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Adams, James, Miller, Andrew

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As the new professional experts, medical practitioners in the Victorian period claimed medicine as the cornerstone of public morals. Working in conjunction with clerics and philanthropists, they elaborated a medico-moral discourse that extensively deployed a set of class and gender-related polarities: health/disease, virtue/vice, cleanliness/filth, morality/depravity, civilization/barbarity. Thus, while the sexuality of the laboring classes was linked with disease, filth, depravity and the threat of an alien and hostile culture, the identity of the middle classes was formed around the themes of health, hygiene, and moral restraint. Oppositional pairs such as normal/pathological and civilization/animality also underpinned the dichotomous construction of male and female that came to dominate medical thought in this period: a notable byproduct of this ideology was the development of gynecology, which crystallized deeply-held beliefs about the instinctual, pathological, and primitive nature of femininity (Moscucci, 1990).

Medical practitioners saw it as their task to promote the health and prosperity of the nation by, on the one hand, reforming the habits of the poor, and on the other preserving the middle-class monopoly over moral hygienics. Active participants in programs of sanitary reform aimed at tackling the evils of urban poverty, they never tired of preaching the gospel of moderation to their middle-class clientele. Warnings against the consequences of sexual excess abounded in the numerous books and pamphlets on personal health which appeared from the 1830s onwards; masturbation in particular became a subject of almost obsessive concern, the masturbator taking on almost sinister connotations as the archetypical sex deviant. One manifestation of the growing concern over the “solitary vice” was the controversial introduction of clitoridectomy as a cure for masturbation. Clitoridectomy was, and still is, part of a long tradition of religious ritual, mostly in Muslim parts of Africa. The term is loosely used to cover several different operations, the most basic of which involve either the excision of the entire clitoris,
together with all or part of the labia minora, or the removal of the hood of tissue that surrounds the organ (circumcision). Until the mid-nineteenth century, the operation was occasionally done in Europe for severe disease of the organ, such as tumors and gross malformations; Western commentators widely rejected the African practice of clitoridectomy, which they regarded as a sign of the barbarity of the "other."

During the 1850s, however, both the removal of the hood of the clitoris and the more radical form of clitoridectomy, involving the excision of the clitoris and labia, were occasionally suggested by medical practitioners as a cure for masturbation. As early as 1848, the English obstetrician Samuel Ashwell recommended excision whenever an enlarged clitoris was "marked by exquisite sensibility of its mucous membrane," giving rise to sexual passion (708). The earliest account of a clitoridectomy I have been able to find dates from 1851; it appears in the collected works of the Italian physician Riberi, who describes a case of onanism successfully treated by the excision of the clitoris and nymphae. The late-nineteenth-century American physician Remondino, on the other hand, recommended cutting the hood of the clitoris. Much favored by American practitioners, who appear to have performed it well into the twentieth century, clitoridectomy never became established in Britain as an acceptable treatment for female masturbation. The majority of British practitioners had grave misgivings about the operation, which they regarded as sexual mutilation, and their opposition was plain for all to see in 1866, when Isaac Baker Brown's account of his clitoridectomy practice provoked one of the most heated medical controversies of the century. The outcome of the debate was that clitoridectomy was discredited in England, and soon fell into disuse; Baker Brown, a gynecologist who had enjoyed fame and acclaim as one of the most talented surgeons of his generation, lost his membership in the Obstetrical Society of London and was forced to resign from his private clinic.

Neither the medical profession nor the lay public, however, objected to circumcision when, from the early 1850s onwards, this predominantly Jewish and Islamic practice began to be recommended as a treatment for masturbation in the male. Indeed, so popular did the procedure become in English-speaking countries, especially among the upper and professional classes, that by the 1930s at least two-thirds of public schoolboys were circumcised, compared with one-tenth of working-class boys. A parallel development occurred in Africa, where by the twentieth century missionaries had given up their attempts to eradicate the practice; their residual worries were focused on its connection with initiation ceremonies, so they tried to have it done in infancy and in a hospital rather than at puberty and in public (Hyam 191).

The new mania for circumcision was truly remarkable, considering that circumcision had for centuries been unthinkable in Christian countries. Sixteenth- and seventeenth-century writers were ambivalent about the practice, which was widely believed to diminish male pleasure, and hence procreative potency (Laqueur, "Amor veneris," 129). "Christendom," wrote Sir Richard Burton, the Victorian Explorer, "practically holds circumcision in horror." It is a view which, interestingly, still has its subscribers in contemporary Britain and America. Recent de-
bates over the continuing practice of clitoridectomy in Africa, for example, have prompted comments about the "mutilating" consequences of male circumcision, revealing a perceived analogy between circumcision and clitoridectomy. The American anthropologist Nancy Scheper-Hughes makes the case against circumcision as a mother who unsuccessfully tried to prevent the performance of the operation on her baby son. Writing in the Medical Anthropology Quarterly for 1991, Scheper-Hughes painfully recalls her fruitless opposition; seventeen years after the event, she still believes that her son was "sexually mutilated and violated as an infant and, as a consequence, that some part of his adult sexual pleasure was forever denied him" (Scheper-Hughes, 28). Similar sentiments were expressed by the English physician John Warren in 1994, when a mother whose son had been circumcised on his father's instruction, but against her wishes, won compensation from the Criminal Injuries Compensation Board on behalf of her son. In a letter published in the Independent on Sunday for 29 May 1994, Dr. Warren wondered why female genital mutilation is illegal in Britain, while surgery on males is not. "Mounting evidence," he claimed, showed that circumcision was traumatic, and that men were permanently harmed by the loss of their foreskin. Dr. Warren invoked anatomical arguments in support of his views: "The foreskin," he said, is richly supplied with specialised nerve endings and is a major source of pleasure during sexual arousal. Furthermore it protects the glans, which when left exposed, gradually loses its sensitivity. The circumcised man also suffers mechanical sexual problems because he is often left with insufficient skin on his penis to allow the natural gliding motion of the skin over the shaft and glans during sex. In addition, many men are psychologically affected by this mutilation. They feel incomplete, and they often feel betrayed by their parents and the medical profession.

What light does all this throw on the mid-Victorian clitoridectomy controversy? It suggests that physiological or anatomical considerations cannot adequately explain why clitoridectomy should have been rejected as a treatment for masturbation. Historical accounts of clitoridectomy have been shaped by the notion of an "essential" but denied female sexuality; thus, for example, Elaine Showalter writes that the clitoris was expendable because "its sole function was female sexual pleasure" (130). I should like to argue very strongly against such essentialist approaches to sexuality, male or female, and instead explore clitoridectomy as a chapter in the history of the social construction of racial and sexual differences. At different times in the history of Western culture, both circumcision and clitoridectomy have been regarded as sexually mutilating operations, and a plethora of medical arguments has been put forward in support of this view, yet such concerns have not prevented circumcision from gaining widespread acceptance, whereas clitoridectomy still provokes fierce debate (Gordon, Boddy, Morsy, Sargent, Scheper-Hughes). Cultural factors must have been at work in this response, and I want to suggest that, by investigating the tangled relations of class and race, gender and sexuality, we might be able to elucidate the reasons why Baker Brown's operation so outraged the Victorian medical profession. The controversy over the propriety of clitoridectomy was a debate not only about the nature of female sexu-
ality, but also about the normalization of sexual practices and the ethical codes to be observed by the doctor in treating his female patients. Exploring these issues will take us deep into the domain of sexuality mapped out by doctors in the Victorian era.

MALE MASTURBATION AND THE OFFENDING PREPUCE

Unease about masturbation began, as is well known, in the early eighteenth century, when a book entitled Onania; or, The Heinous Sin of Self-Pollution (1707–1717) appeared anonymously in Holland and met with great success. By the middle of the century Tissot’s famous treatise, On Onania: or A Treatise upon the Disorders Produced by Masturbation (1760), had given a scientific veneer to the new anxiety about the “solitary vice.” Drawing on ideas about the wastage of bodily energy, Tissot argued that physical illness resulted from loss of semen, leading to general debility, consumption, deterioration of eyesight, disturbance of the nervous system, and so on. From 1800 onwards, the evils of masturbation were widely discussed in medical and moralistic texts; although attitudes to the practice were not monolithic, much was made of its physically and mentally deleterious effects (see Hall; Hare; Engelhardt; Comfort). In essence, masturbation was less a vice than an antisocial activity, an egotistic enjoyment of pleasures that were the proper domain of heterosexual intercourse (Laqueur, Making Sex 227–30). Polluting and debilitating for the individual, it had a destabilizing effect on society, as it prevented healthy sexual desire from fulfilling socially desirable ends—marriage and procreation, which were the foundation of the social order.

Belief in the horrors of masturbation was shared by doctors and patients. As Lesley Hall has shown for a later period (the 1920s), a large component of men’s “hidden anxieties” related to the sense of disgust and self-loathing induced by masturbation: “folly,” “mistake,” “disease” were the words employed by men writing to Marie Stopes, the birth-control pioneer, when they described their “addiction” to the pernicious habit of self-abuse. Such fears were easily exploited by a variety of groups with interests ranging from the religious to the commercial. Quacks were particularly active in the “treatment” of masturbation: posters, leaflets, handbills, and “anatomical museums” illustrating the dreadful consequences of onanism were widely used as marketing strategies, much to the concern of the medical profession, which was anxious to establish its own claims to the treatment of masturbation. In a letter to the Lancet for 1857, for example, an anonymous doctor railed against the “spermatorrhoea imposture” that lay behind the peddling of contraptions such as the “American remedy” recommended as an infallible cure for masturbation. Retailing at two guineas apiece, the device consisted of a metal ring “with a screw passing through one of its sides, and projecting into the centre,” which was to be applied to the “part affected” at bed-time (M. D. A.).

Doctors on the whole favored less heroic means of stopping the habit. Strength-
ening the sufferer’s moral and physical tone was the first line of defense; adjuvants included the avoidance of sexually arousing amusements, and temptations such as lolling in bed in the morning. Sometimes sexual intercourse was prescribed (with prostitutes if necessary) in order to redirect desire toward more constructive heterosexual ends (see, e.g., Cantlie, “Spermatorrhoea,” “Masturbation”; Copland; “Quack advertisements” 124–26; 159–60; 224–25). Occasionally, however, the severity of the case required a more robust approach. The application of caustics to the urethra was recommended in the mid-Victorian period in order to remedy the consequences of chronic masturbation, such as spermatorrhoea and impotence; vasectomy and castration were also practiced, although such radical therapies appear to have been more popular in the United States than in England. In 1870, the use of blisters was recommended by the Lancer as a means of “keeping up slight soreness of the body of the organ . . . sufficient to render erection painful” (“Quack advertisements” 224).

Interest in circumcision as a treatment for masturbation began to emerge in the 1850s. As the medical discourse on sexual hygiene gathered momentum, attention was focused on uncleanliness as a cause of masturbatory activity. The English physician James Copland, one of the first to advocate circumcision in the Anglo-Saxon world, claimed that masturbation was essentially an attempt to relieve, by friction, the “local irritations” caused by smegmatic accumulations under the prepuce. He recommended circumcision as a means of maintaining genital cleanliness, adding that the great physical resilience of the Jewish people was due to the observance of this “salutary rite” (III, 442; 445). By the end of the nineteenth century, the medical pleas for circumcision had become more insistent. The American physician Remondino, author of a best-selling History of Circumcision, pitied the “unlucky and unhappy wearer of a prepuce”: this “tight-constricted, glans-deforming, onanism-producing, cancer-generating” appendage, he claimed, was an “unknown, undiscovered, and therefore unexplored region for some thousands of years,” until the medical profession, venturing at last into this “Darkest Africa,” had revealed the malign influence it exercised on its unlucky victims (255–56). Parents could not make a “better paying investment” for their sons than circumcision: it was like a “substantial and well-secured life-annuity,” making for a greater capacity for labor, a longer life, less nervousness, and fewer doctors’ bills (186).

Physicians such as Remondino had little difficulty in persuading their middle-class readers, who already appreciated the importance of hygiene and moral restraint: it was the observance of regular habits that ostensibly set the middle classes apart from the debauched aristocracy and the degenerate working classes, legitimating middle-class claims to cultural hegemony. By the early twentieth century, circumcision had become common among the upper and professional classes of Britain and America. In the 1930s, the earliest period for which statistics are available, two-thirds of public-school boys were circumcised as compared to one-tenth of working-class boys; the British royal family employed a Jewish mohel for the purpose as late as the end of 1948. By virtue of its association with filth and
sexual excess, the prepuce had become a marker of inferior social status: already by the end of the 1890s an equation was being made in America between being "uncircumcised" and being "uncivilized."

As Ronald Hyam has noted, circumcision was central to the late-Victorian re-definition of manliness in terms of sexual restraint and "cleanliness." As the purity campaign gathered momentum in the last quarter of the nineteenth century, the meaning of manliness shifted from the ideals of moral strenuousness and integrity to a cult of athleticism and robust virility. The offensive on male lust and the double standard of sexual morality presented masculinity as a never-ending battle, requiring watchfulness and supervision: muscular Christianity was the goal, attainable through strict mental and physical discipline. Widely believed to dampen sexual desire, circumcision was seen positively as a means of promoting both the chastity and the physical health of the custodians of the empire ("Hygienic value," 271).

The emphasis on sexual hygiene no doubt also explains why a Jewish ritual like circumcision was adopted by the British ruling elite, notwithstanding the antisemitism of much Victorian culture: at a time of profound concern about the physical decline of British manhood, the resilience of the Jews in the face of adversity and persecution was held up as proof that sexual hygiene was the mainspring of a nation's vigor. While George Eliot's *Daniel Deronda* (1876) opposed the sustaining values of Jewish culture to the shallow conventions of contemporary Victorian society, doctors and politicians noted with envy the longevity and sturdiness of the Jews, testifying to the rarity of venereal disease, tuberculosis, and cancer of the penis in Jewish communities, as well as to the low levels of infant mortality, illegitimacy, and criminality. Over and over again, commentators attributed the physical and moral superiority of the Jews to the religious rituals and prescriptions observed in their culture (Remondino 161–82). In an influential article published in the *Contemporary Review* for 1903, Major General Sir Frederick Maurice, one of the chief contributors to the turn-of-the-century physical deterioration debate, singled out childrearing practices as a factor contributing to the health and longevity of the Jews; although he did not recommend "stereotyped copying" of the Jews, he conceded that the rest of the nation had much to learn from them (Davin 16). The fact that circumcision had biblical sanction probably facilitated the spread of the practice in Christian Britain and America. The language of purity mobilized religious discourse, emphasizing the intimate connection between physical and moral health: circumcision showed that the divine law had scientific validation (Mort 109–12).

**The Baker Brown Affair**

The success of male circumcision contrasts markedly with the reception of clitoridectomy in England, where the practice proved extremely controversial, even in its mildest form. While circumcision was a central plank of the Victorian con-
struction of bourgeois masculinity, clitoridectomy ran counter to prevailing middle-class assumptions about women’s sexuality. This conflict became arresting-ly clear when Isaac Baker Brown’s practice of the surgery came to the attention of the medical press, and the profession rose in protest against this “questionable, compromising, unpublishable” mutilation (“Obstetrical Society charges” 431).

The son of a “country gentleman,” Isaac Baker Brown was born in Essex in 1812. He began his medical career by serving a period of apprenticeship, after which he was entered as a student at London’s Guy’s Hospital. Upon qualifying in 1834, Brown took the popular career route that led from general practice to obstetrics and gynecology. He became an accoucheur of some repute and in the early 1850s he began to carry out his first trials of ovariotomy, a dangerous procedure widely condemned by the medical establishment. Though unsuccessful with his first three cases, he did not hesitate in 1852 to operate on the fourth—his own sister—who luckily survived. Two years later he published his work on Surgical Diseases of Women, which established his reputation as a bold and ingenious surgeon. During the 1850s Baker Brown took an active part in the foundation of St. Mary’s Hospital in London. He worked there as surgeon-accoucheur until 1858, when he resigned his post and founded the London Home for Surgical Diseases of Women. This institution admitted patients on a fee-paying basis, and was intended for a class of patient a cut or two above the hospital population. Meanwhile, Baker Brown continued to develop his innovative surgical treatments. The Home’s operating theater became a magnet for visiting medics, who invariably admired his technique and dexterity: he was said to be particularly skilful in the treatment of uterine prolapse, vesico- and recto-vaginal fistula, and fibrous tumors of the uterus.

Baker Brown was at the zenith of his reputation when, in 1866, he published his fateful remarks on the Curability of Some Forms of Insanity, Epilepsy, Catalepsy, and Hysteria, in Females. In this volume Baker Brown set forth his operation of clito-
idectomy, which he had devised for the cure of disease originating from “periph-
eral excitement of the pudic nerve.” Loosely based on the ideas of Charles-
Edouard Brown-Séquard (the famous neurologist later complained that his work had been taken out of context), Brown’s theory hinged on the belief that many nervous diseases in women were due to the “loss of nerve power” induced by masturbation. He thought that the habit was rife among young girls and that a vast array of symptoms gave the secret addict away. Patients became restless and ex-
cited, or melancholy and retiring, listless and indifferent to domestic life. There was often quivering of the eye-lids and an inability to look one in the face, as well as dyspepsia, sickness, and disturbance in the menstrual function. Sometimes a “great disposition for novelties” was displayed, the patient “desiring to escape from home, fond of becoming a nurse in hospitals, soeur de charité, or other pur-
suits of the like nature.” In the married, a distaste for marital intercourse, sterility, and a tendency to abort early in pregnancy were also often observed (Brown 1866). Baker Brown had no doubt that, if left unchecked, masturbation induced a fearful train of ills, from hysteria through to epilepsy, idiocy, mania and, finally,
death. The only permanent cure was to remove the "cause of excitement" by cutting out the clitoris and nymphae. Brown had performed the operation again and again, and he was so impressed with its results that he warmly recommended it to all "unprejudiced" medical men.

Curiously, it was a religious publication, the Church Times, which first noticed Brown's monograph. In April 1866 a rave review, subsequently reprinted in the British Medical Journal, drew the attention of the clergy to a little book, which will enable them to suggest a remedy for some of the most distressing cases of illness which they frequently discover among their parishioners. . . .

Mr Baker Brown, FRCS, the eminent surgeon, has . . . published . . . a little volume of cases, which prove incontestably the success for the treatment, and which the clergy will be doing a service, especially to their poorer parishioners, by bringing under the notice of medical men, any of whom can, if possessed of ordinary surgical skill, perform the operation with but slight assistance. ("Spiritual advice")

Unlike the Church Times, though, the medical press was notably unimpressed with Brown's claims. The first shot was fired by the British Medical Journal in April 1866. In a review of the book, the journal could not help noticing that Brown's case histories failed to show how much of the cure was due to the operation and how much to the moral treatment that usually followed it. Brown's attempts to publicize the operation also came in for censure. Veiled references to clitoridectomy at fund-raising meetings smacked of impropriety, as did the typography of Brown's treatise: "We feel bound . . . to observe," wrote the journal, "that a serious medical work on the subject of Female Masturbation should bear on its outward facies none of those characters which belong to the class of works which lie upon drawing-room tables" ("On the Curability" 440).

The review served to focus medical unease about clitoridectomy, sparking off a fierce debate in the pages of the medical press: misgivings about the nature, implications, and supposed benefits of the operation were increasingly voiced during the course of 1866. The controversy intensified when, in November 1866, the eminent obstetrician Charles West entered the fray. In a letter to the Lancet, West rebutted Brown's claims about the extent and results of masturbation. Self-abuse in the female, West argued, was much rarer than in the male, and besides, its physical effects were no different from those of excessive sexual indulgence. Furthermore, West alleged that operations had been carried out without the knowledge and consent of patients: "I believe," he stated,

that few members of the medical profession will dissent from the opinion that the removal of the clitoris without the cognisance of the patient and her friends, without full explanation of the nature of the proceeding, and without the concurrence of some other practitioner selected by the patient or her friends, is in the highest degree improper, and calls for the strongest reprobation. (561–62)
described as “historic.” Not only were doubts cast over the physiological justifications for and therapeutic value of clitoridectomy; Dr. Tyler Smith, an obstetrician of some considerable repute, alleged that Brown had obtained the consent of a patient by prophesying insanity and death if the clitoris was not removed. Another doctor reported that one of his patients had had her clitoris removed by Baker Brown without her knowledge or consent: she had expressed “great alarm” upon being told that the parts had been “mutilated” (“On excision” 668).

At the beginning of 1867 Brown got into even deeper water when an advertisement in the *Times* intimated that mental diseases were being treated in the Surgical Home, in open violation of the Lunacy Laws. Baker Brown lamely denied the charges in a correspondence with the Lunacy Commissioners, which was duly published in the medical press. The *Lancet* was not impressed. “Our strictures upon the alleged practice at the Home,” wrote the journal in February 1867, “were not confined merely to the law of the case; we asked whether it were ethically correct to mutilate an insane woman who could not legally consent to any such operation, even if it were possibly useful. To this question we have received no answer” (“Lunatics”).

These allegations shifted the terms of the debate from the efficacy of clitoridectomy to the manner in which Brown had performed it. From the legal point of view, Brown would have been liable at least to battery charges, but the profession was not worried about possible lawsuits; it was, in any case, most unlikely that a patient would have brought charges against Brown, since a public trial would have involved unpleasant revelations about her sexual habits. In the opinion of the medical press, the case was important because it raised “vital questions of moral and professional ethics” which the profession should fully investigate. Had Brown performed, as many believed, “a dreadful operation upon married women without the knowledge and consent of their husbands, and upon married or unmarried women without their own knowledge of the nature of the operation” (“Clitoridectomy” 1867, 420)?

Interestingly it was not to the General Medical Council, the profession’s regulatory body, but to the Obstetrical Society of London, of which Brown was a member, that the question was put. A dossier of the charges against Brown, and Brown’s replies to them, was assembled by the Council of the Obstetrical Society, and in February 1867, after careful consideration, the council recommended Brown’s expulsion.

The resolution was discussed two months later at a special meeting of the Obstetrical Society. Long before the meeting began, members started filling the room, so that when Seymour Haden, vice-president of the society, rose to speak, there was no room to sit or stand. Haden’s uncompromising condemnation of clitoridectomy set the tone for the whole evening. Brown was relentlessly attacked by the leading obstetricians of his day, and he had to justify his conduct amidst the shouting and jeering of the assembly. He defended himself as best he could, but he failed to convince the society of his bona fides. The overwhelming vote in favor of his removal came as no surprise at the end of four hours of bitter discussion.
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After his expulsion from the Obstetrical Society, Baker Brown resigned from the London Surgical Home. He continued to practise as a gynecologist, but his reputation was irreparably tarnished and his private practice sharply declined. Early in 1872 his health deteriorated, and an appeal was made to medical men to help him out of his financial difficulties. He died in 1873, of a brain hemorrhage, leaving a widow, three young children and a crippled daughter from a previous marriage—a tragic ending to a brilliant career.

THE DEVIANT CLITORIS

Over a century later, the Baker Brown case has been revisited by contemporary historians influenced by the writings of twentieth-century sexologists. Ever since Kinsey, and Masters and Johnson, published their investigations in the 1950s and 1960s, modern sexology has stressed the power of a “denied” female sexuality, bringing the “clitoral orgasm” to the forefront of the discussion. This postwar redefinition of female sexuality, eagerly pressed to the service of feminism, has led to the view that female sexuality is of necessity thwarted under “patriarchy.” Historical accounts of clitoridectomy have been shaped by this belief, implicitly endorsing the notion of an “essential” but denied femininity (a mirror image of the conventional view). Ann Dally, for example, has argued that “the clitoris symbolised the aspect of women that men could arouse but not control. . . . Clitoridectomy was the surgical expression of an ideology that restricted female sexuality to reproduction” (163). As Thomas Laqueur has pointed out, however, “there is nothing natural about how the clitoris is construed. It is not self-evidently the female penis nor is it self-evidently opposed to the vagina. Nor have men always regarded clitoral orgasm as absent, threatening, or unspeakable because of some primordial fear of, or fascination with, female sexual pleasure” (“Amor Veneris” 92). Laqueur shows how the “discovery” of the clitoris in the Renaissance was in fact still rooted in the one-sex model of sex difference that had dominated medical thought since antiquity. In this male-centered system, where the female genitalia were construed as a version of the male’s, the clitoris was seen as the analogue of the penis. Throughout the sixteenth and seventeenth centuries, it was accepted that the clitoris was the seat of woman’s sexual pleasure; medical writers were not worried about the potential of the clitoris for lesbianism or masturbation, nor about its size, which was seen positively, as a healthy mark of female lustfulness. By the end of the eighteenth century, however, the clitoris had become much more problematic. As the emerging notion of two opposite sexes made heterosexual coupling “natural,” the capacity of the clitoris for homo- and autoeroticism was increasingly perceived as a threat to the social order. Clitoral eroticism became synonymous with masturbation in the male, attracting widespread condemnation as the “solitary vice.” Both male and female masturbation were seen to lead to self-destruction; however, in women the problem was further compounded, in that it also posed the danger of sexual inversion. Women who masturbated, it was
maintained, made converts, and by exciting their clitorides enough, they developed a kind of penis themselves (Laqueur, *Making Sex* 227–30; “Amor Veneris” 118–19).

However, there is more to this history than the definition of gender norms: as can be seen from the medical/anthropological literature on clitoral enlargement in black races and in prostitutes, the work of sexual normalization carried out in the Victorian period was as dependent on the construction of racial and class differences as it was on the definition of gender categories. Since ancient times physicians and geographers had remarked upon the large size attained by the clitoris of women who lived in hot countries like Egypt. Women affected by this hypertrophy of the clitoris and labia were thought to be given to lesbianism and sexual excesses, and the routine performance of clitoridectomy in large swaths of North Africa was sometimes explained as a measure designed to keep female sexuality in check. By the late eighteenth century, the so-called “Hottentot apron” had come to be regarded as an emblem of the lascivious, ape-like sex appetite attributed to black women: their voluptuousness, said the comparative anatomist Virey in the *Dictionnaire des sciences médicales* (1819), was “developed to a degree of lasciviousness unknown in our climate, for their sexual organs are much more developed than those of whites” (400). Virey, the author of the standard text on race in the early nineteenth century, was responsible for initiating a long line of anatomical investigations into the genitalia of the Hottentot woman. In his work, as in later studies by other comparative anatomists and anthropologists, the enlarged clitoris and labia of the Hottentot became an important criterion of racial classification, confirming the whole range of assumptions about the “primitive” nature of black races.

At the beginning of the nineteenth century Saartje Baartman, the famous “Hottentot Venus,” caused a medical and popular sensation when her grossly enlarged genitalia and out-sized buttocks (steatopygia) were publicly exhibited throughout Europe. After her death in 1815, an autopsy was performed on her and her genitals were subsequently presented to the Academy of Medicine “prepared in a way so as to allow one to see the nature of the labia” (Cuvier; see also Pieterse 180–81; Gilman, *Sexuality* 290–94). While contemporary caricaturists lampooned this interest as a kind of scientific voyeurism, anatomists and anthropologists were more concerned to provide data about the unity or plurality of humankind. With this object in mind, William Flower, editor of the *Journal of Anatomy and Physiology*, included his dissection of the genitalia of a Hottentot in the first volume of the journal; he concluded that the remarkable development of the labia minora was “sufficiently well marked to distinguish the parts at once from those of any of the ordinary varieties of the human species” (293–94). The many discussions about the anomalous nature of the black’s genitalia published during the course of the century were invariably racist arguments in favor of polygenism: by the third quarter of the nineteenth century, it was widely accepted that the “Hottentot apron” was an inherent, biological variation rather than an adaptation. In Bilimoria’s 1877 manual on “gynæcology, the overdevelopment of the clitoris in
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blacks was defined as a malformation, and it was claimed that the anomaly led to "excesses" called "lesbian love" (Hildebrandt).

The elongation of the labia took on still another signification during the last quarter of the nineteenth century, when it became associated with prostitution as well as with blackness. This merging of the image of the black woman with that of the prostitute was already under way in 1870, the year in which Adrien Charpy's analysis of the genitals of 800 prostitutes examined in Lyons was published in the most distinguished French journal of dermatology and syphilology. The analogy between the prostitute and the Hottentot woman was made explicit in La donna delinquente (1893), by the Italian criminologist Cesare Lombroso, in which the "Hottentot apron" was shown alongside the enlarged genitals of prostitutes to demonstrate the atavistic nature of the prostitute. Both the black and the prostitute were associated with "primitiveness," unrestrained sexuality, and venereal disease.

Running like a thread through discussions of masturbation, lesbianism, prostitution, and blackness, the question of clitorial overdevelopment threw into sharp relief the central problem of the clitoris in the nineteenth century: sexual deviation. Sexual pleasure in women was pathological and socially problematic if it was the result of solitary, homosexual, or promiscuous sexual activity, healthy and socially constructive if it was pursued within the context of the marital relationship. Pace William Acton and his well-known views about the asexual woman, most Victorian medical men recognised that sexual pleasure formed an important part of conjugal love and companionship: indeed, the chief objection to clitoridectomy was that it rendered women frigid, thus undermining the stability of marriage (see also Mosccucci, Science of Woman, 34; Mort 80).

What about Baker Brown's own views, though? His position may be inferred from the reply he gave to his critics, when they argued that clitoridectomy extinguished female desire. Speaking at a meeting of the Obstetrical Society in December 1866, he firmly rejected the accusation that women might be rendered frigid by the operation. On the contrary, he claimed, in five of his cases "from previously having disliked marital intercourse and preferred self-abuse, the state of things had completely changed after his operation" ("On excision" 669). Brown's claims look untenable in terms of twentieth-century physiological knowledge, but one or two of his contemporaries would not have found them so extraordinary. Dr. Tanner, for example, believed that clitoridectomy was the analogue of circumcision, since the excision of the clitoris only removed that part of the pudic nerve that corresponded to the dorsal nerve of the penis in the male, and which supplied the fraenum and prepuce (he added that clitoridectomy was useless as a cure for masturbation) ("On excision" 667). Even more interesting is the opinion expressed by "F. R. S." in a letter to the Lancet for June 1866: the clitoris, argued the writer, was of no importance to the female, not because sexual desire was irrelevant to her sex life, but because the seat of female pleasure was in the vagina—the part that did matter in the act of coition. If we put all this together, we are bound to conclude that Baker Brown was not interested in suppressing female pleasure, but
in redirecting it toward an acceptable social end: heterosexual, vaginal intercourse. Within "normal" female sexuality, there could be no place for the clitoris, with its propensity for sexual unorthodoxy and forbidden pleasures. We really are not very far from Freud's theory of the vaginal orgasm, where he argued that the transition from infant to adult sexuality in woman was contingent upon the little girl putting aside her "childish masculinity" at puberty and transferring her "erogotenic susceptibility to stimulation . . . from the clitoris to the vaginal orifice" (99). Significantly, his pupil Marie Bonaparte saw a parallel between the African practice of clitoridectomy and the social pressures that forced the switch from clitoral to vaginal sexuality onto the little girl: "I believe," she wrote in Female Sexuality, "that the ritual sexual mutilations imposed on African women since time immemorial . . . constitute the exact physical counterpart of the psychical intimidations imposed in childhood on the sexuality of European little girls" (203).

Bonaparte's analogy suggests that the meaning of clitoridectomy must be recovered in the context of a wider reappraisal of the significance of the clitoris, which was just beginning at the time of the Baker Brown case. By the early twentieth century, the downgrading of the clitoris was complete, and the vagina had supplanted the "precious jewel" as the most important locus of a woman's erotic life. Even Havelock Ellis, the greatest of British writers on sexuality, played down the importance of the clitoris, and Freud's ambiguous recognition of its role was used by some of his followers to elaborate the idea that the clitoris was a "vestigial penis" (Weeks 148). Looking at the problem as one facet of the Victorian construction of gender, it is clear that the ambiguous clitoris could not be harnessed to a definition of male and female which hinged on the polarization of mutually related qualities. If sexual divergence was an integral part of the evolutionary process, as Darwin claimed in 1871 in his Descent of Man and Selection in Relation to Sex, then it followed that civilization depended on women repressing their "male-like" clitoris. The hypertrophied genitals of "primitive" races stood as a warning that the whole process of evolution might go into reverse if gender roles were threatened: in the last quarter of the nineteenth century, women's demands for access to male preserves such as medicine and higher education invariably raised the fear of hermaphroditism and sexual inversion (Mosucci, "Hermaphroditism"; Science of Woman 39–40).

Baker Brown's operation is thus part of a history in which the enforcement of heterosexuality and the maintenance of gender boundaries, rather than the suppression of female sexuality, have been the dominant themes. It is also an aspect of the history of Western attitudes to race and class. The enlarged clitoris that distinguished the habitual masturbator was also a mark of blackness and low-class criminality; it thus undermined the putatively biological distinctions between races and classes that served as the basis for the hierarchical ordering of society. As the American gynecologist Robert T. Morris argued in a revealing essay published in 1892, evolution was "trying to do away with the clitoris" in educated white women, leading to lessened female desire and greater sexual independence from men. In his view, the proportion of white women with normal sexual organs was
small, and surgery might be necessary to remove their clitoral adhesions. Baker Brown's mistake, he thought, was removing the clitoris rather than adjusting it: like so many pioneers, he had been "led astray."

**CLITORIDECTOMY AND FEMALE PURITY**

The arguments adduced in support of clitoridectomy suggest that medical consensus around the function of the clitoris was beginning to break down in the last quarter of the nineteenth century. The strength of the opposition, however, does indicate that the majority of medical men were still firmly behind the notion that the clitoris was analogous to the penis: as two of Brown's critics put it, the operation left the patient "a different woman" and exposed her to the possibility of being treated as an "imperfect" person—like a kind of female eunuch ("Obstetrical Society" 439, 438). The physician Harry Moore could not have put it in stronger terms: "we have scarcely more right to remove a woman's clitoris," he wrote, "than we have a man [sic] of his penis." Like the removal of the ovaries, clitoridectomy "mutilated" women because it deprived them of an essential part of their sexual system, evoking the inhuman, barbarous practices of primitive tribes. During the last quarter of the nineteenth century, opponents of gynecological surgery often used images drawn from missionary tales of heathen rituals and human sacrifice among the savages as a rhetorical device by which they sought to convey the sense of horror and abhorrence induced by the surgical violation of women. As the surgeon Spencer Wells, one of of the most scathing critics of "Battey's operation," thundered in 1891: "the oophorectomists of civilization touch hands with the aboriginal spayers of New Zealand" (see also "Excision of the Clitoris" 667; Mosucucci Science of Woman 157–60; Pieterse 69–75).

Not only did clitoridectomy violate the integrity and purpose of the female body; it also threatened deep-seated beliefs about feminine purity and morality. The operation left an indelible stigma on a woman's moral character. Its performance suggested sexual depravity and defiling bodily touchings. As a medical man, who signed himself anonymously "A Provincial FRCP," observed in the British Medical Journal,

> There is one question which must occur to everyone, and I put it with all professional propriety: What is the value, in *toto nuptiali*, of a woman on whom the "operation as usual" has been performed? I have heard of bachelors fighting shy of young ladies who are known to have consulted a certain celebrated physician who insists on a "digital exploration" in every case of illness, but this!

Quite apart from the moral objections to clitoridectomy, there were differences of opinion over the causes of masturbation and its role in the etiology of nervous disease in women. Some doctors still believed that masturbation was a moral disorder that should be treated by moral, rather than physical, means; others thought that it was not a cause, but a symptom, reflecting changes in attitudes to masturbation that would become manifest at the end of the nineteenth century. Accord-
ing to Charles West, for example, the removal of the clitoris in cases of epilepsy, hysteria, insanity, and "other nervous diseases" in women was based on "erroneous physiology" (560). The physician Forbes Winslow claimed that the cause of epilepsy was in the head and that Brown began his treatment "at the wrong end." In the opinion of the *Lancet*, it was not necessary to invoke masturbation in order to account for the causes of female insanity: many physiological and pathological processes, from menstruation to uterine disease, caused sexual excitation in women, such as led to a wide variety of mental disorders (1866, 698). Although no careful data were kept by either side in the debate, the etiological models employed by the critics of clitoridectomy all pointed to the same conclusion: the operation did not stop masturbation, nor did it cure insanity and epilepsy.

These arguments reflected the wide range of beliefs and attitudes that underscored medical discussions of masturbation in both men and women; however, they also revealed a set of preoccupations that was specific to the female sex. The notion that women might practice masturbation was not in accordance with prevailing beliefs about female purity and sexual respectability, and doctors favored theories of female insanity that did not implicate masturbation. The reason why Baker Brown resorted to clitoridectomy with "lamentable frequency," wrote the *British Medical Journal*, was that he was "possessed with the idea of the universality of self-abuse, and its power of producing innumerable evils" ("Clitoridectomy" 1866, 664). Elaborating the point, Charles West stated that masturbation was "much rarer in girls and women than in our own sex" (1866, 560). Thus, although theories about masturbation applied indifferently to males and females, in practice there was an important asymmetry, in that female masturbation was regarded as the less salient problem. This resistance to the idea that women were capable of transgressing the norms of sexual behavior resonated in the different treatment of male and female homosexuality in the Victorian era.

Following the introduction of the famous Labouchère Amendment to the Criminal Law Amendment Act of 1885, male homosexuality was subjected to new regulations; lesbianism on the other hand continued to be ignored by the criminal codes. An attempt in 1921 to introduce provisions against lesbianism similar to those of the Labouchère Amendment failed to get through Parliament, and the reasons are illuminating. In the words of Lord Desart, "You are going to tell the whole world that there is such an offence; to bring it to the notice of women who have never heard of it, never thought of it, never dreamt of it. I think that is a very great mischief." The same view was expressed by Lord Birkenhead, the Lord Chancellor: "I would be bold enough to say that of every thousand women, taken as a whole, 999 have never heard a whisper of these practices. Among all these, in the homes of this country . . . the taint of this noxious and horrible suspicion is to be imparted" (Hyde 200 ff.). Paternalistic institutions such as the law and medicine championed the ideal of female purity and they thus had a special obligation to safeguard women’s morals. As the *British Medical Journal* put it, clitoridectomy was a "dirty subject and one with which only a strong sense of duty can induce professional men to meddle; and then it needs to be handled with an absolute pu-
rity of speech, thought, and expression, and, as far as possible, in strictly technical language” (“Clitoridectomy” 665). By writing a popular monograph, Baker Brown had violated the taboos surrounding female masturbation, creating opportunities for moral corruption and bringing discredit to the medical profession. Physicians were shocked to find that the Report of the London Surgical Home, a publication widely circulated among would-be benefactors, contained a list of female diseases “enough to make the blood of any layman curdle. The curiosity of non-professional men I know this list to have excited,” claimed a provincial physician,

from having had to translate some of the hard names. And are we to suppose that feminine curiosity is either less, or seeks no gratification? . . . It seems to me that, if it be possible to suggest to the female mind thoughts which may result in the deplorable habits, the reference to which no euphonious periphrasis can conceal, it is most likely to be done by the circulation among families and non-professionals of publications that will be read chiefly by those to whom it will prove harmful. (“Provincial FRCP”)

There were thus many different reasons why the medical profession objected to Baker Brown’s practice of clitoridectomy. Brown had performed a “mutilating” operation of no clear therapeutic benefit, failed to disclose its nature to his patients, brought “secret” material into the public domain. Taken together, these misdemeanors amounted to quack practice in the eyes of contemporaries. As Seymour Haden explained to the Obstetrical Society, quackery was “the pretended cure of real disease by means which have a secret, unpublishable, compromising character.” Clitoridectomy was, by definition, quackery, since it was “questionable, compromising, unpublishable, and therefore secret” (“Obstetrical Society” 430). These words illustrate the particular vulnerabilities of gynecology to both professional and popular suspicion. The traditional association of the treatment of sexual disorders with quack practice made gynecology a specialty with a particular need to cultivate its professional image; equally, gynecology received more competition from quacks and unqualified practitioners than any other medical specialty. Thus the appeal to quackery was the most rhetorically effective expression of opposition to clitoridectomy, and it is perhaps because it could be used as a screen for the sensitive sexual issues raised by the case that it ended up dominating the debate. Long lambasted as sexual predators by the opponents of male midwifery, gynecologists needed to be seen as paternalistic protectors of women’s welfare if they were to retain the trust of their female patients and of their male relatives—especially husbands. As the Lancet commented at the end of the case, truth-telling formed part of a professional code which rested “partly upon the basis of time-honoured custom, but mainly upon the still more certain foundation of the honour and chivalry of English gentlemen” (“Clitoridectomy” 1867, 420).

Chivalry was, of course, especially relevant to the practice of gynecology, since it was bound up with the notion of devoted service to women. It also had an unmistakably aristocratic stamp which the upwardly-mobile gynecological profession found especially attractive. Gynecologists often depicted themselves as
knights-in-armor rescuing damsels from the perils of unskilled midwifery: at a time when male violence against women was invariably represented as a working-class problem, woman-worship fostered patient confidence and bolstered claims to a higher social status. As Seymour Haden stressed in his harangue against Brown,

we have to remember that in choosing the particular branch of medicine which we follow, practising as we do among women particularly, . . . we have constituted ourselves the true guardians of their interests, and in many cases in spite of ourselves we become the custodians of their honour. We are, in fact, the stronger, and they the weaker. They are obliged to believe all that we tell them. . . . We, therefore, may be said to have them at our mercy. . . . I think, under these circumstances, that if we should depart from the strictest principles of honour, if we should cheat and victimise them in any shape or way, we should be unworthy of the profession of which we are members. (“Obstetrical Society charges” 430)

Baker Brown had failed his patients and his profession: in the end he was someone who was going to give gynecology exactly the kind of bad name that the profession desperately wanted to avoid, and he either had to be brought into line or denounced and disassociated from the professional body. If medicine was to continue its advance into the domain of sexuality, it was essential that people like Baker Brown should not stand in the way.

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