

## Anthropology and Circumcision: Why So Us and Them?

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Panel: Male and Female Genital Surgeries

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Anthropological attention to culturally and socially motivated genital modification tends to be strictly gendered, insofar as procedures affecting female genitals are widely discussed by anthropologists, while consideration of procedures affecting male genitals hardly appears at all, despite widespread agreement that such practices are considerably more common<sup>1</sup>. This state of affairs in the discipline originally led me to think that I should focus my work on male circumcision, but I have since arrived at the notion that what we need is nothing short of an entirely new paradigm for the anthropological consideration of human genital modifications, one in which the gender of the body being modified is itself not a relevant element of the practice compared to who elects the modification, the complexity of the modification, the extent of its occurrence, and the meanings attributed to the practice by those directly and indirectly involved with its performance. This approach differs from that typical up until now because the overwhelming majority of anthropological attention to genital modification, whether culturally, socially, religiously, or medically motivated has been characterized by a markedly differential treatment on the basis of gender and a systematic exception from analysis of genital modifications practiced within the anthropologists' own societies.

Even when both male and female modifications are considered in the literature, they tend to be categorized as such, frequently imposing an artificial separation of practices that fails to reflect the cultural sensibilities of those whose beliefs and behavior is under analysis. After a decade of reflection that began when I read *Wombs and Alien*

*Spirits* (Boddy 1989) as an undergraduate and three years of my doctoral research, I have arrived at the conclusion that this state of affairs in the discipline reflects the relative normalization of male circumcision in the United States, Europe, and other European descendant societies<sup>2</sup>.

I feel it important to state at the outset that I approach this set of practices and their attendant discourses from the perspective of critical medical anthropology, which does not accept biomedical knowledge as factual a priori, but rather seeks to contextualize it within the socially and culturally relevant system of knowledge that has produced it (Kleinman 1995; Rhodes 1996; Romanucci-Ross et al 1997; Lock and Scheper-Hughes 1996), and which commonly frames its inquiries around a focus on the human body (Scheper-Hughes and Lock 1987; Lindenbaum and Lock 1993). Critical medical anthropology is not only an intellectual exercise; like any appropriately engaged anthropology it seeks to apply the knowledge it produces to the real lives of people in the real world in the hopes of improving the social conditions of those who interact with institutionalized medical systems (Chrisman and Johnson 1996; Lindenbaum and Lock 1993; Morsy 1996; Singer 1995). This is the approach that has guided my ethnographic research on parental decision making about neonatal male circumcision in the United States; my choice of topic and site reflects not only the concerns of a critical medical anthropology, but also the strengthening trends toward anthropology as cultural critique and the United States as an appropriate site for anthropological fieldwork (Marcus and Fischer 1986; Ginsburg 2006).

In the course was quite surprised to find upon extensive review of the literature that very few anthropological voices are present amidst the cacophony of physicians,

ethicists, historians, and activists who have participated in, investigated, and commented on the widespread and controversial transformation of non-religious childhood male circumcision from a medical treatment to a social norm in the Anglophone world. So this is the direction from which I am approaching this issue and the background which informs my call for a new approach. And of course, no paper on this topic is complete without the requisite disclaimer about language and terminology: to the extent that language reflects embedded ideology, I strive to use value neutral terminology and/or terms that reflect the accepted usage of the groups of people whose practices are being discussed. So when I use acronyms such as FGM, MGM, or simply GM, please understand that the “M” stands for modification rather than mutilation.

This panel represents a departure in certain respects from typical approaches characterized by certain persistent features: male and female modification practices are treated as categorically separate; African practices tend to be treated categorically apart from practices undertaken in other parts of the world; and practices promulgated by European and European descendant biomedical traditions, when they are considered at all, are considered ‘medical’ practices separate and apart from ‘cultural’ practices. These characteristics are present in the overwhelming majority of governmental, institutional, legislative, human rights, activist, and popular discourses. There are exceptions of course, but they rarely represent the mainstream perspective of their respective disciplines. In this paper I am attempting to outline a different set of categories for the conceptual organization of those human behaviors that modify the genital structures. Of course, even by widely applying the category of genital, with all of its associations and implications, we risk universalizing, we risk seeing expressions of diverse meaning in

ways deeply colored by things taken for granted about the world that in fact not everyone takes for granted. The two key differences are that the categories of analysis I propose are neither gender-based nor exceptionalist in the ways I just described.

The alternative is necessarily based on collective categories that include modification practices that are not necessarily related in the minds of the people who practice them. Some anthropologists have criticized the collective category of “female circumcision” or “FGM” or “FGC”, because it conflates unrelated practices into a single universal collective (e.g. Shell-Duncan et al 2000; Ahmadu 2000), but most writers on the topic, anthropological and otherwise, are quite comfortable addressing a generic FGM. Less commonly, scholars have leveled similar criticisms at the category of “male circumcision,” which likewise includes a wide variety of both meanings and physical operations (Silverman 2004:420-421). To my mind, collective categories are not in and of themselves necessarily problematic; to an extent they are necessary for us to talk meaningfully about human behavior in broad general terms. Problems with collective categories arise based on what the criteria are by which different or unrelated practices are included in a given collectivity. The alternate categories that I propose are designed in part to address some of the problems with collective categories that have been identified by other scholars. I will explain what these categories are, and I will also explain the justifications for a non-gendered, non-exceptionalist approach. Given the scope and nature of my comments, I am necessarily speaking in broad general terms. My point is to try and provoke new ways of fundamentally thinking about what socially motivated genital modification is; this is necessarily a sketchy and unrefined model, but hopefully one that will motivate anthropologists and others to think more critically about

the taken-for-grantedness of the categories of male and female genital surgeries as they have been deployed thus far by the majority of scholars writing on the subject.

First of all, I believe that we should be differentiating genital modifications on the basis of who is electing them. If any of these procedures are to be problematized from a human rights perspective, as female genital modifications are commonly and male genital modifications are occasionally, it seems reasonably evident that this should be done not strictly on the basis of gender, as is currently typical, but rather on the basis of whether the modification is freely elected by the individually whose body is in questions, or chosen by someone other than themselves. This point is commonly made in the legal and bioethical literature, and I believe that there is value for anthropology as well to recognize this difference. There are appropriate limits to relativism, and I believe that an appropriate pluralism is one in which people are free to do what they please in accordance with their local standards of appropriate behavior, but not necessarily free to do what they please to others, without the permission and participation of those others in the decision making process.

Secondly, if this applies to anyone, it should apply to everyone. I believe it to be of utmost importance that we not exclude any practices from our analysis, especially those genital modification practices that we take for granted as ordinary or unremarkable because they are familiar to us or because they are practiced widely in our own society or cultural group. The category of genital modification, whether male, female, or human, includes unrelated practices that have in common only an alteration of the genital structure. If we are going to use such categories to classify and analyze human behavior, categories that collect practices unrelated in the minds of those who engage in them, then

we are very hard pressed to justify the inclusion of some practices and not others. Local meanings are of course very important; that is to say that how people understand what they are doing is a necessary component of any analysis. But when we talk *collectively* about something like circumcision, for example, it does us no good to build in blind spots. In cases where we limit our analysis to certain societies or geographic regions, or to practices understood by their practitioners in a certain way, then we must be explicit about our justifications for doing so. It is not self-evident why the socially motivated genital modification of children in one set of societies is important to discuss together in a collective way while the childhood genital modifications widespread in our own society can unmentioned.

The degree of complexity of the modification is another important aspect for classifying and organizing genital modification. As we are all likely aware, this is a common feature in the FGM literature, and I think that it is a useful exercise as long as we apply it without exception, which is to say not exclusively to African women. Any genital modification can be described in terms of its extent or complexity: is tissue cut, is tissue removed, is the structure modified in part or in whole, is scar tissue intentionally or unintentionally created, are movable parts removed, are structures enlarged or elongated, are objects installed or implanted, and so on. Traditionally in anti-FGM discourse these distinctions are used as a basis to measure the harmfulness of various operations, but I want to make clear that I see the point of such a classification explicitly not as a measure or prediction of harm, because if a modification is desirable for an individual, then framing outcomes in terms of harmfulness is inappropriate and inaccurate. To my mind, the point of classifying modifications in terms of complexity is to facilitate the

appropriate measures for addressing potential complications. A highly complex modification that fundamentally alters the structure of the genitals likely involves a higher potential for complication than a minor modification that does not appreciably modify the structure of the genitals. I want to be clear that the potential for complications should not itself be used as a measure to discuss harmfulness, as complications are never part of the intended outcome of a genital modification. In my opinion, the appropriate contexts to consider genital modifications harmful are when they are performed against the will of or without the consent or knowledge of the individual whose body is being modified. I feel comfortable asserting that in the overwhelming majority of cases, causing harm is not a motivation for the performance of genital modification, and thus (apart from helping to understand why and how a given modification is important to the practitioners) the point of considering the complexity of modification is to help understand the potential for and address any possible complications.

Next, I believe there is a need to classify GMs on the basis of the extent of the occurrence of the modification; this is crucial to understanding the meanings inherent in a given practice and the role it plays in a particular society. Is most every member of a given society modified? Are only some people modified? Most every member of a certain group within a society, like members of a particular religion or group of initiates? Only members of an economically elite class that can afford expensive procedures? This kind of classification leads directly into the final category, which is local meaning. How is a given GM practice understood by the people who are practicing it? What motivates them, what do they understand to be the benefits or the results or the purpose of the modification in question? A good deal of anthropological work on genital modification

thus far has focused on these kinds of questions, and no doubt will continue to. I personally think that this particular category is the most appropriate for cross-cultural comparisons; in terms of initiation or status, or aesthetics, or sexual enhancement, or whatever it is that people understand to be important enough to justify or require them to modify their genitals in particular ways.

I will now comment on the justifications for what I see as my main points of departure from current anthropological work on circumcision: gender and exceptionalism. These departures are of course related, because the overwhelming majority of genital modifications performed in European and European descendant societies, including the United States, are performed on males. So by excepting those practices that are considered normal or familiar, we are simultaneously enforcing a gender based approach. So what about a gender-based approach? If I may quote William Burroughs only slightly out of context: “what’s wrong with that? Just about everything.” My main criticisms are that gender based categories implicitly construct a universal meaning for gender; they serve to differentiate procedures that are understood by practitioners to be related (such as initiation rites in which both male and female members of a social group have their genitals modified); and they allow for the categorical exception of the overwhelming majority of genital surgeries performed in the U.S. and Europe. No less than fifteen years ago Nancy Scheper-Hughes pointed out the profound disparity in the character of anthropological voices on male and female genital surgeries (1991:28), but since then virtually no one has taken up her call, although Bell offered a very well-reasoned analysis of why this gender disparity persists based on how

Westerners tend to think about male and female bodies in relation to dominant conceptions of sexuality (Bell 2005).

The foundation of my approach is of course the social constructionist approach to gender. The current gender-based differential paradigm for genital modification is implicitly derived from a naturalistic model of gender that relies on the presumption of universal meanings of maleness and femaleness. Lurking beneath the surface of this model is a kind of implicit sociobiology or biological determinism, because creating universal categories based on gender implicitly presumes some universal aspect of gender meanings beyond the biology of reproduction, which is itself perhaps not so universally accepted as we might like to believe (Shilling 2003:47-48). Even if we accept the notion that the biology of reproduction is shared universally across the human species, the meanings associated with it are not; that is to say that while biologically male, female, and intersex individuals occur in every human society, what it means to be masculine or feminine varies quite widely across societies (Brettell and Sargent 2005). In simpler terms, the meanings associated with gender are not universal, they are variable.

I believe that most, if not all, anthropologists agree that the meanings and understandings associated with gender are not universal across the human species, they are socially constructed and thus vary from society to society. But what about the body itself? Might there be something intrinsic about male and female bodies that justifies this kind of categorization of genital surgeries? That question was effectively addressed by Bell (2005), who points out that the particular understandings of male and female bodies on which such assertions rely are specific to certain societies at certain times in history; to her analysis I would add that I personally find it very difficult to argue for the

universality of sex as a biological feature without getting caught in the naturalistic models of the body that have been so widely discussed and disclaimed by anthropologists, philosophers, and historians. As a species we certainly share a basic biological condition, but I am cautious to not posit much more than that lest I find myself slipping into the kind of sex-based biological determinism that maintains that females and males are each inherently a certain way. I arrived at this position primarily under the influence of Butler (1993), Lancaster (2003), Laquer (1990), and to a lesser extent Shilling (2003). I understand that by saying this I am moving into terrain that is sometimes highly contested in our discipline; fortunately, my proposed categorization does not rely on nor require an acceptance that sex, as well as gender, is constructed; the fact that gender meanings are not universally shared across societies is sufficient justification to do away with collective categories that implicitly presume that they are.

I will now address the problematization of genital modifications in more depth. As many of my fellow panelists have pointed out here and in other work, there are serious problems with the way genital modification tends to be problematized. In mainstream human rights and international development discourse it is African FGM that is an issue, while genital surgeries on women and children in other contexts go unaddressed. Add to this the postcolonial context that informs almost any interaction between the so-called “West” and Africa (Mbembe 2001), and the hysterical and irrational justifications for intervention, and the status quo represented by this myopic zero-tolerance for African FGM is clearly untenable. Unfortunately however, even the most cogent critiques will not make this campaign simply go away, and there is no putting the genie back in the bottle, so to speak; I imagine that there is not a community

in the world that is so isolated that they are not aware of, if not directly affected by, this campaign. So how to proceed? I do not think that the international anti-FGM campaign will simply stop in its tracks and cease to exist because anthropologists say so. However, they might be persuaded to change the way they go about doing what they do.

As I mentioned before, I find the most compelling standard for determining what is and is not ethically or morally problematic in this regard to be choice and consent. This seems to me to be a reasonable compromise for addressing the difficult challenges that arise when some individuals within a given community or social group report the personal experience of negative consequences from having been genitally modified as children. I am not referring to medical sequelae or health complications, but rather to social, psychological, and emotional consequences. Of course, lots of people are quite happy to have been modified, but lots of people are quite unhappy about it as well. The reasons for this are no doubt as varied and complex as the procedures and consequences themselves, and a socially just solution appears to me to simply allow people to decide for themselves if their own values are important enough for them to choose genital modification for themselves.

When people are freely and willfully electing to have themselves modified, I find it very difficult to justify assertions that these are immoral choices. People make these kinds of decisions based on important reasons, whether social, religious, aesthetic, or personal. The zero-tolerance for anti-FGM approach implicitly and explicitly challenges the social, or religious, or aesthetic, or personal values which underlie and motivate genital surgery. It is not necessary to argue that the values underlying such a choice are wrong to suggest that individuals should have the opportunity to make their own choices

based on their personal feelings about those values. Parents raise children with values and identities derived from their own, but when those children become adults, some of them will arrive at their own identities or values that do not reflect those of their parents. I am not making the claim that for some sort of natural right that allows people to determine their own ethnic and religious identity when they become adults; instead I am simply recognizing the fact that people all over the world make choices that lead them to ethnic and religious identities other than those with which they were raised as children. Of course, ethnicity and identity and religious or spiritual affiliation are complicated and contested constructions in every context in which they occur, and are ascribed to people as much as they are asserted. Nevertheless, individuals all over the world do end up shifting their own adult identity into something other than that with which they were raised. It seems to me to be a reasonable compromise to suggest that the body modifications associated with these values, be they ethnic, religious, social, aesthetic, or whatever, be left to the individuals to choose for themselves. When people are prohibited the opportunity to make such choices for themselves via modifications being made before they have reached an age or station when they can freely choose for themselves, then I believe we are witnessing situations that can legitimately be seen as morally and ethically problematic. Not because I am promoting some historically derived conception of natural rights for the individual, but because I recognize that people everywhere exhibit agency in terms of ethnic and religious identity. I want to be clear that I am not offering this as a justification for intervention, I am suggesting that this is a less controversial message to be carried by those institutions that have already made it their business to be intervening. This should be our message to the international anti-FGM campaign; not

that the values underlying parents' choice to modify their children are wrong, but that the children should be allowed to express their own acceptance of those values when they are old enough to do so.

But this is only a legitimate proposition if we express this position without exception, and it is our own legacy of exceptionalism regarding genital modification on which I wish to make my concluding comments, by examining U.S. genital modification practices in the terms which I have outlined. First of all, the practices to which I am referring are all suitable candidates for ethnographic study to elucidate the motivations and meanings experienced by the people involved in their practice. Instead of pursuing this line, I instead want to attempt to apply the classificatory scheme I outlined. First of all what is the extent of the occurrence of genital modification in the US? Elective genital surgery is available from medical professionals for both men and women in the United States, and may be motivated by body image, sexuality, aesthetics, religious conversion, or social concerns (Androus 2006; Gazzano 2006). Reliable national statistics are not available for the rates of these operations, but based on available information, it is safe to assume that these procedures are not particularly widespread; for example, between 1995 and 2000 one clinic in a southern U.S. town of approximately 50,000 performed just over one hundred adult circumcisions (Fink et al 2002:2113). Reliable statistics for elective female genital surgery in the United States are also unavailable, but it has received much more attention in the media; a surgeon in Florida told a reporter that he performs four to five such surgeries a day, while the aptly named Dr. Alter of Beverly Hills reports performing an average of 40 such surgeries a month; however these numbers must be considered anecdotal at best (Green 2005:172).

An indeterminate number of Americans also participate in so-called ‘alternative’ genital modifications, including the installation of pierced jewelry and, less frequently, modifications performed by non-medical professionals and avocational practitioners, such as excision, infibulation, elongation, penile bifurcation, glansctomy, meatotomy, penectomy, and castration. Again, reliable statistics are not available, but anecdotal evidence suggests that these are not particularly common, with the possible exception of pierced genital jewelry, the installation of which is widely available at the consumer level. By far the most common genital modification procedure practiced in the United States is neonatal male circumcision, with hundreds of thousands of male infants circumcised each year by either medical professionals (National Center for Health Statistics 2005) or specialized religious practitioners. In terms of extent, this is by far the most widespread and common practice, and clearly the one that is most normalized; it is not common for urologists or gynecologists to routinely inquire if their adult patients desire circumcision or labial trimming, whereas it is quite routine for parents of boys to be asked if they want circumcision for their child.

Should any of these practices be considered problematic? Insofar as they are elected by the individuals on whom they are performed, I am not interested in attempting to problematize the aesthetic or so-called ‘alternative’ genital modifications practiced in the United States, even such radical practices as elective castration or penectomy. Of course, I would recommend that such irreversible procedures only be undertaken after lengthy reflection and consultation with appropriate experts, but those considerations withstanding, there is nothing that appears to me be inherently problematic about the relatively few individuals who choose such procedures for themselves. The GM

practices that I do think should be considered problematic are those elected without the consent of the individuals on whom they are performed, namely the circumcision of male infants. The majority of these surgeries in the United States are performed for social reasons rather than religious or ritual requirements, but all of them are subject to the same critique in terms of consent. As I explained before, I am not arguing against religiously or ethnically motivated genital modification per se; I am instead arguing that individuals should be allowed to undertake these procedures themselves once they are old enough to decide for themselves if they wish to share in the religion and tradition of their parents. And since we are American anthropologists discussing an American cultural practice, the criticism of the interventionist anti-FGM discourse do not apply here. Instead, it is an entirely appropriate application of anthropological knowledge to our own society.

As to non-religious neonatal circumcision, the Anglophone bioethical literature has quite a bit to say about the questions of proxy consent and cosmetic surgery, but precious little to say about male circumcision, despite its prevalence and the widespread characterization of the practice as socially motivated cosmetic surgery. A striking contrast appears to me between the mainstream medical and bioethical positions on childhood surgeries generally and the mainstream medical and bioethical positions on neonatal male circumcision particularly. As is so often the case, male circumcision appears to be an unjustified exception. On the one hand we have the mainstream position represented by the AAP Committee on Bioethics which advises that “providers have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses. Although impasses regarding the interests of minors and the expressed wishes of their parents or guardians are rare, the

pediatrician's responsibilities to his or her patient exist independent of parental desires or proxy consent" (315). This is echoed in the advice of bioethicist Adrienne Asch to parents of children with atypical bodies when she "urge[s] delaying all appearance-altering surgery until children can participate in the deliberations" (2006:228). On the other hand we have the AAP statement on circumcision which authorizes parents alone to "determine what is in the child's best interests" in cases in which "the procedure is not essential to the child's current well-being" (Lannon et al 1999:691). This conclusion was echoed in the American Journal of Bioethics four years later by neurologist Michael Benatar and ethicist David Benatar who found that neonatal male circumcision "is a suitable matter for parental discretion" (Benatar and Benatar 2003:35). It is ironic that conflict between child patients' interests and the wishes of their parents is described as rare, given the millions of circumcisions that have been performed in our lifetimes. The contradictions between neonatal circumcision and all other pediatric surgeries are startlingly apparent, and this raises two questions: why is male circumcision the exception, and what is the appropriate response from medical anthropology? I think that the first question has been ably answered by the social historians (e.g., Darby 2003, 2005; Glick 2005; Gollaher 1994, 2000); as to the second question, I feel that it is hardly revolutionary to say that medical anthropology, especially a critically applied medical anthropology, should point out the cultural blind spots that have led to the creation of double standards in medical practice, and socially motivated genital surgery should be a decision made by the individual, in accordance with the standards of pediatric bioethics. Custom is not a valid justification for making so widespread an exception to accepted standards of professional medical practice.

There are several complicated challenges that face anthropologists who wish to engage the questions currently swirling around the various practices of male and female genital surgeries. Potential solutions are neither a naïve relativism that prohibits us from speaking against any practice shielded by the mantle of culture, nor is the solution an uncritical exceptionalism based on our own cultural comfort zones; the solution is a new way of thinking about socially and culturally motivated human genital modifications that is comprehensive, creative, compassionate, and committed to social justice for all people, male, female, and intersex alike.

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<sup>1</sup> Reliable statistics are simply unavailable for males or females; most estimates suggest 100 to 140 million females are genitally modified, which works out to something in the neighborhood of 5% (Abu-Sahlieh 2001:13; Rahman and Toubia 2000:6,13), while estimates for the number of males genitally modified range from about one-sixth or 17% (Williams and Kapila 1993:1231) to one-third or 33% (Crawford 2002:259).

<sup>2</sup> In Europe non-religious male circumcision is uncommon, but religiously motivated male circumcision is considered unremarkable relative to female genital modification (see Gazzano and Androus 2006). In the Anglophone world, medicalized male circumcision was widely promoted from the late nineteenth century to the late twentieth century, entrenching it as a social norm, especially in the United States (see Darby 2005; Gollaher 2000; Glick 2005).

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## References Cited

- Abu-Sahlieh, Sami A. Aldeeb  
2001 Male and Female Circumcision Among Jews, Christians, and Muslims: Religious, Medical, Social, and Legal Debate. Warren Center: Shangri-La.
- Ahmadu, Fuambai  
2000 Rites and Wrongs: A Insider/Outsider Reflects on Power and Excision. *In* Female "Circumcision" in Africa: Culture, Controversy, and Change. Bettina Shell-Duncan and Ylva Hernlund, eds. Pp. 283-312. Boulder: Lynne Reinner.
- Androus, Zachary  
2006 Fitting In and Getting Off: Adult Elective Circumcision in the United States. Paper presented at the Ninth International Symposium on Circumcision and Human Rights, University of Washington, Seattle, Washington.
- Asch, Adrienne  
2006 Appearance-Altering Surgery, Children's Sense of Self, and Parental Love. *In* Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality. Erik Parens, ed. Pp. 227-252. Baltimore: Johns Hopkins University Press.
- Bell, Kirsten  
2005 Genital Cutting and Western Discourses on Sexuality. *Medical Anthropology Quarterly* 19(2):125-148.
- Benatar, Michael and David Benatar  
2003 Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision. *American Journal of Bioethics* 3(2):35-48.
- Boddy, Janice  
1989 Wombs and Alien Spirits: Women, Men, and The *Zār* Cult in Northern Sudan. Madison: University of Wisconsin Press.
- Burroughs, William S.  
1993 Words of Advice for Young People. *From Spare Ass Annie and Other Tales*. New York: Island Records.
- Butler, Judith  
1993 *Bodies That Matter: On the Discursive Limits of "Sex."* New York: Routledge.
- Brettell, Caroline B. and Carolyn F. Sargent, eds.  
2005 The Cultural Construction of Gender and Personhood. *In* *Gender in Cross-Cultural Perspective*, 4<sup>th</sup> ed. Pp. 185-190. Upper Saddle River: Prentice Hall.
- Chrisman, Noel J. and Thomas M. Johnson  
1996 Clinically Applied Anthropology. *In* *Handbook of Medical Anthropology: Contemporary Theory and Method*, revised edition. Carolyn F. Sargent and Thomas M. Johnson, eds. Pp. 88-109. Westport: Greenwood.
- Crawford, D.A.  
2002 Circumcision: A Consideration of Some of the Controversy. *Journal of Child Health Care* 6(4):259-270.
- Darby, Robert  
2003 The Masturbation Taboo and the Rise of Routine Male Circumcision: A Review of the Historiography. *Journal of Social History* 36(3):737-757.

- 
- 2005 *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain*. Chicago: University of Chicago Press.
- Fink KS, CC Carson, and RF DeVellis  
2002 Adult Circumcision Outcomes Study: Effect on Erectile Function, Penile Sensitivity, Sexual Activity and Satisfaction. *Journal of Urology* 167(5): 2113-6.
- Gazzano, Noel  
2005 *Rituali Biomedici: Le Donne e L’Incorporamento Biomedico del Genere in Contesti Sanitari Italiani [Biomedical Rituals: Women and the Biomedical Embodiment of Gender in Italian Healthcare Environments]*. PhD dissertation, Laboratori di Antropologia e Etnologia, Università degli Studi di Firenze e di Torino
- Gazzano, Noel E. and Zachary T. Androus  
2006 *Un Preciso Obbligo Personale: Ritual Circumcision in Contemporary Italian Bioethical Discourse*. Paper presented at the 105th Annual Meeting of the American Anthropological Association, San Jose, CA.
- Ginsburg, Faye  
2006 *Ethnography and American Studies*. *Cultural Anthropology* 21(3):487-495.
- Glick, Leonard B.  
2005 *Marked In Your Flesh: Circumcision From Ancient Judea to Modern America*. Oxford: Oxford University Press.
- Gollaher, David L.  
1994 *From Ritual to Science: The Medical Transformation of Circumcision in America*. *Journal of Social History* 28(1):5-36.  
2000 *Circumcision: A History of the World’s Most Controversial Surgery*. New York: Basic.
- Green, Fiona J.  
2005 *From Clitoridectomies to ‘Designer Vaginas’: The Medical Construction of Heteronormative Female Bodies and Sexuality Through Female Genital Cutting*. *Sexualities, Evolution, and Gender* 7(2):153-187.
- Kleinman, Arthur  
1995 *Writing at the Margin: Discourse Between Anthropology and Medicine*. Berkeley: University of California Press.
- Lancaster, Roger N.  
2003 *The Trouble With Nature: Sex and Science in Popular Culture*. Berkeley: University of California Press.
- Lannon, Carole M., Ann Geryl Doll Bailey, Alan R. Fleischman, George W. Kaplan, Craig T. Shoemaker, Jack T. Swanson, and Donald Coustan  
1999 *American Academy of Pediatrics: Circumcision Policy Statement*. *Pediatrics* 103(1):686-693.
- Laquer, Thomas  
1990 *Making Sex: Body and Gender From the Greeks to Freud*. Cambridge: Harvard University Press.
- Lindenbaum, Shirley, and Margaret Lock, eds.  
1993 *Preface*. In *Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life*. Pp. ix-xv. Berkeley: University of California Press.

- 
- Lock, Margaret, and Nancy Scheper-Hughes  
1996 A Critical-Interpretive Approach in Medical Anthropology: Rituals and Routines of Discipline and Dissent. *In Handbook of Medical Anthropology: Contemporary Theory and Method*, revised edition. Carolyn F. Sargent and Thomas M. Johnson, eds. Pp. 41-70. Westport: Greenwood.
- Marcus, George E. and Michael M.J. Fischer  
1986 Anthropology as Cultural Critique: An Experimental Moment in the Human Sciences. Chicago: University of Chicago Press.
- Mbembe, Achille  
2001 On the Postcolony. Berkeley: University of California Press.
- Morsy, Soheir A.  
1996 Political Economy in Medical Anthropology. *In Handbook of Medical Anthropology: Contemporary Theory and Method*, revised edition. Carolyn F. Sargent and Thomas M. Johnson, eds. Pp. 21-40. Westport: Greenwood.
- National Center for Health Statistics  
2005 Trends in circumcisions among newborns. Electronic document, <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/circumcisions/circumcisions.htm>, accessed July 28, 2006.
- Rahman, Anika and Nahid Toubia  
2000 Female Genital Mutilation: A Guide to Laws and Policies Worldwide. London: Zed.
- Rhodes, Lorma Amarasingham  
1996 Studying Biomedicine as a Cultural System. *In Handbook of Medical Anthropology: Contemporary Theory and Method*, revised edition. Carolyn F. Sargent and Thomas M. Johnson, eds. Pp. 165-180. Westport: Greenwood.
- Romanucci-Ross, Lola, Daniel E. Moerman, and Laurence R. Tancredi, eds.  
1997 Preface: The Cultural Context of Medicine and the Biohuman Paradigm. *In The Anthropology of Medicine: From Culture to Method*, third edition. Pp. ix-xiv. Westport: Bergin and Garvey.
- Scheper-Hughes, Nancy  
1991 Virgin Territory: Male Discovery of the Clitoris. *Medical Anthropology Quarterly* 5(1):25-28.
- Scheper-Hughes, Nancy and Margaret M. Lock  
1987 The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly* 1(1):6-41.
- Shell-Duncan, Bettina, Walter Obungu Obiero, and Leunita Auko Muruli.  
2000 Women Without Choices: The Debate Over Medicalization of Female Genital Cutting and Its Impact on a Northern Kenyan Community. *In Female "Circumcision" in Africa: Culture, Controversy and Change*. Bettina Shell-Duncan and Ylva Hernlund, eds. Pp. 109-128. Boulder: Lynne Reinner.
- Shilling, Chris  
2003 *The Body and Social Theory*, 2<sup>nd</sup> ed. London: Sage.
- Silverman, Eric K.  
2004 Anthropology and Circumcision. *Annual Review of Anthropology* 33:419-445.

---

Singer, Merrill

1995 Beyond the Ivory Tower: Critical Praxis in Medical Anthropology. *Medical Anthropology Quarterly* 9(1):80-106.

William, N. and L. Kapila

1993 Complications of Circumcision. *British Journal of Surgery* 80:1231-1236.