected the woman with HIV, only 44 were infected by circumcised men. Other studies that advocate for circumcision for the prevention of HIV include Berer’s (2007) study in Switzerland that showed a substantial reduction in the contraction of HIV through vaginal sex for men who had been circumcised. Several groups of researchers have found, in both observational studies and in randomized controlled trials with African men, that circumcised men are 50-60% less likely to contract female-to-male transmitted HIV than uncircumcised men (Gostin & Hankins, 2008; Rennie, Muula, & Westreich, 2007; Vardi, Sadeghi-Nejad, Pollack, Aisuodionoe-Shadrach, & Sharlip, 2007). Gostin and Hankins further suggest that accessibility to circumcision treatment is limited by weak health systems in countries with endemic HIV in sub-Saharan Africa, and that reaching disadvantaged individuals is particularly difficult, especially rural residents, ethnic minorities, migrants and refugees, male sex workers, prisoners, drug users, and the poor. Londish and Murray (2008) utilized a mathematical model to simulate observed levels of HIV prevalence under the complete range of current levels of male circumcision. The authors indicate the model developed here is a deterministic, compartmental model that simulates the HIV/AIDS epidemic spread through heterosexual transmission in sub-Saharan Africa. The model was used to simulate the effect of different intervention scenarios on the epidemic and population dynamics over a 40-year period from 1980 to 2020. The mathematical model produced findings consistent with the range of observed 12 correlations between current HIV prevalence and levels of male circumcision in Sub-Saharan Africa. This agreement between simulation and observations from 41 sub Saharan countries confirms that the model generates valid estimates of HIV prevalence in a representative sub Saharan population. Simulations showed adult HIV prevalence decreasing from 12% with no circumcised men to 5% with all men circumcised in a country with average levels of male circumcision.

Other studies have been conducted which present pro-circumcision interpretations of data concerning various medical conditions and infectious diseases. Studies on the relationship between human papillomavirus (HPV) and circumcision have been conducted which advocate for circumcision. It is stated that nearly all cases of cervical cancer are caused by HPV and the odds that circumcised men will get HPV are 60% lower than those for uncircumcised men (Lane, 2002). In a study of over 1000 men in Spain, Burton (2002) found that 20% of uncircumcised men had the HPV, versus only 5% of circumcised men. It is suggested by both studies that the
foreskin offers a portal of entry for HPV when it is exposed, by way of the tiny ulcers and abrasions that occur during intercourse. In other studies, it was found that childhood circumcision offers the greatest protection against penile carcinoma, which is the development of a malignant tumour in the penis (Misra, Chaturvedi, & Misra, 2004 and Mosconi, Roila, Gatta, & Theodore, 2005). Ultimately, through HIV, HPV and cancer prevention, these studies have advocated for circumcision.

Although medical evidence exists which presents circumcision as a desirable medical procedure, many other medical studies have argued against it. Returning to the HIV and circumcision studies presented earlier, Dowsett and Couch (2007) formed a criticism of the research in Africa: the justification behind removing the foreskin is that an intact foreskin presents cellular entryways for HIV into the body, and while the same entryways exist in the clitoris, the labia, and in other parts of both the male and female genitals and there has been no serious suggestion of removing these female counterparts. Second, no cross-cultural analyses have been conducted which look at regions of North America where the rate of male circumcision in certain areas is as high as 65% and where HIV epidemics are still growing. Third, positive correlations between HIV infection and uncircumcised men are being marketed by medical authorities to prevent HIV infection, similar to condom use, rather than as factor that delays HIV infection. Marketing circumcision as a way to prevent HIV infection could lead to higher risk-taking behaviour by at risk, circumcised men. Indeed, the statistical analyses by Dowsett and Couch for circumcising show an average of 55% lower risk of HIV infection vs. uncircumcised men, while the use of condoms boasts an 80% to 90% prevention rate. Why not advocate for increased condom use or put money into research involving the dissemination of better and more ideal condoms? Fourth, Dowsett and Couch note that the clinical trials conducted in Africa were not randomized and that each participant might have responded differently, knowing their role in the research, through behavioural, psychological, and sexual actions. A paper by Garenne (2010) found that overall in Africa there was no difference in risk of HIV infection between circumcised and uncircumcised men. On a country specific basis, they in fact found that only five countries had differences in risk ratios: in two countries risk of HIV infection appeared higher for uncircumcised men, while in three countries risk was greater for circumcised men. These criticisms pose strong arguments against the research done on circumcision as HIV prevention being used to determine definitive medical knowledge and treatment.

Other research presents additional anti-circumcision findings. Bennett et al. (1999) state that male circumcision correlates with heightened infant risk for neo-natal tetanus. Van Howe and Robson (2007) discuss how circumcision in hospitals can facilitate the spread of Staphylococcus aureus, a dangerous bacterial infection, through contamination in circumcision equipment and spread in nursery rooms. Van Howe (2007) presents a study on penile inflammation and states that penile inflammation is more common in circumcised boys than in uncircumcised boys. Tseng, Morgenstern, Mack, and Peters (2001) argue that although findings have suggested that circumcision reduces the risk of penile cancer, circumcising boys to alleviate phimosis (the inability to retract the foreskin) can increase risk. Therefore, there are contradicting studies regarding circumcision and penile cancer risk.

What is left at the end of this comparison is that for most infants, circumcision is not medically necessary. Renshaw (2006) approximates that for 99.9% of baby boys the procedure is
unnecessary. Darby and Svoboda (2007) take a value-based stance, stating that for both boys and girls, circumcision is an unnecessary bodily violation which involves the removal of healthy tissue without the informed consent of the person involved.

**Infants as a Vulnerable Population**

Some of the weight in my assertion, that the routine neonatal circumcision of baby boys is unacceptable, is based on an understanding of baby boys as a vulnerable population. Here, a risk and resiliency framework will be utilized to assess vulnerability. An initial pitfall is encountered as different conceptualizations of the risk and resiliency framework exist. For example, the ecological perspective of SOPAC (2007) defines vulnerability as the opposite pole of resiliency and gives a continuum type approach that places an entity somewhere between the poles of vulnerable and resilient. On the other hand, Fraser, Richman and Galinsky (1999) suggest that in a risk and resiliency framework, protective factors are not merely the opposite of risk factors, rather they can be thought of as separate constructs that may engage resiliency and/or affect risk states (p. 134). One might hazard a guess that Fraser et al. would use the term ‘vulnerable’ in their framework to place an infant somewhere between a risk and protection continuum. Here, vulnerability might be substituted for the resilience concept with the same caveat that resilience carries; that being the recognition that vulnerability can lend itself to helpful or unhelpful givings or misgivings in the organism’s environment, based on who is witnessing the item. For example, one perspective might view infant boys as more vulnerable because they have no language to speak. Contradictorily, the opposing perspective might say infants are less vulnerable because their lack of voice would enrage the oppressor less, thus protecting them from further assault should their words arouse malicious intent in the abuser. For the sake of this paper, I will work with the concept that vulnerability is a state that an entity occupies, between the poles of risk and resiliency, that carries the possibility of different interpretations as to whether the item being assessed is truly one that brings the entity closer to resiliency or closer to risk.

Placing circumcised infants on a vulnerability continuum will involve setting the individual’s potential risks and resiliencies at the personal, cultural, and structural levels as set out by Mullaly’s (2010) contextualization of oppression. First, I will assess risks on the personal level. One of the key elements of oppression at the personal level is the inability of the infant to give informed consent toward the procedure. The literature on African men being circumcised discussed earlier is outside the scope of this analysis and will not be included. Although one might theorize about the various cultural and structural oppressions that men in Africa face, circumcision is predominantly a procedure conducted just after birth. Furthermore, with the evidence for circumcision as a preventative measure against HIV infection it is presumable that African societies might follow western medical practices and begin to conduct circumcisions on babies instead of grown men. Ultimately, the procedure is left for infants who cannot give informed consent to the procedure being conducted.

A counter argument to my claim that infants do not give informed consent might state that infants do not give informed consent for other procedures where consent is left to the parents. First, it must be recognized that circumcision is a practice that is steeped in religious tradition, and prestigious organizations such as the American Pediatric Association have identified circumcision as no longer medically essential for health and hygiene (Renshaw, 2006).
Second, circumcision is not a procedure that requires immediate attention. Circumcision can be done at any point in a person’s life, so why not wait until that person is able to understand the procedure and give consent? In comparison to preventative interventions such as a polio vaccination to remove the risk of polio, the foreskin poses no immediate threat to the infant and it is, therefore, the infant’s lack of ability to give informed consent that poses a personal oppressive risk factor.

In a construction of the personal as political, what has led to circumcision advocacy in the medical field has been the result of the pathologizing of the foreskin. First, as Mullaly (2010) summarized the work of Foucault, the normalizing gaze concerns itself with degenerating bodies that are different from the oppressor. In this sense, looking at the medical system as the oppressive gazer, the infant’s body, and the attached foreskin, signifies difference, and therefore degeneracy, from the strength of the circumcised male body. Quite literally then, circumcision serves as a physical transformation of the infant from the body of the other, to the body of the oppressing group. This pathologizing of the male body engages the masculine gaze discourse and serves as a personal oppression from the structural to the personal in infant boys.

In continuation of the demonization of the foreskin, Mullaly (2010) suggests that oppressed, subordinate individuals are assigned characteristics of sexual licentiousness and this is reflected in the history of circumcision. One of the societal pushes toward the medicalization of circumcision was the 19th century belief that the foreskin led to sexual deviance and masturbation (Darby & Svoboda, 2007). The removal of the foreskin, therefore, desexualized young boys in order to maintain oppressive control over their sexuality. The wording here has a marked similarity to the words used by Mullaly when he speaks of the disapproving gaze of the masculinized medical system on the foreskin, where the foreskin represents the infant’s lack of control, strength, and rationality, especially in sex. Therefore, through the history of circumcision, the themes and perceptions of centuries ago emerge in the present-day personal oppressions that infants face in circumcision.

Another personal oppression that infant boys face is the avoidance behaviour, or aversion, that parents and medical practitioners perpetuate regarding circumcision. Aversion occurs daily as parents give consent for circumcision through naive beliefs that infants do not feel pain or that infants will not remember the pain (Simpson, 2006). Furthermore, aversion occurs with physicians who may deny the infant’s right to pain management in favour of the relative simplicity and ease of the procedure. Simpson states that physicians are willing to perform the procedure, and turn a blind eye to pain management, because it can be done rapidly, with little discussion with parents, under the belief that newborns do not feel pain, that newborns will not remember the pain and under the inconvenience of having to wait for preoperative and intraoperative analgesic and anaesthetic techniques to take effect. This aversion, in favour of parental beliefs and physician preferred efficiency, serves to reinforce the violent and unnecessary act that is validated by the medical system. As parents and practitioners serve to contribute to the oppression through avoidance of the reality of the pain and typical lack of anaesthetic or analgesic used in the procedure, baby boys continue to experience the violent, oppressive act of circumcision on the personal level.

Circumcision when considered in the context of the identity process and its interaction with personal oppression, as described by Mullaly (2010), results in unique outcomes. It is
suggested that subordinate groups are subjected to a double bind where they may either protest or suffer in silence. Infants experience neither of these options because they do not have language or meaning systems to voice or process the injustice being perpetrated toward them. Mullalay further suggests that identity formation concerns the goals of uniqueness, continuity, self worth and autonomy. In looking at circumcision as an oppressive branding practice on young boys in an effort toward masculine structural ownership over the body, consideration of the effect of circumcision on these identity formation characteristics is important. First, as identity formation involves pursuing a unique self, the branding of circumcision homogenizes the oppressed male body with other oppressed male bodies through a permanent branding. Therefore, developing a unique sense of self is always inhibited due to the irreversibility of circumcision. Second, as circumcision is permanent and continuous, the oppressive structure of masculinity binds young men to a permanent branding beset by the medical system. Third, the self worth aspect of identity and circumcision could actually benefit the male in regard to power and social mobility. By being branded as belonging to the masculine group, circumcised boys exist as indoctrinated into hegemonic masculinity and can therefore claim the entitlements that masculinity purports in society. In the last aspect of identity formation, desire for autonomy, the circumcision process inhibits boys from gaining any true autonomy because at the outset of their life, part of their body is claimed by the oppressor. Therefore, boys who are circumcised live their whole lives not wholly owning their body and belonging, at least in part, to the medical system. Ultimately, Mullally’s identification of identity processes has a unique interaction with the personal oppression of circumcision.

In placing infant’s risk toward vulnerability at the cultural level it is important to recognize the post-modern analysis that Baudrillard engages (Mullaly, 2010). Just as Baudrillard states that through the age of hyper-reality people have lost their capacity to be educated, angered, or stimulated, parents of boys facing the circumcision decision are also engaged in the simulation reality. What this means is that parents who have become desensitized to making educated, passionate choices are more likely to trust doctors and hospitals and give permission for the institution to do whatever it suggests to the child. This mindlessness as theorized by Baudrillard is one explanation for why parents might be so insensitive to subjecting their sons to a painful, permanent procedure only hours or days after their child is born.

A second cultural oppression that impacts infants and the circumcision decision is the orgasm-based view of sexuality that western society holds. Darby and Svoboda (2007) state that a common excuse for circumcision and its threat to sexual dysfunction is that even though men might lose some sensation through the removal of the foreskin, they still have no difference in their ability to ejaculate. Thinking like this manifests a continuation of the cultural discourse that places reproduction and orgasm as the only purpose for sex. Packed into this discourse is a lack of recognition that sex for a male could exist as a phenomenon of varying degrees of pleasure or as an experience that may not involve orgasm or reproduction. Furthermore, it implies that sex for a man might not be about pleasure at all and may in fact concern the conquering of the female body through raw penetration with a medically numb invasion tool. Cultural discourse that places the male as the sexual oppressor and the female as the object to be penetrated is tangled up in circumcision, and as society socially constructs girls to grow into the oppressed vulnerable populations, boys are numbed into masculinity and cut into the penetration and aggression that contextualizes sexuality in western culture.
At this point it is important to reflect on the cultural differences ascribed to male and female circumcision. Darby and Svobodka (2007) present a criticism of the tendency for female circumcision to be labelled as oppressive and unnecessary and male circumcision to be validated, and their work will fuel my argument. Historically, the foreskin has been constructed as an unimportant body part compared to the importance placed on the female genitalia. Jewish practices were admired for their sanitary wisdom in the nineteenth century, which is suggested to have led to the medical adoption of circumcision. Darby and Svobodka argue that one of the reasons this occurs is due to an inconsistency ascribed to the processes which affect both sexes, and it is argued that both fall under the category of ‘genital alteration’. It is stated that a great paradox exists, which is exemplified in a case study of a women in Australia who could not legally get cosmetic genital surgery for herself, yet she had the right to alter the penis of her son (Darby & Svodobka, 2007). Here it is argued that western sexed body construction labels males as resistant to harm or in need of being tested by painful ordeals, and female bodies as highly vulnerable and in need of protection.

Darby and Svobodka (2007) continue by suggesting a response to the World Health Organization’s grouping of types of female genital mutilation. They apply a similar labelling structure to circumcision and state that a type one circumcision is the excision of foreskin extending beyond the glens, type two as the excision of the foreskin partway along the glens, type three as the excision of foreskin at the corona of the glens and type four as the excision of the foreskin at the point where the foreskin joins the main penis shaft. This is an important distinction because it affords the dimension and degrees of severity to the circumcision process that were previously only applied to females. Furthermore, most of the procedures done in the USA on baby boys are at the level of type three or four.

A further point raised by Darby and Svobodka (2007) concerns the sexuality debate, which questions the effect of genital mutilation on sexual sensation. It is stated that just as genital mutilation can affect female sexual function, so too can it affect male sexual function. As most women who are victims of genital mutilation lose the ability to achieve sexual pleasure, Darby and Svobodka argue that males experience a similar phenomenon. As stated earlier, an analysis of the foreskin finds that that the densest concentrations of blood vessels and nerves are found in the foreskin itself. It is argued that this is further backed up by the anti-masturbation movements of the 18th century that worked to decrease sexual desire and feeling through removal of the foreskin. Therefore, the argument that only women experience loss of sexual feeling must be flawed to some degree.

In a return to my focus on the masculine gaze, it is crucial to recognize an important comparison that Darby and Svobodka (2007) make. One of the justifications for male circumcision is that it nearly eliminates the risk for penile cancer. Why not, then, remove women’s breasts as they have a strong propensity toward cancer development? One in everyone hundred thousand men is diagnosed with penile cancer (Marconi, Roil, Gate, & Theodore, 2005), while one in every nine women is diagnosed with breast cancer (Baudette, Gentleman, & Lee, 1998). So why then do we not remove breasts at birth or in the teenage years to alleviate women of this terrible risk? I find the only answer to be the masculine, objectifying gaze which places sexual and aesthetic importance on the presence of breasts and the lack of foreskins.
What is left at the end of this cultural debate is clear evidence that there is cultural oppression behind the circumcision of infant boys. This oppression has perpetuated the mindlessness facilitated by a post-modern society as well as the binary that has been constructed which places female genital mutilation as an oppressive practice and male genital mutilation as a preventative health measure. Ultimately, infant boys are subjected to a violent and painful cutting of a body part due to oppressions on the cultural level.

The last level finds structural oppression in the form of structural violence. Mullaly (2010) states specifically, “… when (violence) happens to someone because he or she is a member of a particular social group, then it is a form of oppression.” (pp. 114). To place this assertion into the context of circumcision, male babies are having perfectly healthy body parts removed by the medical profession without their consent and often while in immense pain by the medical profession. This violent and unnecessary act happens to this group of people because they belong to the group ‘infant’. This social group is the core entry way that oppressive medical practitioners use to inflict pain on this vulnerable population. Therefore, I find infants to be oppressed on the structural level due to their signification as infants and the susceptibility to medical violence this label entails.

Returning to the vulnerability continuum, it is found that an overwhelming number of risks outnumber resiliencies in regard to routine neonatal circumcision. The risks outlined include the personal risks of inability to give informed consent, the pathologizing of the male body, the desexualisation of the male body and psyche, the parental and physician aversion of pain, the lack of language and meaning systems available, the inhibition of unique identity and the permanent branding of infant’s bodies. On the cultural level, risks include post modern parental mindlessness, the orgasm-based view of sex inherent to the cultural discourse and the polarization of male bodies from female bodies. On the structural level, risks include institutional violence against the group ‘infant’. These risks must be considered with the medical risks presented earlier including uncertainties around HIV prevention, increased risk of contracting tetanus, increased risk of Staphylococcus aureus, increased risk of penile inflammation and increased risk of penile carcinoma in the treatment of phimosis. Risks are posted in contrast to the resiliencies that routine neonatal circumcision may offer. Resiliencies include group belonging with hegemonic masculinity and medical implications such as possible prevention of HIV, reduction of HPV contraction and reduction in prevalence of penile carcinoma. In this vulnerability assessment, it is found that the sheer number of biopsychosocial risks outnumber biopsychosocial resiliencies.

As to the value placed on each item there is more discrepancy. I find the personal, cultural and structural oppressions of circumcision much more substantial than the benefits presented for routine neonatal circumcision, although this comes very clear to me as a social worker. Different eyes in different contexts might place greater value on the resiliencies that circumcision affords. It is here that I place the call to social workers, that professionals may evoke the great power of generalist and ecological social work to help cultivate a much different value base on the personal, cultural and structural levels throughout western society and perhaps the rest of the globe.

Implications for Social Work

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Many implications exist around the problem of circumcision and social work and these include the promotion of narrative based letter writing, clinical implications, social worker self-reflection, protection of children, influence in parenting courses, work in hospitals, policy advocacy, value-based research, and the challenging of existing discourses. Although my biological recovery from circumcision would have lasted only a few days, my social and psychological recovery will likely last a lifetime. I have begun my journey in grieving the colonized part of my body and coming to a loving relationship with my body through the activity of letter writing. I have included one of my letters to my foreskin as an appendix. Letter writing has allowed me to have a voice in the masculinised voicelessness in which I feel entranced. Even as my foreskin has been pillaged from my body, it can still exist in a hermeneutic relationship. This narrative type of therapy can serve as a gateway to empowerment through deconstructing the hidden oppressions of circumcision and reconstructing personal life stories. Furthermore, even in the nature of the problem of circumcision as a bodily affliction, it can be externalized through letter writing and personified to emphasize healthy recovery relationships to the problem. Therefore, letter writing to mutilated penises and dead foreskins could have great potential in men’s recovery groups and in individual counselling sessions for men grieving the loss of their foreskin.

The work and research discussed in this paper suggests that the oppression of circumcision is embedded deep inside of cultures all over the globe. It is hard to see so far back into the 18th century when much of the discourse that demonized masturbation and blamed the foreskin began. On the other hand, as it is hard to identify with historical discourses and implications, it is easy to side with the medical model, especially as allopathic medicine has recently claimed that circumcision dramatically reduces HIV risk. With all this packaging, social workers must continuously engage in a self reflection process that involves a critical analysis of all that occurs in the human experience. What humankind has come to accept as normal and conventional may very well be a deep seeded oppression that roots itself in historical dominations of oppressed groups. I have set out in this work to illuminate circumcision as one of the oppressions that began hundreds of years ago in the interest of a particular group continuing their domination. In this sense, social workers must carry a deep and continuous critical analysis of the social functions in society so that the oppression of vulnerable people can be brought to light.

As infants have been labelled here as the vulnerable population, social workers must continue to fight for this silenced group. I worry that society places too much trust in what is coined the ‘maternal instinct’, or the altruistic nature, of human beings. Even as parents care deeply for their children, a tremendous amount of trust is put in the authority of social institutions toward the health and welfare of a parent’s children. Mothers are conditioned through woman-targeted media input to view the uncircumcised penis as unattractive, and as an impediment to their son’s sexual desirability as an adult (Young, 2009). Here, social workers must take an active role in addressing the oppression of infants by educating parents on the history and current complexities of circumcision, and one way to do this is through parenting courses. Social workers who facilitate parenting courses can come into the course with value based professional ethics and work toward the discontinuation of genital cutting for all human beings though engaging educational, anti-oppressive discussion around the issue. Social workers who create parenting programs can incorporate circumcision discussion into the curriculum and
educate facilitators on the oppression of genital mutilation as it applies to both boys and girls. Therefore, parenting classes offer a strong opportunity to address the problem of circumcision.

Further opportunity exists for social workers who work in hospitals. In the multidisciplinary team of doctors, nurses and social workers it is important for the social worker to provide a voice to the voiceless infant and this may involve confrontation with other members of the team. Furthermore, social workers in neonatal units have a great opportunity to advocate for the non-mutilation of baby boys through having value-based discussions with parents and staff that are geared in the interest of protecting infants. Therefore, there are many possibilities for the social worker in hospitals to advocate for the infant.

One of the most profound effects a social worker can have on the oppression of circumcision is through challenging policy. Darby and Svobodka’s (2007) scale for the severity of circumcisions shows that the pain and lack of necessity of male circumcision is like female circumcision. Advocacy could engage such organizations as the World Health Organization, which has constructed a strong anti-circumcision campaign toward female circumcision but have not paid any attention to male circumcision (Darby & Svobodka, 2007).

Conclusion

Social workers must adhere to value-based professionalism and this must involve challenging the system instead of bending to work inside of it. As a social worker we must challenge the oppressions that are packed deep into the reality around us and engage in the struggle for social justice for all members of society. The infant boys who are subject to circumcision are undeniably vulnerable in their lack of language, immunity, and mobility and it is the task of social workers to protect this population. Packed into circumcision is a history of patriarchal initiation, masculine branding, and hegemonic masculinity that forces itself upon boys in the practice of circumcision. As these social forces impact boys on the personal, cultural, and structural levels, the medical institution and society at large validates this oppressive practice and contributes to the suffering of infants. Social workers could be key players in stopping the mutilation of boys through advocacy, anti-oppressive practice and value-based interventions. With social workers challenging the oppression of infants by circumcision, it is possible that this form of infant suffering can be abolished.
References


Appendix

Dear Foreskin,

It has been 27 years since you were taken from me. Much of this time for me was spent in the dark, not knowing that you ever existed or that you were once an integral part of my body. I now wonder what my life would be like if you were still here. I wonder if I would still look at others in jealousy; those who have whole bodies, others who have not been mutilated and who get to live their lives whole and intact.

It has been devastating for me lately, knowing that you are gone. I lay sleepless at night picturing me lying on that table as a baby. I had no language, no strength and no power as you were viciously sliced from the most intimate part of me. Taken by a man in a green coat and discarded into a valueless void. His words ringing “welcome to masculinity,” coercing me into a sick indoctrination. His justification that I might be one in one hundred thousand. This insignificant number that allowed him to conquer us and rape our connection. What blood would have signified our separation and the pain that we endured as I screamed in pain and you silently died?

I grieve your loss. Your life that would have made me whole and enriched my connection to my partner in the most intimate of human activities. I grieve for the reality that butchers me into a life of sexual numbness. Without you I stand here raw and deformed and punished for being a man. Conquered by the conqueror so I might go out and do his bidding. Here, every time I push into her, watching him laugh and bellow at the unfeeling penetration. You, my most feeling skin, raped from me to mould me to conquer others.

Here in this monster I still scream out, not to forget you but to honour you through great efforts for awareness and love. In all my rage to the colonist in the green coat, I risk wasting the limited remaining hours I have on this earth. With the fuel of emotion that is evoked in my body out of your loss I dedicate my pursuits to work that will ensure that others do not lose you. Our paths have crossed, and we are no longer together, but every day someone new is born into the world who risks being parted from you. May our loss have purpose, and may your death bring hope to my and other’s lives.

I will always miss you and forever be un-whole in circumcision,

Missing you always,

Writer.