‘Where Doctors Differ’:
The Debate on Circumcision as a Protection against Syphilis, 1855–1914

By ROBERT DARBY*

SUMMARY. During the late nineteenth and early twentieth centuries there were two views on the relationship between syphilis and male circumcision: one was that circumcision provided protection against syphilis, another that circumcision was itself a significant source of syphilitic infection. This article reviews this debate, relates the first view to an influential article by Jonathan Hutchinson in 1855 and considers the subsequent use made of his statistics. It is suggested that the original statistics were of dubious value and that the promise of protection against syphilis was an additional argument for doctors who were keen to introduce universal circumcision of male infants for other reasons, the most significant of which was related to the conviction that it would discourage masturbation. The article further considers the controversy over whether Jews were healthier than other peoples, and the interaction among medical, moral, and customary/religious reasons for circumcising boys, and concludes that, while the operation never played any role in the control of syphilis, circumcision was indeed a significant cause of illness and death among male infants before the standardization of aseptic operating techniques.

KEYWORDS: circumcision, foreskin, syphilis, venereal disease, Jonathan Hutchinson, Abraham Wolbarst, E. Harding Freeland, masturbation, diseases of children.

Advocates of routine male circumcision have frequently sought to justify their policy by reference to the health value of amputating the foreskin, especially when the practice has been under attack. Defending the rite against Graeco-Roman critics, who regarded it as a barbarous mutilation,1 Philo Judaeus asserted that its practical benefit was the protection it conferred against a certain kind of carbuncle on the penis which he called anthrax.2 What he was referring to has never been clarified (perhaps chancroid?), but the idea that circumcision could save a man from venereal disease became popular as syphilis spread across Europe in the sixteenth century and doctors found themselves powerless to cure, or even significantly alleviate, its ravages. The proposition was sufficiently widespread in the late seventeenth century to attract the derision of Gideon Harvey,3 and in the mid-eighteenth century Robert James suggested a connection between the length of a man’s foreskin and his vulnerability to venereal disease: ‘Those who have their foreskins naturally very long are very much more easily infected by impure

* 15 Morehead Street, Curtin ACT 2605, Australia. E-mail: robjld@webone.com.au
3 Gideon Harvey, Great Venus Unmasked; or a More Exact Discovery of the Venereal Evil (London, 1672), p. 64.
embraces than others, as we learn from both reason and experience,\textsuperscript{4} he wrote in his Medicinal Dictionary, although he did not elaborate his reasoning or provide evidence. These ideas had little immediate impact, but they helped to create a climate of medical opinion which eased the introduction of circumcision as a treatment for masturbation, spermatorrhoea, and phimosis in the mid-nineteenth century.\textsuperscript{5} Venereal disease was rampant in the eighteenth century, but in the relaxed moral climate of that period it was seen more as a recreational hazard than a serious public health problem;\textsuperscript{6} in the more puritanical atmosphere of the Victorian age, however, it came to be viewed as ‘the monster social evil of the day’, as William Acton put it,\textsuperscript{7} a ‘most destructive enemy’ and a ‘foul and loathsome disease’, implying ‘a breach of the moral laws’.\textsuperscript{8} Society was desperate to find an effective means of cure or prevention. It was in this context that Jonathan Hutchinson declared that circumcision provided such significant protection against syphilis that it should be widely performed on male infants.

In his capacity as surgeon to the Metropolitan Free Hospital in London, Hutchinson recorded the incidence of venereal cases among his Jewish and non-Jewish patients during 1854 (see Table 1). On the basis of these figures, Hutchinson claimed that he had demonstrated a conclusion ‘long entertained by many surgeons of experience’, namely, that ‘the circumcised Jew is . . . very much less liable to contract syphilis than an uncircumcised person’, and the reason was obvious: circumcision rendered ‘the delicate mucous membrane of the glans hard and skin-like’. Hutchinson did not explain why a damaged (‘hard and skin-like’) glans should provide this protection, but he showed no such reticence when it came to the clinical implications. Given these facts, he suggested that it was probable that circumcision was by Divine command made obligatory upon the Jews, not solely as a religious ordinance, but also with a view to the protection of health . . . One is led to ask, witnessing the frightful ravages of syphilis in the present day, whether it might not be worthwhile for Christians also to adopt the practice.\textsuperscript{9}

On this point he was following ‘Dr Copland’s renowned Dictionary of Medicine’,\textsuperscript{10} one of the first medical texts to suggest that Judaic circumcision had a sanitary

\textsuperscript{6} R. Trumbach, Sex and the Gender Revolution: Heterosexuality and the Third Gender in Enlightenment London (Chicago, 1998), chs 1 and 7.
\textsuperscript{7} W. Acton, ‘On the Rarity and Mildness of Syphilis among the Belgian Troops . . .’, Lancet, 25 February 1860, 197.
\textsuperscript{8} Comments from 1850 and 1904, quoted in R. Davenport-Hines, Sex, Death and Punishment: Attitudes to Sex and Sexuality in Britain since the Renaissance (London, 1990), pp. 162–3.
\textsuperscript{9} J. Hutchinson, ‘On the Influence of Circumcision in Preventing Syphilis’, Medical Times and Gazette, NS II (1855), 542–3.
rather than strictly religious rationale, and that its chief value was to discourage masturbation. Such a small and unrepresentative statistical sample was a flimsy foundation on which to erect such an ambitious therapeutic edifice. All that Hutchinson’s observations showed was that, while non-Jewish venereal cases had more syphilis than gonorrhoea (60.6 to 39.3 per cent), Jewish cases had more gonorrhoea than syphilis (81 to 19 per cent). Although Hutchinson insisted that the high level of gonorrhoea among the Jews proved that less promiscuity could not have been the reason for the difference, the statistics revealed nothing about the relative susceptibility of cut and uncut men to venereal infection, and could as well be cited to show that circumcision increased the likelihood of getting gonorrhoea as to prove it offered protection against syphilis. Indeed, it is quite easy to manipulate these figures in such a way as to suggest a conclusion rather different from Hutchinson’s by comparing the syphilis cases with the Jewish and non-Jewish populations. In 1851 London held about 2,360,000 people, and in 1858 there were about 36,000 Jews in England, of whom two-thirds (24,000) lived in the metropolis. Taking Hutchinson’s patients as a proportion of the respective populations, we arrive at Table 2. It can readily be seen that circumcised Jews had a rate of syphilis infection many times higher than their gentile neighbours.

Nobody would take these extrapolations seriously, yet they are scarcely more illegitimate than the implications drawn from Hutchinson’s own figures, which were taken so seriously that for the next century they were regarded as the ‘hard data’ needed to prove the health-giving value of foreskin amputation. That nobody until the 1890s challenged them is an indication of how strongly the tide of medical opinion was running in favour of circumcision: any evidence would apparently do. Circumcision was already being urged as a treatment for masturbation, spermatorrhoea, and a number of other complaints, not all imaginary, by respectable scientists and physicians, and its advantages were claimed to be potent enough to make it a panacea rather than a cure for the ailments it was said to treat. On the contrary, the existing population of Jewish patients was said to have shown that circumcision was essential to the health of the race.

Table 1. Incidence of venereal cases among Hutchinson’s Jewish and non-Jewish patients during 1854

<table>
<thead>
<tr>
<th>Venereal cases</th>
<th>Gonorrhoea</th>
<th>Syphilis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Jews</td>
<td>272</td>
<td>107 (39.3%)</td>
</tr>
<tr>
<td>Jews</td>
<td>58</td>
<td>47 (81%)</td>
</tr>
</tbody>
</table>

Table 2. Number of cases of syphilis among Hutchinson’s patients, showing rate of cases as a proportion of the London population of Jews and non-Jews

<table>
<thead>
<tr>
<th>Syphilis cases</th>
<th>London population</th>
<th>Rate of syphilis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Jews</td>
<td>165</td>
<td>2,336,000</td>
</tr>
<tr>
<td>Jews</td>
<td>11</td>
<td>24,000</td>
</tr>
</tbody>
</table>

physicians,¹³ and it was Hutchinson’s own prior belief in the value of the operation which led him to make his observations at the hospital and communicate them to the medical press. He made clear that he was not writing primarily as a venereologist seeking a way of reducing the incidence of syphilis, but as an advocate of circumcision seeking arguments for its more frequent application to boys. He explains that he was ‘induced to communicate’ his experience of venereal cases in support of a paper by ‘my friend, Mr Cooper Forster, recommending the more general practice of circumcision as a preventive of certain diseases of childhood’; he had ‘long held a similar opinion’, with Forster, that it was ‘the duty of the surgeon invariably to remove the prepuce of infants born with congenital phimosis’.¹⁴ That was indeed the message of Forster’s article, which offered only the barest mention of syphilis but described congenital phimosis as a condition in which the child is ‘in perfect health’ yet wants to urinate a lot and ‘and frequently seizes the penis, as if it itched, and elongates the prepuce’.¹⁵ There is no space here to analyse the tragic medical misunderstanding by which the natural condition of the infant penis (a non-retractable foreskin) was turned into a pathological abnormality requiring surgical correction;¹⁶ the essential points are that Hutchinson was seeking evidence to support his colleague’s policy of circumcising boys who exhibited signs of phimosis; and that the main problem with phimosis was that it provoked boys to handle their penis and thus led to the greatest of all nineteenth-century sexual sins, masturbation.¹⁷

That (Sir) Jonathan Hutchinson (1828–1913) gained a reputation as Britain’s leading authority on syphilis is a sobering comment on the backwardness of British venereology in the nineteenth century. He is chiefly remembered for ‘Hutchinson’s triad’, three signs by which congenital syphilis could be recognized in young children,¹⁸ but his contribution to the understanding and treatment of the disease was insignificant compared with Ricord and Fournier, to say nothing of the German researchers who identified the bacterium.¹⁹ In personality, Hutchinson was a reserved and gloomy Quaker whose watchword was self-denial and who

¹⁸ Oxford Companion to Medicine (New York, 1986), I, p. 569. The signs were interstitial keratitis in the cornea of the eyes; nerve deafness; and notched teeth. See also the entry on ‘Venereology’, II, 1428.
rose early each morning to read the Bible, study his textbooks, and pray.20 In 1890, *Vanity Fair* described him as 'a great authority on defective and diseased eyes' and a 'sensitive man who tends his patients with quite fatherly care';21 but a modern scholar comments that his attitude to venereal patients was coloured by 'moral revulsion against sexual sin'.22 Hutchinson held deeply puritanical objections to non-procreative sex and regarded methods of contraception with 'disgust'; such practices were 'prejudicial to both moral and physical health'.23 Although he changed his mind on how best to control the spread of venereal disease via prostitution, he originally supported the Contagious Diseases Acts of the 1860s and even joined William Acton and James Paget in urging their extension from garrison towns to the general population.24 J. D. Oriel has described Hutchinson as not much interested in bacteriology and his response to the discovery of *Treponema pallidum* in 1906 as 'cool',25 yet it is surprising that he did not make a greater contribution in this area, since he had predicted that the cause of syphilis would be found in a micro-organism (or 'cryptogamic germ'), and had shown quite an advanced understanding of how the disease was transmitted. In a lecture to the London Pathological Society in 1876, he stated that syphilis was 'due to one virus which, having been introduced into the body by contagion, develops within it, with tolerable uniformity as regards stage and time'; the disease depended on 'a living material which is capable of self-multiplication, which breeds in the blood and tissues, and which is destined to pass through various stages of development'.26 Unfortunately, he seems to have heeded the *Lancet*‘s editorial advice not to waste time on such unimportant side-issues,27 and it was left to the French and German bacteriologists to make the discoveries which led to the development of a means to cure the disease, while Hutchinson himself turned from pursuing the cryptogamic germ to attacking the parts of male bodies which might harbour it.

Hutchinson’s suggestion for the surgical control of syphilis did not at first win much support. In 1860, in an influential paper which helped to prepare the ground for the Contagious Diseases Acts, William Acton proposed a quite different strategy. He observed that venereal disease was rare in Brussels and that among the Belgian troops the incidence of syphilis was only one in 56, compared with one in four among the London Foot Guards. He attributed the difference to a system of surveillance whereby the men were inspected each week and any found to be infected were required to reveal their sexual contacts, who were then examined in turn and sent to hospital for treatment if found to be diseased. He also felt that Belgian prostitutes were less aggressive than the English and not so obvious in the streets, leading to less patronage. Acton did not propose such an intrusive scheme

for England, merely the provision of washing facilities for the soldiers, but the implication was there for others to draw.28 In the 1880s, however, with the rise of the social purity movement and the success of the campaign to repeal the Contagious Diseases Acts, the blame for syphilis slowly shifted from female depravity to male lust, and the focus of the control strategy moved accordingly from inspecting prostitutes to curbing the adventurism of their clients. The double standard was to be equalized by imposing the rule of chastity on everybody, and in this context any means which restrained men’s sexual exuberance was considered useful.29 The main target of the social purity movement was masturbation, viewed not as a safe substitute for intercourse but, in Acton’s terms, as a premature awakening of the sex drive which would lead boys to prostitutes during adolescence;30 but many writers were sure that circumcision would as be as effective in protecting against syphilis as discouraging secret vice. In her Confidential Talks on Home and Child Life (1898), Mrs Henry deployed the most syrupy language to advocate the mutilation of both male and female genitals in the interests of moral and physical hygiene:

As a religious ordinance circumcision is still in existence among the Jews, and as some special forms of venereal disease became more and more manifest among other nations, while the Jews went almost entirely free, the discovery was made that the old rite had a value for both boys and girls as a cleansing and preventive process.

The foreskin bore ‘the mark of Satan’ and was ‘a spot of irritation and uncleanness which bred diseased imaginings’ as much as physical illness; but the remedy was at hand: ‘this harmless operation in the flesh of the little child removes the principal cause of that peculiar irritation that leads to secret vice, giving physical freedom from . . . downward-dragging self-consciousness’.31 By the turn of the century, it was accepted that the three main justifications for early circumcision were treatment of congenital phimosis (itself believed to be a cause of many nervous complaints, bed-wetting, epilepsy, cancer, and masturbation); diminishing the sexual appetite; and protecting against syphilis.32

Hutchinson’s enthusiasm for circumcision grew in step with this changing emphasis. In 1890, he issued ‘A plea for circumcision’ in which he insisted that ‘the superior cleanliness of a Hebrew penis’ was in itself an argument for the amputation of the foreskin: ‘It constitutes a harbour for filth, and is a constant source of

29 There is a vast literature on this: see Townsend, ‘Private Diseases in Public Discourse’, chs 2 and 3; Davenport-Hines, Sex, Death and Punishment, ch. 5; J. Walkowitz, Prostitution and Victorian Society: Women, Class and the State (Cambridge, 1980); E. J. Bristow, Vice and Vigilance: Purity Movements in Britain since 1700 (London, 1977).
31 Mrs S. M. I. Henry, Confidential Talks on Home and Child Life (Edinburgh, 1898), pp. 70–1, 74.
irritation. It conduces to masturbation and adds to the difficulties of sexual con-
tinence. It increases the risk of syphilis in early life, and of cancer in the aged.33 Later that year he published a further article in which he urged circumcision as a
disincentive to masturbation and regretted that public opinion would not permit
the introduction of castration as a more radical approach to the problem.34 Three
years later he was advising the circumcision of baby boys as ‘imperatively required
whenever the prepuce is unusually long and contracted at its orifice’, but adding
that the surgeon should also ‘avail himself of every possible opportunity of inducing
parents to have their male children circumcised’, an operation with ‘great advant-
ages’ on which he provided detailed procedural instructions. Although he stated
that the operation had ‘no drawbacks whatever’, he warned that haemorrhage was a
danger and that ‘many children have died after the operation as a consequence of
carelessness in this matter’.35 Hutchinson returned to the topic at the turn of the
century with a lecture, ‘The advantages of circumcision’, delivered at the Poly-
clinic and widely reported in British and US medical journals. He considered that
the strongest argument in favour of ‘the general practice of circumcision’ was that
it ‘would reduce the prevalence of syphilis’, in support of which opinion he cited
his statistics from 1854, ‘which proved’ that, while gonorrhoea was as common
among Jews as among Christians, syphilis was ‘much less frequent’. This fact
showed that it was not superior morality which gave Jews their ‘comparative
immunity’, but some ‘adventitious advantage’ which could only be ‘the absence of
the prepuce’; and not surprisingly, for it would be ‘difficult to contrive an append-
age more likely to facilitate the implantation of the syphilitic virus’. Hutchinson
assured readers that no measure for the prevention of syphilis was as efficient as
circumcision, but he made no mention of condoms (mass produced and available
since the 1880s),36 a silence consistent with his opposition to contraception as
morally unacceptable and physically harmful: any measure which made ‘irregular
sexual intercourse less dangerous’ was ‘injurious to the sense of decency . . . and
detrimental to the moral conscience of a community’. Circumcision did not
present this drawback: ‘Effected in early infancy, and with other avowed objects, it
would silently become the means of preventing . . . a loathsome and misery-
producing disease.’ The value of the operation would be enhanced by its effect in
diminishing the sexual appetite:

The only function which the prepuce can be supposed to have is that of maintaining the
penis in a condition susceptible of more acute sensation than would otherwise exist. It may
be supposed to increase the pleasure of the act and the impulse to it. These are advantages,
however, which in the present state of society can well be spared, and if in their loss some
degree of increased sexual control should result, one should be thankful.37

In other words, in controlling syphilis, circumcision was preferable to condoms or
health checks because it would discourage pre- and extra-marital sex.

34 Hutchinson, ‘On Circumcision as a Preventive of Masturbation’, Archives of Surgery, II (1890),
267–9.
36 Davenport-Hines, Sex, Death and Punishment, p. 194.
Despite their flaws, Hutchinson's figures came to be regarded with such reverence that they were still being cited as proof that circumcision reduced vulnerability to syphilis (and even gonorrhoea, so little attention did later writers pay to his fine print) in the 1940s. As enthusiasm for circumcision spread among the medical profession, Hutchinson's 'oft-quoted statistics', as Herbert Snow referred to them in the 1890s, were increasingly valued as the sort of hard evidence scientific men needed. In 1872, Dr Francis Cadell gave a paper in which he claimed that the operation would 'diminish the secretion from the glans, so that the great cause of non-venereal excoriation would be removed, and thus render the mucous surface less susceptible to the venereal poison'. In the discussion which followed, Dr Watson (probably Patrick Heron Watson) supported this view by reference to Hutchinson's paper, which showed that, although 'the proportion of Jews to Christians among the out-patients was as one to three', the proportion of syphilis cases 'was only as one to fifteen'. He repeated Hutchinson's comment that this 'was not the result of any higher degree of morality on the part of the Jewish population' because 'one half of the cases of gonorrhoea occurred in Jews'; this being the case, it had to be the foreskin. A couple of years later a book in favour of circumcision by an Egyptian writer cited Hutchinson's observations as proof of 'the immunity of the circumcised from venereal diseases'. In 1883, Mr Fletcher Little described 'the dangers to health and morals' arising from possession of an 'elongated prepuce' and advocated the circumcision of every male child soon after birth. He believed that 'masturbation would thus be reduced by one half and that venereal infections would become much less common'. In 1893, M. Clifford published a short book on the advantages of, and procedure for, circumcision in which he claimed that, if such a simple operation were added to other protective measures, many common diseases (such as syphilis, masturbation, 'hysteria, epilepsy, chorea etc.') would become extinct. His explanation for its prophylactic effect was closely modelled on Hutchinson's remarks:

The prepuce tends to keep the surface of the glans penis moist and ... little cracks ... are liable to occur on and around it. These may easily be inoculated by any noxious or contagious matter ... Hence they are often the starting point of chancres or syphilis in young persons, and of cancer in the aged.

Even the wording was copied. At the dawn of the twentieth century, Mr Millbank Smith urged 'a much more frequent performance of circumcision' on the grounds that 'there would be less liability to venereal disease, to masturbation and to hernia'.

41 Review of De la circoncision, by Aissa Hamdy, in Edinburgh Medical Journal, 20 (1874), 282. The reviewer reported that M. Hamdy was insistent on the utility of circumcision as a hygienic measure and believed that it was 'a preventive against venereal diseases, onanism, certain affections of the genito-urinary organs, and ... that it favoured fecundity'.
42 BMJ, 3 March 1883, 417.
44 BMJ, 23 June 1900, 1562.
One of the most ardent crusaders for universal male circumcision in the late nineteenth century was Dr Peter Charles Remondino, an Italian-born US physician whose tub-thumping tract on the evils of the foreskin was published in 1891. In his *History of Circumcision from the Earliest Times to the Present: Moral and Physical Reasons for its Performance*, he asserted ‘the well-known greater exemption of the Jew to syphilitic infection, owing to the protecting influence of circumcision’ and cited Hutchinson’s paper of 1855 as ‘proof’ of ‘less syphilization among circumcised men’ even before considering the evidence in favour of these propositions. That was in fact his only evidence, but if Remondino was short on data he was long on explanation, and followed his mentor’s reasoning in accounting for the phenomenon: ‘the absence of the prepuce and the non-absorbing character of the skin of the glans penis made so by constant exposure’. But he departed from Hutchinson’s original article by suggesting that it was not only via the glans that the disease entered the body, but through the tissue of the foreskin itself; primary sores, he claimed, were usually found on the inside of the prepuce and especially around the frenum, ‘the retention of the virus seemingly being assisted by the topographical condition . . . of the parts, and its absorption facilitated by the thinness of the mucous membrane, as well as by the active circulation and moisture and heat’. Accordingly, ‘any protecting mechanical aid that interferes with the favouring conditions grants an immunity to the individual, even when he is freely exposed’. Remondino offered no evidence for these assertions and weakened his argument with the concession that circumcision was not the only reason for the Jews’ immunity to syphilis: the ‘well known chastity of their females’ was another factor—a direct contradiction of Hutchinson’s original point that morality had nothing to do with it. By suggesting that behavioural factors like promiscuity were relevant, Remondino undermined the argument that it was all to do with the presence or absence of a foreskin.

Hutchinson’s statistics surfaced again at the turn of the century in an article by E. Harding Freeland which was probably as influential as the original communication. His thesis was nothing if not ambitious:

if it were possible to secure the efficient circumcision of every male in infancy not only would many of the disorders [of] . . . the genito-urinary organs . . . be prevented, but . . . the incidence of that scourge of humanity, syphilis . . . would be materially diminished.

Freeland made no bones about the fact that he was advocating ‘the universal practice of an operation which has for its object the wholesale removal of a certain healthy structure as a preventive measure’, and recognized that he therefore had to provide ‘good evidence’ that (1) the operation was free from risk; (2) the removal...
of the foreskin would inflict no physical disability on the individual; and (3) the
benefits of the amputation were substantial and commensurate with the sacrifice.
On the first point, Freeland contented himself with the assertion that the risk of the
operation was ‘infinitesimal’. On the second, he conceded that circumcision
‘dull[ed] the sensibility’ of the penis and thereby ‘diminish[ed] sexual appetite and
the pleasurable effects of coitus’, but countered that this was no bar to procreation
and thus not a serious deprivation. On the third point, he produced Hutchinson’s
statistics, which showed
not only that the incidence of syphilis is far less frequent among the Jews but that the
incidence of gonorrhoea is far more frequent, thus clearly proving that their comparative
immunity from syphilis is not due to their excessive morality, but rather, in the absence of
any other reason, to circumcision.
Freeland claimed that his own experience as a ship’s surgeon treating circumcised
Lascars and uncircumcised Europeans and ‘Sedi boys’ confirmed this picture, although he
was unable to produce figures. In their place, he offered evidence from authorities
on syphilis that the majority of primary lesions (73 per cent) in uncircumcised men were
found on the prepuce or retro-preputial fold and that between 25 and 46 per cent
of them occurred on the prepuce proper. He therefore predicted that universal
circumcision, by abolishing the site of most infections, would reduce the incidence
of syphilis by 49 per cent.

Despite Freeland’s tone of triumph, it is not immediately apparent that the site
of the initial sore proved as much as he thought it did. As one of his cited
authorities, John Hunter, had pointed out, one function of the prepuce is to pro-
vide the slack necessary to accommodate the penis when tumescent, unfolding as
the erectile tissue expands;50 when erect, the penis is entirely covered by what, in
its flaccid state, is the foreskin. (In circumcised men, by contrast, the surviving skin
must stretch as best it can). It follows that, if syphilis enters the body through the
part which has been inside an infected vagina, the initial lesion must be either on
the glans or on the covering of the penis shaft, and if it is on the latter when erect,
it will probably appear on the foreskin when the penis is flaccid. It was understood
that syphilis normally entered the body through lesions in the skin, but nobody had
proof that it could penetrate undamaged mucous membrane.51 Although Freeland’s
suggestion that the foreskin itself was the point of entry for whatever caused the
disease departed from Hutchinson’s original explanation that it was the foreskin-
sofened glans which formed the weakest link, he glided over this difference in
trying to explain why circumcision should provide the prophylaxis it so manifestly
did. With the glans permanently exposed, the retro-preputial fold obliterated and
the frenum completely excised, the ‘pocket-like folds which . . . favoured the
retention of secretion are smoothed out’, and the risks of irritation, excoriation,

51 The parliamentary committee on venereal disease in 1868 concluded that the ‘venereal poison’
entered the body through minute lesions in the skin (Townsend, ‘Private Diseases in Public Dis-
course’, p. 62). The consensus today seems to be that the syphilis bacterium can sometimes penetrate
mucous membranes: see K. Kiple (ed.), Cambridge World History of Human Disease (Cambridge, 1993),
p. 1025.
and ‘implantation of disease germs’ are minimized. As well, the ‘thickened condition of the epithelium of the glans . . . offers an additional barrier to any local infection’. Like Remondino, Freeland made up in rhetoric what he lacked in data, and much of his paper was taken up with emotive descriptions of the ravages of syphilis and sheer vilification of the body part he considered guilty of abetting it:

Anyone who has taken the trouble to compare the dry, pink-parchment-like cleanly appearance of the glans of the circumcised with the sodden, swollen, uncleanly structure which is frequently presented to view when the prepuce of the uncircumcised is retracted cannot fail to have been struck by the contrast.52

This sounds more like an aesthetic preference than a scientific judgement.

Freeland’s article was read not only in England, but also in the USA, where it became the subject of an editorial in the authoritative Medical Record. For the most part, the editorial just gave a summary, but it introduced a couple of distortions to Freeland’s account which are worthy of note. First, it claimed there was ‘no evidence’ that circumcision ‘dimin[ished] sensuality’, when Freeland had stated plainly that it did reduce sexual excitability and pleasure and argued that this was a good thing. Secondly, it tried to provide a fuller explanation of why the presence of so many primary syphilitic sores on the foreskin meant that its amputation would offer protection against infection:

the prepuce . . . is the seat of election for the primary lesion of syphilis, so that if this structure were removed, a most prolific site for infection would be withdrawn and thereby a most important source for the transmission of the disease would be destroyed.53

This was indeed Freeland’s argument, but it is astonishing to see doctors advocating the pre-emptive removal of a significant part of the body merely because it was, like most body parts, potentially subject to disease or a link in the chain of disease transmission. Had society been less terrified by the spectre of an incurable, shameful, and often fatal disease, and the medical profession more critical of schemes to control it, somebody might have questioned both the logic and the ethics of so perverse a proposal, and where it might lead. It was perhaps in order to forestall such reflections that Freeland downplayed the significance of the foreskin to the bodily economy. Even though he tacitly acknowledged its contribution to erotic sensation, he prefaced his article with a quotation from the greatest of all nineteenth-century venereologists, Philippe Ricord, on its inconvenience. Freeland was probably unaware that this passage, supposedly from one of Ricord’s lectures, was of dubious authenticity.54

52 Freeland, ‘Circumcision as a Preventive of Syphilis’, 1870.
53 ‘Circumcision as a Preventive of Venereal Disease’, Medical Record, 59 (April 1901), 541.
54 Freeland sourced the quote to Dr Watson at the discussion of Francis Cadell’s paper, and Watson claimed it was from one of Philippe Ricord’s published lectures. It is more likely he saw it quoted in William Acton, A Practical Treatise on the Diseases of the Urinary and Generative Organs (In Both Sexes), 2nd edn (London, 1851), pp. 69–70. Acton states that the comment was from one of Ricord’s clinical lectures, but a diligent search has failed to turn it up. Ricord’s ‘Lectures on Venerial and Other Diseases Arising from Sexual Intercourse’, were delivered at the Hopital du Midi in the summer of 1847 and published in the Lancet in 1847–8. Nor does any such passage or sentiment appear in his A Practical Treatise on Veneral Diseases (New York, 1842, repr. Gryphon Editions, Birmingham AL, 1988).
In the USA, Abraham Wolbarst relied on Hutchinson’s statistics to support his call for ‘Universal circumcision as a sanitary measure’ in 1914. Citing Remondino’s summary rather than the original article, as well as the figures on the site of the primary chancre reported by Freeland, Wolbarst asserted that ‘these data show conclusively that there is far more syphilis among the uncircumcised than among those who have been circumcised’. He had collected statistics from his own patients which showed that, while gonorrhoea was more common than syphilis in both the circumcised and the normal, the difference was smaller among the latter (59 to 41 per cent, compared with 78 to 22 per cent for the circumcised). This was a departure from Hutchinson’s original finding that there was more gonorrhoea among the circumcised, but the point that Wolbarst wanted to emphasize was that, while 41 per cent of his uncut venereal patients sought treatment for syphilis, the figure for the circumcised was only 22 per cent. The suspicious feature of the samples, however, is that they included an equal number of cut and uncut men (400 each) at a time when most adult men in the USA were not circumcised, suggesting that they were highly unrepresentative. There is thus no reason to think that Wolbarst’s figures bore any relation to the actual number of cut and uncut venereal cases throughout the USA, and it seems likely he simply made his sample 400 each for ease of calculation and because his aim was to demonstrate the ratio of gonorrhoea to syphilis among his patients, not to estimate the respective rates of venereal disease among the circumcised and intact populations: although it is the only statistic that would prove anything, it has always been difficult to achieve. Wolbarst himself acknowledged that figures could be ‘distorted to prove almost any contention’, and he seems to have been aware that he had only a shaky foundation for his claim that he had proved a higher rate of syphilis among the uncircumcised, for he sought to buttress it with the results of an informal poll of his medical colleagues. He did not reveal how many letters he sent, but he quoted from 15 replies. Not surprisingly, most of these (11) agreed that the uncircumcised were more vulnerable to syphilis (although many of these asserted that they also exhibited increased susceptibility to gonorrhoea, herpes, masturbation, and other problems demanding circumcision), but none was able to offer figures; two were undecided; and two were firmly of the view that there was no difference at all. Given that only 25 per cent of American males at this time were circumcised, it would not be surprising if three-quarters of patients with venereal disease were uncut. The sample represented a majority view in Wolbarst’s favour, but nothing like a consensus could be said to have emerged; and as Herbert Snow had asked in 1890, ‘Where doctors differ, who shall decide?’

It should be noted that Wolbarst did not prepare his influential paper because he

56 Ibid., p. 93.
57 Ibid., p. 94.
59 Snow, Barbarity of Circumcision, p. 32.
was concerned primarily to combat syphilis, but because he was anxious to defend the Jewish rite against criticism and to see circumcision more widely enforced among the general community. As he explained in the first paragraph, he wanted to combat ‘a decided tendency on the part of some medical men, mostly paediatricians, to condemn the ancient practice of ritual circumcision’, on the ground that infections were often communicated from the operator to the child in the course of the procedure. As we shall see, the paediatricians had ample grounds for concern. Wolbarst evidently believed that the most effective way to defend a tribal custom was not by justifying it on the ground of ethnic privilege, as might be attempted in today’s multicultural confusion, but by promoting circumcision among the gentile community on sanitary grounds. Prophylaxis against venereal disease was only one of these: equally important was the value of circumcision in preventing genital warts, herpes, cancer, balanitis, phimosis, and, of course, masturbation.

As the response to Wolbarst’s survey indicates, there were always sceptics as to the association between circumcision and reduced liability to syphilis. In the late seventeenth century, Gideon Harvey (c. 1640–1700) rejected the opinion of a certain Riolan that a denuded glans helped prevent contagion because ‘the virulence, otherwise being hidden under the prepuce’ finds it easier to enter the body: for which reason he asserts that the Jews, because they are circumcised, may venture with less danger: a gross mistake certainly; we grant them less pockified for want of occasion, it being a capital crime to miscolate themselves with Christians, notwithstanding at Venice I was told of two Armenians, who are likewise subject to the law of circumcision, that were abominably clapt. To the contrary the prepuce is rather a defence since those whose glans is well covered come off with less harm.

This remarkably astute judgement anticipated the conclusion of many nineteenth-century European observers that any reduced liability to common diseases observed among Jewish people was due to personal habits and the quarantine effect of segregation. With sympathy for circumcision running so strongly in nineteenth-century England, the voice of doubt was muted, but John L. Milton was not convinced that the Jews enjoyed significant immunity to syphilis. He did not comment directly on the circumcision issue, but in an article on the history of the disease he reported the speculation of a Dr Adams that Jews fleeing the Spanish Inquisition in the late fifteenth century carried it with them to Rome and Africa. Milton is better known today as an authority on spermatorrhoea and the inventor of spiked penis rings and alarm devices to prevent nocturnal emissions and masturbation; it is interesting that, although he wrote vehemently against the dangers of seminal loss, he did not support the increasingly common practice of treating it by circumcision, illustrating the point that belief in the foreskin as a risk factor for syphilis was

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61 Harvey, Great Venus Unmasked, p. 64.
62 This is taken for granted by modern scholars such as Wallerstein, Circumcision, pp. 12–13.
63 J. L. Milton, ‘Some Remarks on the History and Origin of Syphilis’, Edinburgh Medical Journal, 19 (1873), 14. This suggestion is probably no more than an expression of anti-semitism, but the point is that Milton, an influential expert in diseases of the skin, did not believe Jews to have the immunity to syphilis attributed by Hutchinson and others.
more likely to be found in those already disposed towards circumcision. Another sceptic was the rationalist Charles Drysdale, who thought that Jews should assimilate by dropping circumcision, not by encouraging everybody else to do it. As one might expect from a passionate opponent of routine circumcision, Herbert Snow was very critical of Hutchinson’s statistics, commenting that the testimony of such an eminent figure ‘cannot but receive considerable weight’, but urging caution because of his ‘evident bias in favour of radial measures’. He mentioned the obvious, but usually overlooked, point that the figures showed that Jews were more prone to gonorrhoea, but concluded with the very fair comment that the data were simply not sufficient to prove anything. An interesting example of the difference between received wisdom and actual observation is provided by Arthur Powell, surgeon to the police hospital, Bombay, in the late nineteenth century. Having practised amongst a mixed Hindu and Moslem population, he had formed ‘a very definite impression’ that syphilis was ‘much more common’ among the uncircumcised Hindus, and commented that his ‘belief in the protective value of circumcision is held by most surgeons. Mr Hutchinson . . . notes the immunity of Jews as compared with Christians.’ But when he checked the actual figures he found a different story. Out of an average strength of 1,570 Hindus there were 523 syphilis cases, compared with 105 cases among 523 Moslems, giving a rate of infection of 13.3 per cent among the uncut and 20 per cent among the circumcised. As Powell remarked with some surprise, ‘these figures are quite opposed to one’s preconceived opinion’. Like the doctors in Wolbarst’s poll, his impression of more syphilis among the uncut was probably a consequence of there being more uncut patients among his clientele.

Medical interest in whether Jews had any natural or acquired resistance to syphilis was part of a wider nineteenth-century debate about the relative importance of heredity and environment, partly spurred by Darwinism, and a more limited one about the significance of racial characteristics. The Jews were valued as a control group population in which it might be possible to test various hypotheses, including the effects of circumcision, and syphilis was not the only disease from which it was thought their racial heritage, lifestyle, or customs might protect them. Whether the Jews enjoyed superior health and, if so, for what reason, was a major topic of debate in the last third of the century. Remondino relied heavily on data from the US census compiled by John S. Billings to show that American Jews had a lower death rate in youth, greater longevity, and a high level of immunity to tuberculosis and cancer. Billings did find this, but his data also showed that Jews were markedly more subject to diseases of the nervous, circulatory, and digestive systems, and the skin. Most awkwardly for Remondino’s claims about syphilis,

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66 Snow, Barbarity of Circumcision, pp. 32–3.
Billings found that the incidence of diseases of the urinary organs among Jewish males was 50 per cent greater than for gentiles (33 compared with 22 per thousand) and three times greater for females (27 to 10 per thousand).\textsuperscript{69} Such a finding contributed so little to Remondino’s case against the foreskin that he made no mention of it. Billings did not discuss circumcision or venereal disease and was open-minded as to the cause of the differences he had observed: were they due ‘to original and inherited differences in bodily organization, or are they . . . to be attributed to the customs, habits and modes of life of the two classes of people?’ he wondered.\textsuperscript{70} Billings concluded that most of the differences in the vital statistics were ‘connected with the occupations, social relations and mode of life of the people rather than with special race characteristics’, and that Jewish peculiarities would disappear as they assimilated into mainstream American life.\textsuperscript{71}

In Britain, the interest in Jewish lifestyle and child-rearing practices was stimulated by the sanitary movement and, later, by fears of physical deterioration and racial decline. Copland had praised the Jews for maintaining both their racial and cultural identity in the teeth of constant persecution,\textsuperscript{72} and this idea became a recurrent theme of late nineteenth-century commentary. In a lecture delivered in 1870, W. H. Corfield admired Moses as the author of the ‘most excellent hygiene regulations’, many of which would do credit to public health reformers of the present. He singled out circumcision as one of the most salutary regulations that was ever imposed on a people, especially in an eastern country, where the difficulty as well as the necessity of scrupulous cleanliness is so much increased. . . . What wisdom was shown by Moses, and by Mahomet in later times, in retaining this wholesome custom as a religious rite, and thereby ensuring its perpetuation.\textsuperscript{73}

In 1876, a Dr Gibbon commented on ‘the immunity of the Hebrew race from syphilis and scrofula’ during the discussion of Hutchinson’s lecture to the Pathological Society, but Edgar Sheppard MD replied that the cause was not circumcision, but because the Jews were ‘more moral and religious than Christians’ and ‘carry their religion more into the details of their daily life’, with the result that there was less drunkenness and fornication among them.\textsuperscript{74} Ernest Hart agreed, comparing the sanitary laws of Moses to the public health acts of the nineteenth century, although he had to admit that Britain had not yet caught up with the Mosaic standard. He praised the Jewish people for their cleanliness, industry, sobriety, family focus, and thrift, and for their immunity to many ailments, particularly ‘filth diseases’ (cholera, typhoid, typhus, and others spread by infected water or failure to isolate human waste), and he further commented that ‘Jewish children have no hereditary syphilis and scarcely any scrofula. Their greater tenacity of life is therefore due not only to better maternal care and nursing, but to the inheritance

\textsuperscript{70} Ibid., p. 80.
\textsuperscript{71} Ibid., p. 84.
\textsuperscript{73} W. H. Corfield, ‘Introductory Lecture . . . on Hygiene and Public Health’, \textit{BMJ}, 18 June 1870, 617–19 and 645–6, p. 617. Corfield was Professor of Hygiene at University College, London.
\textsuperscript{74} \textit{Lancet}, 25 March 1876, 465, and 1 April 1876, 518.
of a better physical constitution than the Christian child.\textsuperscript{75} Such an emphasis marked Hart as a believer in heredity over environment, so it is not surprising that he did not mention circumcision; but the opposite view was taken by Dr Alexander Davidson, who suspected that ‘a nation like the Jews, whose ideas of sanitation were so far advanced as to include the “dry earth” system of the nineteenth century, adopted the practice as much for its substantial benefits to health as out of regard to religious ceremonial’.\textsuperscript{76} He accepted the conventional wisdom that circumcision provided protection against syphilis, although he performed the operation mainly as a precaution against phimosis. By the 1890s, sanitary reformers had cleaned up the cities and overcome most of the lethal ‘filth diseases’,\textsuperscript{77} but interest in Jewish child-rearing practices was rekindled at the turn of the century, when the Boer War revealed the poor bodily condition of military recruits, particularly from working-class districts, and intensified fears about imperial decline. The Committee on Physical Deterioration (1904) was particularly interested in how Jewish parents looked after their children, and many of the witnesses confirmed that they were better nourished, stronger, and healthier than their Christian neighbours, and that Jewish parents were thriftier, more abstemious, and generally better housekeepers.\textsuperscript{78} In their chastity, sobriety, industriousness, cleanliness, and family feeling, the Jews had become model Victorians.

The debate was more complex and less conclusive in Europe, where physicians were as likely to claim that Jews suffered more venereal disease rather than less, while their opponents often explained lower rates by reference to cultural rather than physiological factors. The original idea (perhaps dating from the late fifteenth century, when one of the names for syphilis was ‘Peste of the Marranos’, alluded to by Milton’s Dr Adams),\textsuperscript{79} was that Jews were carriers of, and particularly prone to, syphilis. This view was put forward by a number of German and Austrian observers in the nineteenth and early twentieth centuries, including the Jewish physician, Heinrich Singer, who asserted that Jews were subject to particularly destructive forms of syphilis.\textsuperscript{80} The opposite opinion, first expressed in early sixteenth-century Spain by Isaac Abravanel, was that syphilis was hardly found among Jews at all. Confirmation of this was provided by studies of eastern European Jews in the late nineteenth century, but, where gentile researchers were inclined to attribute their low rate of infection to anatomical differences (particularly circumcision), Jews themselves offered a cultural explanation. A. A. Brill pointed out that the populations studied included mainly orthodox (strict) Jews, whose relative immunity was the result of continence and segregation: ‘owing to their rigid religious tenets and early marriages they lead a pure sexual

\textsuperscript{76} A. Davidson, ‘Genital Irritation in Boys’, \textit{The Practitioner}, XLII (1889), 356.
\textsuperscript{78} Hyam, \textit{Empire and Sexuality}, pp. 71–87.
\textsuperscript{80} Gilman, \textit{Freud, Race}, p. 62.
Nineteenth-century German Jews also appreciated that any lower incidence of syphilis and alcoholism was a consequence of ‘moral and ethical purity’, early marriages, and avoidance of prostitutes and other forms of promiscuity, and that assimilation was exposing them to these conditions as much as anybody else. A Dr Niemann of Magdeburg stated that circumcision ‘does not render the individual less susceptible of infectious diseases, as some suppose’, and he reported that he had often seen gonorrhoea and syphilitic ulcers in Jewish men. He considered the origins of circumcision to lie, first ‘in the great length of the prepuce among Jews’ and consequent need to remove it in order to prevent the accumulation of irritating secretions; and secondly to lessen the excitability of the penis in a people who reached puberty at an early age and thus, as Maimonides had explained, to reduce the attraction of ‘venereal pleasure’. The sceptical position was put very clearly in 1874 by Ephraim Epstein, a Russian Jew practising as a physician in Cincinnati, USA, commenting on a claim that Jews enjoyed comparative immunity to both tuberculosis and syphilis:

In common with others . . . I once believed that circumcision affords a protection against venereal [diseases], but my practice in Vienna . . . and in this country since 1862 persuaded me fully to the contrary. The apparent immunity which the Jews of Russian and European Turkey . . . seem to enjoy from venereal diseases arises from their greater chastity and the practice of early marriage. That chastity refers not only to the unmarried youths, but also to the married, whose observance of the ancient laws of purification after the menses and after childbirth is very stringent. . . . The singular pre-eminence of the Jews in health is a mere fiction, propounded either by those who are not acquainted with the Jewish race in this country, or by certain Jewish enthusiasts who have a special axe to grind. Epstein considered that the intention and effect of Jewish circumcision was to promote endogamy and thus preserve racial purity. There is a certain irony in the fact that gentile physicians were more likely to ascribe any lower rate of venereal disease to the absence of the foreskin, while the Jews themselves agreed with Harvey that ‘want of occasion’ was the most important factor. Like their colleagues in England, German doctors were obsessed with finding ways to stop masturbation, and their interest in circumcision, and thus its association with resistance to syphilis, arose from this angle.

Jewish scepticism found particularly eloquent expression in the work of Dr Julius Preuss, author of a compendium of traditional medical practice first published in Germany in 1911. Although he accepted Remondino’s assurance that many illnesses were caused by the foreskin and could be prevented by its timely amputation, Preuss was distinctly cool towards sanitary explanations for the origins of the Jewish rite, and sceptical of contemporary claims that circumcision provided protection against syphilis. Referring to a study by Breitenstein (details not cited)

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81 Ibid., pp. 63, 65.
84 E. Epstein, ‘Have the Jews any Immunity from Certain Diseases?’, Medical and Surgical Reporter (Philadelphia), XXX (1874), 440–1, part quoted in Gilman, Freud, Race, p. 64.
85 This suggestion has been confirmed by L. A. Hoffman, Covenant of Blood: Circumcision and Gender in Rabbinic Judaism (Chicago, 1996).
in the Dutch East Indies, which found that its incidence among the (circumcised) native troops was 0.8 per cent and among the (uncircumcised) Europeans 4 per cent, and although these figures were far more telling than anything reported by Hutchinson, Preuss commented:

one should not forthwith attribute the difference to circumcision, as does Breitenstein. One must also know the attitude of the Malayans towards the satisfaction of illegal libido (and body cleanliness), either for religious or other reasons. One must also take into consideration that all Europeans are inclined to indulge in sexual excesses as soon as they arrive in the Tropics.86

Even in relation to claims for the value of circumcision in preventing other illnesses, Preuss considered that cultural and behavioural factors might well be more important:

a comparison of the number of illnesses among circumcised and uncircumcised Jews does not provide absolute proof of the value of circumcision; for . . . the neglect or omission of circumcision . . . was often accompanied by the abandonment of other precepts and customs of their people, and the influence of such deviations from the Torah on the acquisition of venereal disease cannot be disputed.87

In his awareness of the confounding effects of non-physiological variables, Preuss was in agreement with Epstein and far ahead of contemporaries like Freeland.

Wolbarst had sought to defend ritual circumcision against the criticism of paediatricians who were concerned that the operation carried a significant risk of injury, infection, and death, but they were not the first to recognize this problem. Modernizing Jews in mid-nineteenth-century Europe were keen to bring their religion up-to-date and do away with many of Judaism’s more anachronistic observances, and a few even urged the abandonment of circumcision.88 Those who wanted to retain the practice sought medical justifications for it and proposed that it be carried out in accordance with modern surgical procedure and that the metitsiah phase of the ceremony, the sucking of blood from the wounded penis, be dropped. As John Efron has shown, the extravagant claims for the practical benefit of traditional rituals were made in response not to the slanders of anti-semites, but to the scepticism of Enlightenment rationalists who considered the Jewish religion to be particularly superstitious and primitive, ruled by hidebound rabbis and based upon an autocratic deity which demanded ‘the observance of ritual . . . in an atmosphere of fear’. To defend their culture against attacks from liberal-minded thinkers, the Jews employed medicine, and especially the recent discoveries of Victorian doctors, ‘as a rationalization and . . . scientific justification for the continued practice of ancient rituals’ and as a means of strengthening ethnic identity.89 Jewish defenders of circumcision thus came up with the same arguments as Victorian physicians: that it prevented sexual malfunction, deviance, bed-wetting, hernia,

87 Ibid.
89 Efron, Medicine and the German Jews, p. 189.
hydrocele, phimosis, and diabetes (although Billings found diabetes more common among Jews); provided protection against venereal disease; and, most importantly, that it ‘lessened if not eliminated entirely the instinct to masturbation’.90

In seeking the necessary reforms, as early as the 1840s, Joseph Bergson had recognized that metsitsah could transmit diseases, including syphilis, from the operator to the child, and urged that it be abolished.91 Dr Niemann particularly deplored the practice, and warned that the penis could be further injured by the operator’s teeth, and that the child could be infected with ‘syphilitic and cancerous ulcers’; he cited the case of one circumciser who had transmitted syphilis to four babies in this manner.92 In 1874, in a short booklet, an Austrian Jewish physician, Eugen Levit, whose son had died as a result of infection communicated during the procedure, had attacked circumcision as cruel and harmful and urged that it be made illegal. The pamphlet was discussed at a meeting of the Viennese Medical Society, where there was much agreement as to the danger of infection and some support for the abolition of the entire rite.93 The Lancet printed a brief notice on the discussion and reported that Levit knew of six other deaths in Vienna over the previous 35 years. Among the reasons for his opposition to the ritual was the ‘ready exposure of syphilitic infection . . . soon after birth, from the mouth of the operator, which is employed in stopping haemorrhage’.94 This item elicited a strong rejoinder from ‘a Jewish surgeon’ in London, who countered that Levit’s argument failed because ‘many venereal infections were physically impossible in the circumcised, and the liability to contagion is lessened by the greater facilities which exist in them for keeping the parts clean’. He flatly denied that the deaths reported by Levit were the result of circumcision and asserted that a race ‘equally distinguished for its rapidity and keenness of perception and for devotion to its young . . . would have, ages ago, abolished . . . an operation . . . if there had been the slightest reason for supposing it dangerous’.95 The correspondent certainly seems to have heeded Maimonides’ injunction that circumcision should not be carried out ‘for any other reason but pure faith’,96 for Levit was quite right: between the 1870s and the First World War there were numerous reports of babies becoming infected with syphilis and tuberculosis in the course of their circumcision, both in ritual and clinical situations. Hutchinson himself recorded ‘a series of cases in which a Jewish circumciser communicated syphilis by unclean lint’, and he knew of at least one other in which a surgeon did the same by his instruments.97 The first instance involved an unknown number of infants (at least seven) who had been infected by an operator who placed the severed foreskins in the same box as he kept the lint for bandaging the wound of his next clients.98 In 1873, the New York Board of

90 Ibid., pp. 228–9.
91 Ibid., p. 229.
93 E. Levit, Die Circumcision der Israeliten (Vienna, 1874) cited in Gilman, Freud, Race, pp. 66–7. I am grateful to Dr Leonard Glick, who is translating the pamphlet, for this reference.
95 Letter, Lancet, 12 December 1874, 856.
98 Hutchinson, Syphilis, pp. 47–9.
Health investigated the deaths of three Jewish children, and the illness of a fourth, with a view to establishing whether they had been infected with syphilis via circumcision. Although the results of the inquiry were inconclusive, the investigator reported that there was a serious risk of contagion and that the practice of sucking the wound ought to be abolished so as to 'render a rite which has useful sanitary bearings less liable to fall into disrepute'. In 1899, Herbert Miller attacked the 'evils' of the ritual because

The child is very apt to become infected with disease and may perhaps die from haemorrhage. As a means to stop haemorrhage from the penis the mohel takes it in his mouth and sucks the first blood off directly after the circumcision. The child is thereby exposed to the danger of inoculation with various diseases, among which syphilis and tuberculosis are the most prominent.

Miller had no objection to circumcision for modern medical reasons in a sanitary setting, but objected to its performance by untrained or otherwise incompetent operators who lacked the surgical skill and medical knowledge necessary to do it safely. In 1907, a British supporter of routine circumcision acknowledged that there were cases in which syphilis and tuberculosis had been communicated during the procedure, and even that 'infants have died from bleeding and sepsis when the operation has been performed by medical men', but he evidently felt that such casualties in the battle against disease were acceptable wastage: "These things only serve to show that an element of risk pervades all human actions." Summarizing Wolbarst’s article in 1914, the Archives of Pediatrics referred to L. Emmett Holt’s finding of no more than 40 cases of infants infected with syphilis or tuberculosis, and agreed with Wolbarst that such a low rate of complications merely went to show what a safe operation circumcision really was. At this distance, it is impossible to calculate how many boys suffered illness or death as a result of circumcision before the standardization of aseptic operating techniques; but while there is not one proven case of circumcision having saved a man from syphilis or tuberculosis, it is evident that many children contracted these diseases through circumcision, that many of these died, and that yet others died as a result of bleeding or sepsis.

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100 H. Miller, ‘The Evils of the Ritual Practice of Circumcision’, Medical Record, 56 (1899), 302–3.

101 J. Bland-Sutton, ‘Circumcision as a Rite and as a Surgical Operation’, BMJ, 15 June 1907, 1408–12.

102 Archives of Pediatrics, 31 (1914), 545. It is not clear what period and area Holt’s survey covered.

103 It is ironic that at the very time when medical experts (all from circumcising cultures) are stridently demanding compulsory circumcision of African boys as the latest means of combating the spread of AIDS, news reports reveal that circumcision is itself a major cause of death and injury among African teenagers. In August 2001, it was reported that 35 South African boys had died as a result of traditional ‘bush’ circumcisions during their tribal initiation and that several hundred had been hospitalized with ‘horribly injured genitals’ (New York Times, 6 August 2001, A6).
Although estimates of the death rate are hard to come by, syphilis was a serious disease in the nineteenth century. In 1846, syphilis cases made up half the outpatients at St Bartholomew’s Hospital, and in 1864 they represented a third of the British army’s sick list. In 1916, the Royal Commission on Venereal Disease estimated that a minimum of 10 per cent of the population was infected. Although the development of Metchnikoff’s ointment and Salvarsan, as well as the establishment of venereal disease clinics after the First World War, made a difference, syphilis remained incurable until the introduction of penicillin in the 1940s brought it quickly under control. Circumcision played no role in one of modern medicine’s micro-biological triumphs. The claim that it could protect men from syphilis has a long history, but it has been made more often in texts arguing the need for circumcision than in serious studies of venereal disease; the claim belongs to the history of circumcision, not of sexually transmitted diseases. Despite Hutchinson’s much-cited figures, few reputable books on syphilis even mention circumcision, let alone discuss it as a prophylactic, and in his influential and much-reprinted textbook Hutchinson himself discussed it only as a vector of syphilis, not as a preventive at all; he was also silent on the topic in his lengthy introduction to D’Arcy Power’s vast System of Syphilis, published in 1914. In a recent survey of the medical literature, R. S. van Howe concluded that ‘no solid epidemiological evidence has been found to support the theory that circumcision prevents STDs or to justify a policy of involuntary mass circumcision as a public health measure’. Exponents of the claim that circumcision does protect against syphilis and that mass circumcision would eliminate or ‘materially diminish’ its incidence have generally been inspired by other motivations: for Hutchinson (and nearly all nineteenth-century physicians), by the desire to discourage masturbation and promote continence; for Remondino, by a personal crusade against the foreskin as a ‘moral outlaw’; for Freeland, by an aesthetic preference for a dry and ‘pink-parchment-like’ glans; and for Wolbarst, by a determination to defend an ancient religious custom against the legitimate concerns of paediatricians. The same tendency may

104 Walkowitz, Prostitution and Victorian Society, p. 49.
105 Ibid., p. 270, n. 9.
106 Works consulted were: H. Coote, A Report on some of the more Important Points Connected with the Treatment of Syphilis (London, 1857); A. Cooper, Syphilis and Pseudo-syphilis (London, 1884); F. N. Otis, Practical Clinical Lessons on Syphilis and the Genito-urinary Diseases (New York, 1888); C. H. Browning and I. McKenzie, Recent Methods in the Diagnosis and Treatment of Syphilis (London, 1911); D. Power and J. Keogh Murphy (eds), A System of Syphilis (London, 1914); L. W. Harrison, Modern Diagnosis and Treatment of Syphilis, Chancroid and Gonorrhoea (London, 1924); D. Lees, Practical Methods in the Diagnosis and Treatment of Venereal Disease, 3rd edn (Edinburgh, 1937); R. D. Catterall, A Short Textbook of Venereology (London, 1965); L. Marr, Sexually Transmitted Diseases: A Physician tells you what you need to Know (Baltimore, 1998). Historical studies of disease are also silent on this curious byway of medical history. See W. Spink, Infectious Disease: Prevention and Treatment in the Nineteenth and Twentieth Centuries (Minneapolis, 1978); A. M. Brandt, No Magic Bullet: A Social History of Venereal Disease in the United States since 1880 (New York, 1985); Oriel, Scars of Venus; M. Lewis, Thorns on the Rose: The History of Sexually Transmitted Diseases in Australia in International Perspective (Canberra, 1998).
be observed even today. In recent articles arguing the case for mass male circum-
cision as a preventive of HIV-AIDS and cervical cancer, both sets of authors have
cited Hutchinson’s article of 1855 as ‘reporting’ that ‘circumcision might prevent
syphilis’. In a recent booklet on the desirability of restoring the routine circum-
cision of baby boys in Australia, Brian Morris cites several studies which purport to
show a higher incidence of gonorrhoea and syphilis among normal males and
reaches the equivocal conclusions that (1) ‘based on the bulk of evidence it would
seem that at least some STDs could be more common in uncircumcised males
under some circumstances’; but that (2) ‘there may be little difference in most
STDs between those with and those without a foreskin’. Despite the ready
availability of penicillin, growing social acceptance of an effective prophylaxis in
the form of condoms, and an array of safe sex practices revealed on video, it would
seem that venereal disease remains a useful bogey for those whose real target is the
portion of the penis known as the prepuce. After 150 years of debate, doctors still
differ on this significant point.

108 L. Lavreys et al., ‘Effect of Circumcision on Incidence of Human Deficiency Virus Type 1 and
other Sexually Transmitted Diseases: A Prospective Cohort Study of Trucking Company Employees
in Kenya’, Journal of Infectious Diseases, 180 (1999), 330–6; X. Castellsague et al., ‘Male Circumcision,
Penile Human Papillomavirus Infection and Cervical Cancer in Female Partners’, New England Journal
of Medicine, 346 (2002), 1105–12.

109 B. Morris, In Favour of Circumcision (Sydney, 1999), pp. 38–9. See also the scathing review by
the world of the male foreskin’ and some of his claims as ‘so dangerous’ that the publishers ought to
withdraw the book.