Male circumcision – the surgical removal of the foreskin of the penis – has long been a contested practice in Anglo-American countries. Competing beliefs about pain as potentially redemptive and as essentially malign have fueled the controversy, with medical professionals and lay people alike debating whether circumcision causes or ameliorates physical or emotional pain, as well as how to respond to that pain. Because circumcision is a surgical intervention performed on bodies that are physiologically male, arguments about circumcision and pain have been indelibly shaped by changing cultural beliefs about boys, men and masculinity – beliefs which have informed approaches to circumcision and pain in turn.

This study, which focuses on the period from 1960 to 2000 in the United States and Canada, examines how shifting understandings and enactments of masculinity, in concert with evolving practices in biomedicine, have transformed approaches to circumcision pain. My analysis centres on routine circumcision – the excision of the foreskin as a matter of course, for social, cultural or preventive health reasons, rather than as a religious observance or remedy for specific medical complaints. I examine the multiple ways in which pain is conceptualised and articulated, recognising that physical and emotional pain are inextricably intertwined (despite frequent efforts to differentiate them), and that separating them reinforces mind-body dualism.¹

To be sure, pain is just one of many factors that propel debate over male circumcision. Also contested are the questions of whether the practice protects or imperils health, whether it belongs under medical jurisdiction, whether it can be ethically consented to by parental proxy, and whether it exceeds the degree of religious and ethnic difference societies can tolerate (to name but a few possible issues). A thoroughgoing analysis of these and other broad battles waged around and through controversy over foreskin removal is, however, beyond the scope of this single article.²

Like other feminist scholars, I conceptualise gender not as universal or static, but rather as constructed through social processes and taking distinctive forms in different contexts.³ What ideals and norms are associated with masculinity and femininity

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and how they are enacted and regulated in particular places and periods influences myriad other aspects of social life, including medicalised cultural practices like male circumcision. Conversely, social and cultural practices influence gendered norms and behaviours in ways which hold possibilities for social change. Since the late 1800s, masculinity in Anglo-America has, mostly – but not always – been associated with imperviousness to pain. Delineating the circumstances under which male pain is recognised, as well as what responses the recognition of boys’ and men’s pain inspires, can open new ways to think about gender and sex and about the relief of human suffering.4

This analysis springs from a larger study examining controversy over male circumcision in the United States, Canada and Great Britain from 1870 to 2015. It takes a case-comparative approach, using similarities and differences across national contexts to illuminate and theorise broader patterns and processes while recognising historical specificity. As settler-colonial offspring of Great Britain, Canada and the United States share a great deal, both with one another and with Britain, including democratic political systems, cultural practices and institutions and affluent capitalist economies, as well as highly sophisticated medical and scientific establishments which have enjoyed close ties for over 200 years.5 The countries also show some similarities in terms of their experience of tensions and transformations around gender and family life.6 Of particular relevance here, two competing approaches to pain, deriving from British political theory, have been highly influential in both nations (and throughout the West).7 According to one perspective, initially articulated by eighteenth-century conservative thinkers like Edmund Burke, pain is educational and annealing. According to the other view, propagated by nineteenth-century liberal theorists like John Stuart Mill, pain is something wholly negative and worthless that ought to be avoided altogether.

My comparison is additionally inspired by the countries’ similar yet divergent histories around male circumcision. In the 1870s, British, US and Canadian medicine transformed circumcision from a Jewish and Muslim religious rite, to a routine medical procedure, which grew increasingly popular through the 1930s.8 Although routine foreskin removal subsequently fell out of favour in Britain, rates continued to climb in Anglophone North America, peaking in the early 1970s at roughly 70 per cent in Canada and 90 per cent in the United States.9 At that point, Canadian and US approaches to circumcision began to diverge.

This article focuses on the period from the 1960s – when North American medical elites (chiefly physicians) began to seriously question routine circumcision on multiple grounds, including its relationship to pain – through to the late 1990s, when US and Canadian medical associations revised their policies on foreskin removal to reflect new views about pain (as well as concerns about consent, efficacy and more). My account centres on the elite physicians (primarily pediatricians), biomedical scientists and grassroots opponents who have driven the public debate about circumcision pain.10 These actors mainly address practices in their own nations, but communicate regularly across borders. My data comes primarily from major medical journals (chiefly Pediatrics and the Canadian Medical Association Journal).11 Additional data come from materials produced by the American Academy of Pediatrics (AAP), Canadian Paediatric Society (CPS) and key anti-circumcision groups (such as the US-based National Organization of Circumcision Information Centers [NOCIRC] and the National Organization to Halt the Abuse and Routine Mutilation of Males [NOHARMM], along with the Canada-based Association for Genital Integrity [AGI]).
After a brief review of Anglo-American approaches to foreskin removal and pediatric pain from the 1870s to the 1950s, I narrow my focus to the United States and Canada from the 1960s to 2000, delving into the ways in which changing understandings of masculinity, in combination with new perspectives in medicine, affected beliefs about, and responses to, circumcision pain, as well as vice versa. This discussion reveals how social and scientific trends in late twentieth-century Anglophone North America helped to perpetuate and to challenge the equation of masculinity with im-perviousness to pain. It also highlights the conditions under which Canadians and US Americans have perceived boys and men as vulnerable to emotional suffering: namely, when they experience their genitals as differing from those of other males. Moreover, because women played unusually prominent roles in interpreting male circumcision pain, my analysis offers insight into the ways gender influences who constructs knowledge about whose pain – a central theme of this forum. My study additionally explores another important dynamic Bourke and Wood identify in their introduction: how gender intertwines with other identity categories – here, age – to shape interpretations and experiences of pain.

Medicalising male circumcision and denying pediatric pain: 1870s–1950s

For centuries, Britons and their North American cousins viewed male circumcision as a Jewish or Muslim religious ritual at best and a disfiguring, heathen practice at worst. In the 1870s, however, Anglo-American physicians – the great majority of whom were White, Christian men – began to medicalise circumcision, advocating it as a cure for ailments from epilepsy to masturbation, then seen as a disease. By the late 1880s, physicians on both sides of the Atlantic were promoting routine foreskin removal as a means of preventing ‘congenital’ phimosis (foreskin not retractable at birth) and ‘venereal’ disease, among other ills.

During the same period, western European scientists (who, like physicians, were predominantly White men) were challenging the commonsense belief that humans of all ages experienced physical pain. Previously, doctors and lay people generally had agreed that the younger the person, the more intense their experience of pain – though whether pain was beneficial or harmful was contested. In the 1870s, however, a new, scientifically-derived view emerged. Scholars like German neuroanatomist Paul Emil Flechsig proposed that infants could not feel pain because their nerves were not completely myelinated (covered with insulating matter). Others, like German surgeon Alfred Genzmer, used experimental methods, like ‘prick[ing] premature infants with fine pins’, to conclude that pain is ‘exceptionally poorly developed in the neonate’.

Many Victorian physicians embraced the perspective that infants did not feel pain. For one thing, it was convenient. Even though effective and relatively safe anesthesia and analgesics became available in the 1840s, they remained risky, particularly for the very young. Moreover, this belief meshed with popular Darwinian views that infants, like women and members of ‘savage’ races, were ‘primitive’ beings who experienced reflex responses, rather than pain as adults knew it.

The medicalisation of male circumcision and new ideas about age differences in pain dovetailed perfectly. If logic dictated that preventive procedures should be performed before there was anything to prevent, and human beings developed the capacity to feel pain only gradually, as their nerves myelinated, it made sense to
circumcise boys in infancy, when it could be done without the risk and bother of anesthesia. It may seem counterintuitive that circumcising baby boys without pain relief became popular during this period, given that urban middle-class Anglo-Americans – the people who could afford elective surgery – tended to sentimentalise childhood, at least with respect to their own offspring. However, children were still widely viewed as economic assets, rather than as priceless and non-productive.  

New cultural beliefs about boys and men being, or needing to become, tough, strong and impervious to pain also helped facilitate the spread of routine circumcision. In the early 1800s, Anglo-Americans generally associated ideal manliness with selflessness, earnestness and integrity. By the late 1800s, concerns about urbanisation and modernisation led to a new emphasis on physical courage, stoicism, endurance, and the rejection of the feminine – including girlish sensitivity to pain. These beliefs about masculinity remained influential in the early twentieth century, even as the rise of Freudian theory prompted some Anglo-American medical professionals to worry that circumcision could cause emotional suffering among boys old enough to remember the surgery, particularly if they were ‘sensitive’ (read: feminine). These concerns became largely moot in Britain when routine circumcision fell out of favour in the 1950s, for reasons mostly unrelated to pain. In North America, however, whether foreskin removal caused or prevented male suffering came to be a topic of considerable controversy.

Rediscovering pediatric pain and reconceiving masculinity: 1960s–mid-1970s

Routine infant circumcision enjoyed strong support from the Anglophone North American medical community. Buoyed by the expansion of private, fee-for-service health insurance and hospital birth following the Second World War, circumcision rates rose from approximately 50 per cent of Canadian and 60 per cent of US males in the 1930s to roughly 70 per cent and 90 per cent, respectively, by 1970. The popularity of routine foreskin removal depended in part on the belief, supported by Freudian theory, that boys would suffer emotionally if their penises did not resemble those of their (increasingly) circumcised fathers and brothers. As Dr Benjamin Spock opined in his bestselling childcare guide, ‘circumcision is a good idea, especially if most of the boys in the neighborhood are circumcised – then a boy feels “regular”’. 

Although postwar ideals favoured ‘strong and silent’ men who could endure pain, and fears of ‘feminised’ boys and dependent men abounded, efforts to forestall emotional pain by ensuring boys’ genital conformity apparently were not interpreted as coddling or emasculating. Due to the persistent, widespread belief that babies did not feel physical pain, anesthesia and analgesics were rarely used in routine circumcision. As Chicago surgeon Max Thorek advised in his popular 1938 textbook, Modern Surgical Technique: ‘Often no anesthesia is required. A sucker consisting of a sponge dipped in some sugar water will often suffice to calm a baby’. Yet, some mid-century scientists began to question prevailing perspectives on pediatric pain. For example, in 1952, animal experiments by French neurologist André-Thomas demonstrated that a creature’s nerves did not need to be myelinated for it to feel pain. Not coincidentally, the liberal view that pain should be avoided and ameliorated whenever possible was ascendant during this period.
The 1960s also saw heightened intensity in the enduring debate over whether medicine was more art or science – the pendulum was swinging toward science – as well as a general atmosphere of challenging received wisdom (seen, for example, in the incipient youth counterculture). North American physicians (still mostly White men) began asking whether routine circumcision really offered the health benefits claimed for it – the empirical evidence was scant and varied in quality – and some raised questions related to pain. For example, University of Toronto microbiologist John MacKay urged his fellow doctors to trust their firsthand observations of infants’ reactions to circumcision rather than platitudes from senior colleagues:

When as an intern I was compelled to circumcise the babies delivered by members of the staff, I protested against the cruelty of doing this procedure without an anesthetic. I was assured by everyone that the babies felt no pain, they only screamed that way because they didn’t like to be held still while the operation was in progress. For some reason I remained unconvinced.

MacKay moreover noted that some adult men experienced so much emotional distress from having been circumcised as youths that they sought to restore their foreskins.

In a major review of the literature on circumcision’s risks and benefits published in 1970, US Air Force pediatrician Noel Preston drew on research from child psychology to posit that post-operative discomfort (‘the fretful, circumcised newborn, his glans swollen and cyanotic for three to five days’) represented the kind of ‘tension’ that could result in (unspecified) delayed ‘psychologic’ complications. Preston also dismissed as outmoded the fear that intact boys would suffer emotionally if their penises differed from those of circumcised fathers, brothers and male peers. ‘This is the latter half of the 20th century, a time supposedly to celebrate individuality and freedom of choice’, he wrote. ‘If being uncircumcised is embarrassing to a boy he can always be circumcised later’.

Other physicians emphatically rejected the idea that circumcision could provoke emotional suffering. University of Toronto surgeon Philip Klotz spoke for many when he declared that men seeking foreskin restoration ‘require the services of a psychiatrist rather than a surgeon’. Dismissing those men who could not resign themselves to the results of an operation performed in their youth as mentally disturbed befitted and reinforced the postwar equation of masculinity with strength and stoicism.

Yet, ideas about gender were beginning to change. Following the lead of second-wave feminists, who had been critiquing traditional gender norms for a decade, some men in the 1970s began advocating for new, less impassive versions of masculinity. Participants in the early men’s movement, most of whom were White and middle-class, believed that boys and men could and should admit to feeling physical and emotional pain. To the extent that they convinced the broader public of this, these men paved the way for physicians and lay people to reconceive of foreskin removal as a potential cause of pain for males in multiple ways.

The lack of consensus about circumcision and pain was apparent in the first US and Canadian medical association policies on the surgery, both issued in 1975. The American Academy of Pediatrics (AAP) and Canadian Paediatric Society (CPS) agreed that circumcision was not ‘medically necessary’ but took different stances on pain. The all-male AAP Task Force’s statement did not mention physical pain or discuss pain relief, but it suggested that delaying circumcision beyond the preschool years could
‘induce psychologic problems’. In contrast, the (apparently) all-male CPS Foetus and Newborn Committee described foreskin removal as physically painful and denounced the practice of offering newborns ‘only a sugar ball to suck on as a soother’ during circumcision, noting that ‘no one would perform a circumcision on a two-month old infant without first administering anaesthesia’. Given the absence of ‘any known neurophysiological difference between these two age groups’, the CPS declared that infants should either receive anesthesia during circumcision or retain their foreskins. The Canadian statement also addressed concerns about boys suffering from a lack of ‘genital resemblance’ by invoking the changing social context: ‘conformity must now be considered in relation with the peer group in a society with a rapidly diminishing demand for circumcision’.

Rates of routine circumcision began to decline in the 1970s, more rapidly in Canada than in the United States. The advent of national health insurance in Canada in the late 1960s contributed to the divergence, insofar as it discouraged procedures deemed unnecessary (though the United States also saw growing concern with high medical costs). Subtly different national norms of masculinity may have exerted some influence as well. Insofar as popular media portrayals of Canadian men as ‘victims’ and ‘losers’ disposed to ‘melancholy and masochism’ reflected real-life dispositions, male pain may have garnered more sympathy in Canada than in the ‘will to win’-oriented United States, where conflict over the Vietnam War may have fueled ongoing tension about whether ‘real’ men were supposed to be violent or peaceful, impervious or susceptible to pain.

Disputing how to prevent pain and potential trauma: late 1970s–early 1980s

Research on the risks and benefits of foreskin removal increased in the wake of the 1975 policies. Whether circumcision caused or curbed psychological pain was one of many issues that remained up for debate; the relationship between physical and emotional circumcision pain was another. In a prominent review, Atlanta obstetrician-gynecologist David Grimes (1978) suggested that circumcision, as typically performed, represented a kind of ‘trauma’ with ‘psychological consequences’ even for boys too young to remember the surgery:

For the baby to be plucked from his bed, strapped in a spread eagle position, and doused with chilling antiseptic is perhaps consistent with other new-found discomforts of extrauterine existence. The application of crushing clamps and excision of penile tissue, however, probably do little to engender a trusting, congenial, relationship with the infant's new surroundings.

In other words, Grimes proposed that the physical pain caused by circumcision was problematic not only because it was inherently bad (as he saw it), but also because it could cause emotional harm.

In fact, Grimes was one of a handful of mainstream North American physicians in this period who publicly likened unanesthetised circumcision to child abuse. To Grimes, such operations represented an abuse of adults’ power over children: ‘Physicians apply different standards of pain tolerance to newborn infants, perhaps because these patients cannot articulate their anguish’. Similarly, University of Toronto psychiatry professor Harvey Armstrong worried that physical pain from circumcision could have a negative effect ‘on the child’s relations with his caring adults’ and noted that ‘other unnecessary
tissue trauma to very young children is perceived by the rest of society as a form of child abuse’. Such arguments coincided with the ‘discovery’ of child abuse and growing concern with child victims of all kinds then underway, as well as with the broader children’s rights movement. They also reflected a paradigm shift in the conceptualisation and management of psychological trauma, prompted in part by the experiences of US soldiers in Vietnam and accordingly associated with beliefs about men and masculinity.

On the whole, however, North American doctors were not inclined to treat male circumcision as tantamount to child abuse. Many prominent physicians continued to believe that routine foreskin removal was beneficial to health, or warranted to prevent medically indicated surgeries. In their review of the (admittedly scant) literature, Toronto physicians Ellen Warner and Elliot Strashin allowed that ‘neonatal circumcision is not an entirely painless procedure’, but concluded that the ‘physiologic reaction to stress that it induces is usually brief’ and that ‘the afferent nerves are sufficiently immature during the first 2 to 3 months of life that an anesthetic is unnecessary’. From this perspective routine infant circumcision was advisable, both to avoid the need for anesthesia at older ages, which added risk to the procedure, and because, as one advocate put it, ‘Neonatal circumcision does not appear to have any long-term psychologic effects’ whereas circumcision after infancy would ‘remain in [a boy’s] memory as, at best, an unpleasant experience or, at worst, a psychosexually traumatic event’.

Gender is notable in these discussions mostly for its absence, which comes as a surprise, considering that the 1970s were the heyday of second-wave feminism and the early men’s movement, and that women (like the aforementioned Ellen Warner) were entering medical school in increasing numbers. One exception was a 1976 analysis of existing research, published by psychologists Martin Richards and Judith Bernal from Cambridge University (UK) and Yvonne Brackbill from Georgetown Medical School (USA), which asked whether ‘Early Behavioural Differences’ were due to ‘Gender or Circumcision?’ Richards and colleagues observed that ‘American studies have frequently reported newborn gender differences in . . . sensory thresholds or sensitivity’ – boys being more sensitive – but ‘British and Dutch studies of the newborn did not’. They proposed that nation-specific circumcision practices might be why. The study attracted little attention, however, even in academic circles. Of the fifteen articles that cited the study between 1977 and 1980, three appeared in medical journals. All three used Richards and colleagues’ research to support the claim that neonatal circumcision affected ‘immediate postoperative behavio[u]r and possibly long-term behavio[u]r’, but none of them discussed gender differences and only one focused on circumcision and pain. A 1980 follow-up by Brackbill, then at the University of Florida, and colleague Kerri Schroder, failed to find any gender differences in infant behaviour in the first place.

At the time these studies were published, foreskin removal featured so often in research on pediatric pain that one research team felt it worth remarking that ‘circumcision of full-term male infants has frequently been used as a model to study the physiologic response of newborns to pain’. Yet, Richards, Brackbill and colleagues framed their inquiry chiefly in terms of general human development and did not ask what many might wonder today: could it be problematic to study infant pain in only one sex or gender? Their disregard is consistent with common medical research practice.
into the 1990s (which Wood and Bourke discuss in their introduction), focusing on males and extrapolating to females.

Grassroots opponents highlight pain, US medicine equivocates: mid-1980s –1990s

Despite growing medical critique, routine circumcision remained popular in Anglophone North America, prompting the birth of grassroots opposition groups in the 1980s in the United States and 1990s in Canada. As one strand of the broader radical health movement that emerged in the 1960s and 1970s, the anti-circumcision movement shares much – including some members – with the patients’ rights and women’s health movements, including skepticism about medical authority and the conviction that people are their own (or their child’s) best health interpreters and advocates. Notably, opposition to foreskin removal has evolved alongside the contemporary anti-vaccination movement. Some – but far from all – activists see rejecting circumcision, vaccination, medicalised childbirth and infant formula as part of a single package.

Many early activists were women trained as nurses or midwives who had been horrified when they saw newborns circumcised without pain relief. For example, Marilyn Milos, founder of California-based NOCIRC, recalled, ‘As a nursing student . . . I saw a circumcision for the first time . . . . When the doctor began the operation, the baby let out a piercing scream . . . . To see part of a baby’s penis being cut off – without anesthesia – was shocking.’ Other women and men came to oppose foreskin removal through involvement in the natural childbirth movement, motivated by the desire to minimise medical intervention in women’s and infants’ birth experiences and to make birth as gentle as possible for infants. Also protesting were adult men distressed about having been circumcised in childhood; some of these men had been, or became, active in the broader men’s movement as well.

Women’s prominence in grassroots efforts to construct knowledge about male circumcision pain is noteworthy, and not unrelated to their traditional expertise on infants, as I discuss below.

Grassroots opponents refused to believe that circumcision was not painful, on both commonsense and observational grounds. (They rejected other conventional claims as well, especially regarding the surgery’s health effects.) When lobbying medical organisations, rank-and-file doctors and nurses and parents, activists regularly highlighted research demonstrating that circumcision hurt. For example, an item in the 1987 NO-CIRC newsletter noted that ‘Recent medical reports confirm that the surgery ‘is a stressful and painful event/with/changes in heart rate, respiratory rate, transcutaneous, adrenal cortical hormone secretions, sleep patterns, and behavioral patterns during and/or following circumcision’.

Often, activists’ claims were less circumspect versions of claims made by some in mainstream medicine (see above).

Circumcision opponents rejected the notion that boys who kept their foreskins would suffer emotionally, especially given changing practices. According to a typical riposte: ‘With 40 per cent of the boys now intact, the locker rooms of the 1990’s will have both circumcised and intact boys. Most circumcised boys in the US do not tease intact boys anymore [sic] than intact boys tease circumcised boys in other countries.’ Activists additionally argued – often based on their own experiences (for men) or those of friends or family members (for women) – that routine childhood circumcision caused emotional pain which could be severe and long-lasting.
extrapolated from emerging research about trauma, especially post-traumatic stress disorder (PTSD), which had been formally recognised in the DSM-III in 1980.\textsuperscript{57} For example, activist Rima Laibow argued that infants who are ‘subjected to intolerable, overwhelming pain’ – like unanesthetised circumcision – ‘retain significant memory traces of traumatic events’, which could impede their ability to trust others well into the future.\textsuperscript{58} Some activists argued that circumcision pain could even lead to self-harm and adult suicide. An article in NOCIRC’s spring 1987 newsletter speculated that ‘circumcision performed on day-old infants is “birth trauma” which can incline males to self-violence and suicide later in life’.\textsuperscript{59}

Gender held a prominent place in many activists’ arguments about circumcision pain, especially compared with medical elites. Some activists argued that, because circumcision was painful and violent, boys who experienced it grew up to perpetrate gendered forms of interpersonal violence, such as sexual assault and child abuse. For example, M. L. of Illinois wrote to NOCIRC, contending that circumcision was ‘a major wound to males which is acted out by battering, wars, rape, child abuse, and random violence’.\textsuperscript{60} Others, like psychotherapist Jed Diamond, proposed that circumcision was the root of emotional difficulties associated with masculinity: ‘feelings of shame about our bodies, our concern about the size of our penises, our anguish over sexual performance, our frozen feelings, or the male ability (liability?) to ignore pain’.\textsuperscript{61} Convinced that circumcision was painful emotionally as well as physically (and never preventive of suffering), and concerned that the operation endangered children’s health and violated their bodily rights, grassroots foes favoured abolition, not improvements in pain relief. In the words of activist Edward Wallerstein, ‘the best way to avoid the stress of circumcision is to abandon the practice’.\textsuperscript{62}

For their part, US and Canadian physicians continued to disagree about routine circumcision, arguing mainly about the relative balance of health benefits and risks. Few agreed with activists’ dire pronouncements about circumcision pain, but many expressed increasing concern about pediatric pain in general, especially after the 1985 death of US infant Jeffrey Lawson following unanesthetised major surgery.\textsuperscript{63} Studies in the early- and mid-1980s consistently found that infant circumcision ‘altered’ adrenal cortical response, heart rate, respiration and transcutaneous oxygen levels in ways that could be ‘attributed to the pain response’, and that those responses had short- and long-term effects, including social withdrawal and sleep problems.\textsuperscript{64} Arguably, the fact that only male babies experienced these effects might be hypothesised to contribute to sex or gender differences in development or health. Yet the literature remained largely silent on the topic, perhaps because cultural beliefs that boys and men should be invulnerable to pain remained dominant, despite the efforts of feminists and men’s movement activists to disrupt them, and notwithstanding women’s growing representation among physicians and biomedical scientists.\textsuperscript{65}

Increasingly certain that circumcision was physically painful, clinicians and scientists sought safe ways to reduce or prevent that pain. For example, physician Paul Williamson and nurse Marvel Williamson, both at the University of Iowa, found that pain from a nerve block injection hurt less than pain from unanesthetised circumcision and that nerve block was safe and easy to use.\textsuperscript{66} In light of this and similar studies, US pediatricians began inching toward their Canadian counterparts’ position on circumcision pain. In 1987, the AAP declared that newborns should receive anesthesia and analgesia when undergoing surgery. In 1989, an AAP Task Force, comprising five
men and one woman, stated that circumcision was physically painful. However, the organisation rejected the possibility of lasting trauma due to that pain, and it presented local anesthesia as understudied and up to physician and parental preference. The AAP approved of circumcision for ‘social reasons’, implicitly supporting the position that not ‘matching’ other males could induce suffering.

Yet, despite the AAP and CPS stances on pain relief, studies indicated that the ‘vast majority of physicians performing newborn circumcisions either do not employ analgesics or employ analgesics of questionable efficacy’. Some physicians continued to maintain that administering local anesthesia caused more pain than circumcision itself. For example, Quebec pediatrician Murray S. Katz, who also was a mohel (traditional Jewish circumciser), opined that penile nerve blocks ‘can be as painful as the procedure itself’ and contended that ‘pain can be greatly reduced through the use of the Mogen [clamp]’ and ‘a sweet Jewish wine’.

Debating the long-term consequences of circumcision pain: mid-1990s–early 2000s

In the mid 1990s, several high-profile studies which compared boys who had been circumcised with and without pain relief indicated that the negative effects of circumcision pain were broader and more enduring than many thought. One US research team found that the pain provoked by circumcision negatively affected infant feeding, and was not alleviated by acetaminophen. University of Toronto pediatrician Anna Taddio and colleagues demonstrated that male babies circumcised without anesthesia had stronger pain responses when they were vaccinated, months later, than girls and intact boys. They posited that this ‘greater vaccination response . . . represent[ed] an infant analogue of a post-traumatic stress disorder triggered by a traumatic and painful event and re-experienced under similar circumstances of pain during vaccination’.

North American medical associations swiftly incorporated this new wave of research into their policies on circumcision (along with revised health risk-benefit calculations and new attention to sexual effects and informed consent) and called for additional studies to determine optimal methods of pain relief. In 1996, in a statement written by eight men and two women, the CPS reiterated its position that pain control was necessary during circumcision, and praised physicians for increasingly providing it. In 1999, a seven-member AAP Task Force – which included two women, one serving as chair – at last added insistence on pain relief to its policy on circumcision, an addition the organisation saw as sufficiently innovative to highlight in a press release: ‘if parents decide to circumcise their infant, it is essential that pain relief be provided’. Both organisations took more cautious stances on emotional pain, largely ignoring the issue of PTSD. The CPS noted that genital resemblance mattered to parents, but neither embraced nor condemned this as a rationale for routine circumcision, stating only that it ought ‘to be discussed during physician counselling of parents’. The AAP said nothing explicit about circumcision and psychological suffering, but approved of foreskin removal for ‘social reasons’, ostensibly including concerns about conformity.

Grassroots circumcision opponents praised and publicised the new research on circumcision pain, which confirmed – and brought mainstream scientific credibility to – claims they had been making for a decade. Yet, with Canadian and US pediatrics associations unequivocally insisting on pain relief during circumcision, grassroots
opponents found one of the key weapons in their arsenal defused. They soon began venturing new arguments about circumcision pain and reinvigorating old ones (as well as emphasising arguments about sexual sensation and bodily integrity). Some of these arguments targeted physical pain. Activists stressed the limitations of anesthesia and analgesics, with objections such as ‘pain medication is . . . never 100% effective’ and ‘being stuck with a needle in the penis is itself painful for a baby, just as if would be for anyone else’.74

Other arguments focused on emotional pain. Activists conducted and publicised research ‘document[ing] PTSD from neonatal circumcision in middle-aged men’, arguably drawing broader conclusions than Taddio and colleagues intended. According to the US-based National Organization for Restoring Men (NORM):

Self-confidence and hardiness is diminished by forcing the newborn victim into a defensive psychological state of ‘learned helplessness’ or ‘acquired passivity’ to cope with the excruciating pain which he can neither fight nor flee. The trauma of this early pain lowers a circumcised boy’s pain threshold below that of intact boys and girls.75

Additional testimony came from parents who said their intact sons did not suffer from having penises that looked different from those of their fathers or peers. In the words of one mother who contributed to a webcast featuring US activist group Doctors Opposing Circumcision:

My boys have seen circumcised boys and my husband and I explained the difference. They thanked us for leaving them exactly the way they were born. Why is everyone so concerned that an uncircumcised boy will be traumatized for life?76

Although activists deployed findings from studies that used circumcision to study infant pain, they also critiqued scientists who employed such research designs. For example, physician and activist Robert Van Howe railed in a letter to Pediatrics against institutional review boards that permitted ‘unanesthetized surgery on children, which would not be allowable in the study of laboratory animals’.77 Canada’s Association for Genital Integrity (AGI) was especially active in this regard, with members sending numerous letters to medical, academic and state institutions to complain that studies of circumcision pain were being conducted in inappropriate ways. For example, AGI director Dennis Harrison repeatedly wrote to Henry B. Dinsdale, President of the National Council on Ethics in Human Research, ‘to raise questions in regard to a medical study undertaken by the University of Alberta for the purpose of measuring pain responses in infants undergoing circumcision. The study was halted prematurely after two of the infants were traumatized so severely that they became ill’.78 Dinsdale responded that individual research projects were assessed by local research ethics boards, not NCEHR, and recommended that Harrison wait for a reply from Dr Donald Morrish, chair of the University of Alberta’s ethics committee, to whom Harrison had also written.79

Overall, most North American medical associations, rank-and-file doctors and nurses, biomedical scientists, journalists and the general public did not agree that circumcision pain was so extreme or harmful in the long term. Many expressed skepticism about adult men’s claims that foreskin removal in childhood had resulted in enduring physical pain or emotional trauma.80 Others mocked as insufficiently manly those men who ‘can’t get over’ their circumcision, as when journalist Sam McManis called R.
Wayne Griffiths, founder of NOHARMM and creator of a popular foreskin restoration device, ‘another kooky Californian promoting a wacky cause that would send Aunt Martha from Idaho into a conniption fit’. Rates of routine infant and childhood circumcision remained high in North America, especially in the United States, where about 58 per cent of boys are circumcised, compared to about 32 per cent in Canada nationwide.

**Conclusion**

Cultural notions about boys, men and masculinity have profoundly influenced approaches to circumcision pain in ways which vary across time and place and which intertwine with beliefs about age. The conviction that infants were not fully human, and that masculinity entailed tolerating physical pain, were critical in making male circumcision a routine Anglo-American pediatric practice in the late 1800s. Nearly a century later, new scientific approaches to pain, revised understandings of child development and challenges to traditional masculinity made it possible for Anglophone North American scientists and physicians to reconceptualise infant circumcision as physically painful, and alleviation of that pain as imperative. This rethinking occurred only gradually, however, perhaps because old ideals of masculinity coexisted with new ones. It seems unlikely that medical elites could have ignored research about circumcision pain and vacillated about anesthesia as long as they did – and for two decades more in the United States than in Canada – for a surgery that was performed on girls as well. In fact, numerous US and Canadian medical associations have adamantly opposed all forms of ritual female genital cutting (FGC) since the 1990s, in part due to the conviction that they cause irreparable emotional and physical pain. Conversely, these medical groups have dismissed arguments that even extremely attenuated forms of FGC, such as nicking the clitoral skin, might be warranted to prevent suffering among girls who do not ‘match’ their mothers or sisters.

Gender additionally shaped the construction, dissemination and reception of knowledge about circumcision-related pain. As Bourke and Wood observe in their introduction, many historical examples involve men declaring themselves to be experts on women’s pain. However, women – as nurses, midwives, mothers and men’s sexual partners – played prominent roles in grassroots efforts to advance the claim that males suffer when their foreskins are removed. Reflecting the changing gender composition of North American medicine, women also represented a growing number of scientists studying pediatric pain and male circumcision, and contributing to medical association policies on the surgery and its relationship to pain. Yet, it is telling that both groups of women were constructing knowledge about the suffering of boys. Although women have long been accepted as lay and even professional experts on infants and children, that acceptance does not necessarily extend to expertise on adult men’s bodies.

The developments recounted in this article set the stage for further conflict over circumcision pain in North America, both inside and outside of medicine. Since the mid 2000s, several cases of physicians failing to anesthetise infants during circumcision have prompted outrage from doctors, activists and the general public alike. Some events, like the nearly successful effort to include a measure prohibiting circumcision of minors on the 2011 San Francisco city ballot, suggest increasing sympathy for men
who claim to have suffered from (or otherwise been harmed by) having their foreskins removed, even as jokes about ‘intactivists’ proliferate. New policies from the AAP in 2012 and CPS in 2015 have reiterated the need for pain relief before and after infant circumcision (while presenting revised health risk-benefit calculations), but questions about whether routine circumcision prevents or causes emotional pain remain the subject of intense and rancorous debate. The same period has seen traditional and pro-feminist masculinities coexisting with increasingly visible gender fluidity and the reinvigoration of the misogynist strand of the men’s movement. Unraveling how this complex moment in the history of masculinity will influence approaches to circumcision pain – and how approaches to circumcision pain will influence masculinities in turn – will be a crucial task for future feminist scholars.

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Notes

1. Gillian A. Bendelow and Simon J. Williams, ‘Transcending the Dualisms: Towards a Sociology of Pain’, Sociology of Health and Illness 17 (1995), pp. 139-65; Joanna Bourke, The Story of Pain: From Prayer to Painkillers (Oxford: Oxford University Press, 2014).
2. The multifaceted fight over male circumcision is the subject of my current book project.
3. Joan W. Scott, ‘History-Writing as Critique’, in Keith Jenkins, Sue Morgan, and Alun Munslow (eds), Manifestos for History (Abingdon: Routledge, 2007); Michael S. Kimmel, Jeff Hearn, and R. W. Connell (eds), Handbook of Studies on Men and Masculinities (Thousand Oaks, CA: Sage, 2005).
4. Although feminist scholars conventionally distinguish between sex and gender, respectively denoting biological and social/cultural factors, sex and gender are co-constructed and separating them may be unwise, especially in medicalised contexts. I understand male circumcision as involving both gender and sex, masculinity and maleness. See Anne Fausto-Sterling, ‘The Bare Bones of Sex’, Signs 30 (2005), pp. 1491-527.
5. Antonia Maioni, Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada (Princeton, NJ: Princeton University Press, 1998); Constance A. Nathanson, Disease Prevention as Social Change: State, Society and Public Health in the United States, France, Great Britain, and Canada (New York: Russell Sage, 2007).
6. They share additional tensions around sexuality, religion, race/ethnicity, immigration and social class. Nathanson, Disease Prevention as Social Change.
7. Keith Wailoo, Pain: A Political History (Baltimore: Johns Hopkins University Press, 2014).
8. Laura M. Carpenter, ‘On Remedicalisation: Male Circumcision in the United States and Great Britain’, Sociology of Health and Illness 32 (2010), pp. 613-30.
9. Edward O. Laumann, Christopher M. Mas, and Ezra. W. Zuckerman, ‘Circumcision in the United States: Prevalence, Prophylactic Effects, and Sexual Practice’, Journal of the American Medical Association 277 (1997), pp. 1052-7; John L. Wirth, ‘Current Circumcision Practices: Canada’, Pediatrics 66 (1980), pp. 705-08. Francophone Canada, which historically has hewed closer to continental European medical practices, never embraced routine foreskin removal.
10. As the medical specialty dedicated to children’s health, pediatrics has ‘owned’ the medical debate about male circumcision. However, obstetricians perform most routine circumcisions in hospitals, and urologists perform most medically indicated circumcisions. Pediatric urologists have played prominent roles in circumcision debates.
11. These are the journals in which AAP and CPS, respectively, have published their policy statements.
12. Carpenter, ‘On Remedicalisation’; Robert Darby, A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain (Chicago: University of Chicago Press, 2005); David L. Gollaher, Circumcision: A History of the World’s Most Controversial Surgery (New York: Basic Books, 2000).
13. Doris K. Cope, ‘Neonatal Pain: The Evolution of an Idea’, American Association of Anesthesiologists Newsletter 62 (1998), pp. 6-8; Bourke, The Story of Pain.
14. Cope, ‘Neonatal Pain’.
15. Cited in Elissa N. Rodkey and Rebecca Pillai Riddell, ‘The Infancy of Infant Pain Research: The Experimental Origins of Infant Pain Denial’, Journal of Pain 14 (2013), pp. 338-50, here p. 343.
16. For a fuller discussion, see Rodkey and Riddell, ‘The Infancy of Infant Pain Research’.
17. Bourke, The Story of Pain.
18. Viviana A. Zelizer, Pricing the Priceless Child: The Changing Social Value of Children (Princeton: Princeton University Press, 1985); Paula S. Fass, Children of a New World: Society, Culture, and Globalization (New York: NYU Press, 2006).
19. James Walvin (ed.), Manliness and Morality: Middle-Class Masculinity in Britain and America, 1800-1940 (Manchester: Manchester University Press, 1991), p. 1.
20. Christopher Dummitt, The Manly Modern: Masculinity in Postwar Canada (Vancouver: University of British Columbia Press, 2007); Michael Kimmel, Angry White Men: American Masculinity at the End of an Era (New York: Nation, 2013).
21. See, for example, the series of 25 letters about circumcision published in the British Medical Journal from July through November 1935.
22. Carpenter, ‘On Remedicalisation’; Darby, A Surgical Temptation. In the 1930s, roughly 1 in 3 British boys were circumcised; by the 1970s, roughly 6 in 100 were, mostly for religious reasons.
23. Canada instituted taxation-funded national health insurance in the late 1960s. Maioni, Parting at the Crossroads; Laumann et al., ‘Circumcision in the United States’.
24. Benjamin Spock, The Common Sense Book of Baby and Child Care (New York: Duell, Sloan and Pearce, 1946), p. 18. Spock revised his opinion about routine circumcision in the late 1970s.
25. Dummitt, The Manly Modern; Kimmel, Angry White Men; Wailoo, Pain.
26. Max Thorek, Modern Surgical Technique (Philadelphia, PA: Lippincott, 1938), p. 2021. Though a number of women psychologists (e.g., Margaret Gray Blanton, Myrtle McGraw, Frances K. Graham) were prominent in pediatric pain research from the 1910s through 1950s, their conclusions differed little from those of their male colleagues.
27. Wailoo, Pain.
28. Marc Berg, Rationalizing Medical Work (Cambridge, MA: MIT Press, 1997). The shift toward medicine as science in this period contributed to the rise of evidence-based medicine.
29. John S. MacKay, ‘More About Circumcision’, Canadian Medical Association Journal 95 (26 November 1966), pp. 1156-57.
30. E. Noel Preston, ‘Whither the Foreskin? A Consideration of Routine Neonatal Circumcision’, Journal of the American Medical Association 213 (14 September, 1970), pp. 1853-58.
31. Philip G. Klotz, [untitled letter] Canadian Medical Association Journal 95 (26 November 1966), p. 1157.
32. Michael A. Messner, Politics of Masculinities: Men in Movements (Lanham, MD: AltaMira Press, 1997); Christine Ramsay (ed.), Making It Like a Man: Canadian Masculinities in Practice (Waterloo: Wilfrid Laurier University Press, 2011).
33. H.C. Thompson, L.R. King, E. Knox et al., ‘Report of the ad hoc task force on circumcision’, Pediatrics 56 (1975), pp. 610-11.
34. Foetus and Newborn Committee, ‘Circumcision in the Newborn Period’, CPS News Bulletin Supplement 8 (1975), pp. 1-2.
35. Foetus and Newborn Committee, ‘Circumcision in the Newborn Period’, CPS News Bulletin Supplement 8 (1975), pp. 1-2.
36. Margaret Atwood, Survival: A Thematic Guide to Canadian Literature (Toronto: Anansi, 1972), as discussed in Ramsay, Making It Like a Man, p. xvi.
37. David A. Grimes, ‘Routine Circumcision of the Newborn Infant: A Reappraisal’, American Journal of Obstetrics and Gynecology 130 (1978), pp. 125-29.
38. Harvey Armstrong, ‘Circumcision’, Canadian Medical Association Journal 127 (15 September 1982), p. 459.
39. Joel Best, Threatened Children: Rhetoric and Concern About Child-Victims (Chicago: University of Chicago Press, 1990). Children’s rights organisations have largely ignored activist entreaties to take up circumcision as an issue.
40. Edgar Jones and Simon Wessely, ‘Psychological Trauma: A Historical Perspective’, Psychiatry 5 (2006), pp. 217-20.
41. Best, Threatened Children.

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42. Ellen Warner and Elliot Strashin, ‘Benefits and Risks of Circumcision’, Canadian Medical Association Journal 125 (1981), pp. 967-76, here pp. 973, 976.
43. John S. McKim, ‘Neonatal Circumcision’, Canadian Medical Association Journal 125 (1981), p. 955.
44. M. P. M. Richards, J. F. Bernal and Yvonne Brackbill, ‘Early Behavioral Differences: Gender or Circumcision?’, Developmental Psychobiology 9 (2013), pp. 89-95.
45. According to Thomson Reuters Web of Science Citation Index, search performed 8 March 2007. My analysis excludes the 1980 follow-up article discussed in note 44. Nine of the remaining 15 articles appeared in human development or psychology journals; three of these focused on sex differences in infant behaviour, none on circumcision or pain. David J. Rawlings, Patricia Anne Miller, and Rolf R. Engel, ‘The Effect of Circumcision on Transcutaneous PO2 in Term Infants’, American Journal of Diseases of the Child 134 (1980), pp. 676-78, here p. 678.
46. Yvonne Brackbill and Kerri Schroder, ‘Circumcision, Gender Differences, and Neonatal Behavior: An Update’, Developmental Psychobiology 13 (1980), pp. 607-14. Grassroots circumcision opponents have subsequently publicized and worked to produce research along these lines.
47. Paul S. Williamson and Marvel L. Williamson, ‘Physiological Stress Reduction by a Local Anesthetic During Newborn Circumcision’, Pediatrics 71 (1983), pp. 36-40, here p. 36. After the AAP and CPS mandated pain relief, circumcision lost much of its usefulness as a model for studying pain, insofar as there remained, in theory, no ‘anesthesia-free’ control group. The wave of research on gender and pain that began in the 1990s apparently did not investigate circumcision. Roger B. Fillingim, Christopher D. King, Margarete C. Ribeiro-Dasilva, Bridgett Rahim-Williams, and Joseph L. Riley, III, ‘Sex, Gender, and Pain: A Review of Recent Clinical and Experimental Findings’, Journal of Pain 10 (2009), pp. 447-85.
48. Steven Epstein, Inclusion: The Politics of Difference in Medical Research (Chicago: University of Chicago Press, 2007).
49. Anti-circumcision activism emerged in Britain in the 1990s, focused on assisting unhappy, already-circumcised adult men and reducing rates of medically indicated circumcision.
50. Elena Conis, Vaccine Nation: America’s Changing Relationship with Immunization (Chicago: University of Chicago Press, 2015).
51. For example, see Gloria Lemay, ‘Breastfeeding, Intact Penis, and Natural Immunity’, (23 March 2009), np. Retrieved from http://wisewomanwayofbirth.com/breastfeeding-intact-penis-and-natural-immunity/ [accessed 3 May 2012].
52. Cat Saunders, ‘One Woman, One Cause: Marilyn Milos and Genital Autonomy’, Verve (March 2002), np. Retrieved from https://www.drcat.org/articles-and-interviews/marylin-milos-circumcision-opponent/ on 5 December 2017. Milos told versions of this story at numerous public appearances and in the NOCIRC Newsletter 6 (Spring 1992), p. 2.
53. Author’s interviews with activists at the International Symposium on Genital Integrity, Berkeley, California, 30 July 2010; Messner, Politics of Masculinities.
54. NOCIRC cited S. Dixon, J. Snyder, R. Holve, and P. Bromberger, ‘Behavioral Effects of Circumcision With and Without Anesthesia’, Journal of Developmental and Behavioral Pediatrics 5 (1984), pp. 246-50. Overall, activists referenced some research that would be accepted as legitimate in conventional medical circles and some that would be judged as ‘fringe’ science.
55. ‘Circumcision Prejudice’, NOCIRC Newsletter 2 (Winter 1987), p. 5.
56. On health social movements employing embodiment by proxy, see Harmony D. Newman and Laura M. Carpenter, ‘Embodiment without Bodies: Analysis of Embodiment in the Pro-Breastfeeding and Anti-Male Circumcision Movements’, Sociology of Health and Illness 36 (2014), pp. 639-654.
57. Jones and Wessely, ‘Psychological Trauma’. The research activists drew on generally did not make this claim.
58. ‘The Second International Symposium on Circumcision: Highlights’, NOCIRC Newsletter 5 (Fall 1991), p. 1.
59. ‘Birth Trauma Leads to Suicide And Drug Abuse’, NoCirc Newsletter 2 (Spring/Summer 1987), p. 8.
60. ‘Letters to the Editor’, NOCIRC Newsletter 6 (1992, spring), p. 4.
61. Jed Diamond, ‘The Silent Knife – Why Isn’t Circumcision a Men’s Issue’, NOCIRC Newsletter 6 (Fall 1992), p. 6.
62. Edward Wallerstein, ‘Is Non Religious Circumcision Necessary?’, Journal of the American Academy of Child Psychiatry 24 (1985), pp. 364-65.
63. See P. J. McGrath, ‘Science is Not Enough: The Modern History of Pediatric Pain’, Pain 152 (2011), pp. 2457-59.
64. Williamson and Williamson, ‘Physiological Stress Reduction by a Local Anesthetic During Newborn Circumcision’, p. 36.
65. In fact, traditional ideals for manliness experienced something of a renaissance in the late 1980s, when some participants in the North American men’s movement began seeking a more ‘authentic’ masculinity and others framed women, especially feminists, as the problem and traditional masculinity as the solution; still others became feminist allies. See Michael A. Messner, ‘Forks in the Road of Men’s Gender Politics: Men’s Rights vs. Feminist Allies’, *International Journal for Crime, Justice, and Social Democracy* 5 (2016), pp. 6-20.

66. Williamson and Williamson, ‘Physiological Stress Reduction by a Local Anesthetic During Newborn Circumcision’.

67. N. Wellington and M. J. Rieder, ‘Analgesia for Newborn Circumcision’, *Pediatrics* 92 (1993), pp. 541-43.

68. Murray S. Katz, untitled letter, *CMAJ* 155 (1 September 1996), pp. 507-08, here p. 508.

69. Cynthia R. Howard, Fred M. Howard, and Michael L. Weitzman, ‘Acetaminophen Analgesia in Neonatal Circumcision: The Effect on Pain’, *Pediatrics* 93 (1994), pp. 641-46.

70. Anna Taddio, Joel Katz, A. Lane Ilersich and Gideon Koren, ‘Effect of Neonatal Circumcision on Pain Response During Subsequent Routine Vaccination’, *Lancet* 349 (1997), pp. 588-603; Anna Taddio, Morton Goldbach, Moshe Ipp, Bonnie Stevens, Gideon Koren, ‘Effect of Neonatal Circumcision on Pain Responses During Vaccination in Boys’, *Lancet* 345 (1995), pp. 291-92.

71. As before, pediatrics associations took the lead, with urology and obstetrics-gynecology associations either adopting the pediatricians’ policies or creating similar policies of their own.

72. CPS, ‘Neonatal Circumcision Revisited’, *Canadian Medical Association Journal* 154 (1996), pp. 769-80.

73. AAP Task Force on Circumcision, ‘Circumcision Policy Statement,’ *Pediatrics* 103 (1999), pp. 686-93.

74. ‘Answers To Your Questions About Infant Circumcision’. Brochure dated September 1995, retrieved from http://www.nocirc.org/publish/3pam.pdf. Accessed 1 November 2004.

75. ‘The Lost List’, NORM (circa 1999). Retrieved from http://www.norm.org/lost.html. Accessed 7 June 2006.

76. ‘A Case Against Circumcision’ [webcast], ABC News Chat with Dr George Denniston [founder of Seattle-based Doctors Opposing Circumcision] (6 July 2001). Retrieved from https://www.doctoropposingcircumcision.org/ [accessed 16 February 2006].

77. Robert Van Howe, ‘Pain Relief for Neonatal Circumcision: Serious Design Flaws?’,* Pediatrics* 103 (1999), p. 196.

78. Letter, 18 September 1998, retrieved from AGI website, http://www.courtchallenge.com/ [accessed 15 June 2009].

79. Letter, 23 October 1998, retrieved from AGI website, http://www.courtchallenge.com/ [accessed 15 June 2009].

80. In contrast, these parties appear to believe women who make similar claims about female genital cutting, and discount women who say they have not been harmed by FGC in these ways. See Laura M. Carpenter and Heather Hensman Kettrey, ‘(Im)perishable Pleasure, (In)destructible Desire: Sexual Themes in US and English News Coverage of Male Circumcision and Female Genital Cutting’, *Journal of Sex Research* 52 (2015), pp. 841-56.

81. Pam Belluck, ‘Doctors Reverse Stand on Circumcision’, *New York Times* (27 May 2010). Although some late-nineteenth and early-twentieth century Anglo-American physicians advocated clitorectomy (a.k.a. ‘female circumcision’) on girls for much the same reasons as they advocated male circumcision, the practice never gained widespread support. G. J. Barker-Benfield, *The Horrors of the Half-known Life: Male Attitudes Toward Women and Sexuality in Nineteenth-Century America*, second edition (New York: Routledge, 2004).

82. Rates in Canada range from virtually 0 per cent in Newfoundland and Labrador to 44 per cent in Ontario and Alberta. Maria Owings, Sayeedha Uddin and Sonja Williams, *Trends in Circumcision for Male Newborns in US Hospitals: 1979–2010*, (US) National Center for Health Statistics (August 2013); Public Health Agency of Canada, *What Mothers Say: The Canadian Maternity Experiences Survey* (2009). https://www.canada.ca/content/dam/phac-aspc/phac-aspc-rhs-ssg/pdf/survey-eng.pdf [accessed May 8, 2019].

83. Pam Belluck, ‘Doctors Reverse Stand on Circumcision’, *New York Times* (27 May 2010). Although some late-nineteenth and early-twentieth century Anglo-American physicians advocated clitorectomy (a.k.a. ‘female circumcision’) on girls for much the same reasons as they advocated male circumcision, the practice never gained widespread support. G. J. Barker-Benfield, *The Horrors of the Half-known Life: Male Attitudes Toward Women and Sexuality in Nineteenth-Century America*, second edition (New York: Routledge, 2004).

84. AAP, ‘Technical Report on Circumcision’, *Pediatrics* 130 (2012), pp. 756-85; Canadian Paediatric Society, ‘Newborn Male Circumcision’, *Paediatric and Child Health* 20 (2015), pp. 311-15.

85. Messner, ‘Forks in the Road’; Hans Rollmann, ‘Patriarchy and Higher Education: Organizing around Masculinities and Misogyny on Canadian Campuses’, *Culture, Society & Masculinities* 5 (2013), pp. 179-92.