# VIEWS & REVIEWS

"Why not?" Mary E Black on inspiring all children to study medicine, p 446

# Circumcision in boys and girls: why the double standard?

PERSONAL VIEW **Mihail Evans**

New legislation in France has led to more debate on whether wearing the veil amounts to the sexual repression of Muslim women. Islam's treatment of women is a regular topic in the Western press, yet few jump to the defence of Muslim and other little boys subjected to childhood circumcision. Indeed, the circumcision of the grandson of President Sarkozy, ironically a proponent of the veil ban, made only the gossip pages in France. As a permanent surgical genital alteration, circumcision is arguably a much more serious matter. After all, a Muslim woman has, at least in theory, the option to throw away her veil. The circumcised man's foreskin has been thrown away already.

Few countries have banned male circumcision, but even symbolic alternatives to female genital mutilation are banned in almost all Western jurisdictions. While I was a student, a female academic at my institution published a piece supportive of male circumcision. This prompted a thought experiment: suppose we found a male academic supportive of the surgical modification of female genitals. Would his views be accepted? Why can a Jewish woman speak openly to defend male circumcision and a Somali man not defend female circumcision?

Physiological research has undermined beliefs that the foreskin is "just a flap of skin" and shown it to be an integral part of the penis. With the foreskin considered an erogenous, multifunctional tissue, the established view of circumcision as a non-damaging excision is fatally undermined. It would be more appropriate to change our terminology, to speak of male genital mutilation rather than circumcision in the same way that we use female genital mutilation and not cliteradectomy.

**That any man would spend several hours a day for several years using taped, weighted, and tensioned devices is testimony to the suffering caused**

Finland is among the few places where male circumcision is illegal, although recent judicial decisions have backtracked on this law, making exceptions for some religious circumcisions. Bulgaria banned male circumcision in the 1980s, but more as part of a cultural war on its Muslim minority than out of any overtly humanitarian concern. My partner is Bulgarian, and it amazes me that under law in the United Kingdom I could legally take my son there and subject him to the sort of horrific circumcision recorded by a Bulgarian current affairs programme (www.vbox7.com/play:72a1576e), yet my Somali neighbours would be prosecuted for attempting to appease traditional opinion by replacing female circumcision with a symbolic pinprick to the clitoral hood.

We rarely glimpse more than the very tip of the iceberg of the sexual and psychological damage caused by male circumcision. One symptom is the considerable number of men interested in foreskin restoration. That any man would be prepared to spend several hours a day for several years using taped, weighted, and tensioned devices to try to regrow a foreskin is testimony to the suffering caused in some cases. In browsing online forums such as www.restoringforeskin.org, you get a sense of the great missing continent of male conversations that are unspeakable in public: the Iranian brought up in the West who always feels something is missing when he sleeps with a woman, or the gay US man depressed that he does not have the penis he was born with, like his European lover.

Male circumcision in developed countries is treated simply as a question of opinion. Most women in the UK do not circumcise their sons, but if a mother says she has had her son circumcised "to be like daddy" or for "tradition," hardly an eyelid is batted.

I was shocked by some comments from mothers, which seemed more callous than would be tolerated if gender roles were reversed. In one a mother wrote "LOL" ("laugh out loud") after telling the forum that her circumcised 4 year old "wants his old penis back." In another, a mother from South Africa says she has kept the dried foreskin "in case he wants it back later." Elsewhere on the web, it is completely acceptable to express a preference for a "cleaner" circumcised penis on women's sites. I cannot imagine that a man who advocated ways of making the vagina more "attractive" and "hygienic," let alone by surgical means, would be given a moment's hearing.

Legislation to outlaw male circumcision was put forward in Massachusetts, and although it was defeated campaigns continue in other states (see www.mgmbill.org). Dutch doctors also discussed a ban last year (*BMJ* 2010;340:c2987). A better way to protect the genitals of young boys might simply be to use existing laws. The Tasmanian Law Reform Institute has suggested that male circumcision may breach existing child protection laws (http://bit.ly/eLfxId). And the media have hinted at the possibility of a test case in the UK (http://bit.ly/4GviWc). Finally, little boys in the West might be given the same rights as their sisters, but resistance is peculiarly high and comes from the most surprising quarters.

ROB WHITE

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REVIEW

# Older and wiser

This multimedia exhibition explores aspects of ageing and longevity, challenges our attitudes to old age, and gives new perspectives on successful ageing, finds **Graham P Mulley**

FRAENKEL GALLERY SAN FRANCISCO

**Coming of Age: The Art and Science of Ageing**
An exhibition at the Great North Museum: Hancock, Newcastle upon Tyne
Until 2 March 2011
www.twmuseums.org.uk includes a podcast about the exhibition
Rating: ★★★☆

If the rigours of crisis care, community geriatrics, and academic work left me weary, an afternoon in the outpatient clinic would always lift my spirits. Although some elderly patients advised me not to get old (saying that it was not much fun), most would delight me with their humour, resilience, wisdom, and patience. I was impressed by their individuality, their remarkable devotion to care giving, and their contributions to the cohesion of the local community. It occurred to me that they were the healers; I was the patient.

My joy in being a geriatrician often puzzled my colleagues and non-medical friends, who considered the specialty worthy but dull and depressing. Perhaps some feared their own mortality or worried about decrepitude, disability, dementia, and dependence. All would have read newspaper headlines warning of the demographic time bomb, grey hordes, silver tsunamis, and portents of intergenerational warfare.

Journalistic clichés about the negative economic and social effects of an ageing population outweighed the occasional articles on successful ageing. National newspapers might feature marathon running centenarians, but the local rags showed pictures of frail and bewildered elderly women, clutching a letter from the Queen, not recognising the family members around them.

Ambivalence about ageing—jogging shoes or rocking chair?—has always existed and has been expressed by artists over the centuries. Despite the unprecedented improvements in longevity and in the care of elderly people, elders rarely feature in major exhibitions. How refreshing it is, then, to find a university museum that celebrates ageing, combines artistic and scientific perspectives, and gives us tips on how we might positively influence our own ageing by simple lifestyle choices. The exhibition's main themes are biology, vitality, vulnerability, and wisdom.

**Mitochondria are tiny batteries; replication of cellular damage is a biological game of Chinese whispers; the human body is continually at war with itself**

**The Brown sisters, photographed yearly by Nicholas Nix: above, 1976; left, 1999**

Do make the effort to visit Newcastle, but expect to be challenged and changed. The team that is behind the exhibition, from Newcastle University's Institute of Ageing and Health, wants us to think about old age and how it will affect us, to confront our attitudes, to make us aware of the ageing process, to understand the science of ageing, and to consider the opportunities and responsibilities of ageing.

The main part of the large exhibition room features work by contemporary artists, some of whom have spent time in the institute. There you will find art, poetry, sketches, videos, photographs, sculpture, and lithographs. Our views of beauty are questioned. A nude woman stands in front of dunes and mountains, radiating dignity and composure; the beauty of her ageing face challenges the current fad for minimising wrinkles. Graphic pictures of rheumatoid hands do not distinguish disease from ageing.

A few works are by established artists: Henry Moore illustrates Shakespeare's *The Seven Ages of Man*. Degas's visual impairment causes his *Ballet Dancers*' faces to be hazy. A larger exhibition might include artists who continued to be active and successful in later life (Renoir, Munch, Kandinsky, Hokusai, Tintoretto, Titian, and Rodin, to name but a few) and the depiction of old age in many art forms over the centuries.

The exhibits on the science of ageing are understated. No details are given of the institute's important work on falls and stroke; there is nothing on critical analysis or the excitement of discovery and little on technological innovations. We receive sound advice on diet and exercise and the importance of social networks and mental stimulation but are not given the evidence base for these recommendations. The language of science makes biological gerontology highly accessible: mitochondria are tiny batteries; replication of cellular damage is a biological game of Chinese whispers; the human body is continually at war with itself.

On the "words of wisdom" wall visitors are encouraged to post memorable sayings of elders. Here are pithy aphorisms, homespun philosophy ("It's never too late to be the person you always wanted to be"), and sage advice ("Have a good laugh at least once a day"). Some of the saltier sayings made me laugh out loud.

The exhibition works best when art and science combine. A poet brings a new vocabulary to pathological realities: τ proteins strangle and swamp; plaques are like fingerprints; nuclei are as clear as strawberry pits. The three dimensional sculptures of the hippocampus and amygdala are beautiful.

Top marks to Newcastle University for having the vision to set up a pioneering institute of ageing that has achieved international stature. Congratulations must go to Tom Kirkwood, the institute's director, for orchestrating this original, creative, and stimulating exhibition, which will do much to inform the general public about the mechanisms of ageing, the importance of research, and the things we can all do to maximise our enjoyment of our later years.

**Competing interests:** See bmj.com.

Graham Mulley, immediate past president, British Geriatrics Society, and retired geriatrician, Leeds

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REVIEW

# Alive and kicking

An exhibition of living artworks shows off our biotechnological advances while challenging our lack of ease with tissue engineering, finds **Muiris Houston**

**Visceral: The Living Art Experiment**
An exhibition at the Science Gallery, Trinity College Dublin
Until 25 February 2011; admission free
www.sciencegallery.com/visceral
Rating: ★★★★

Is medicine an art or a science? It's a question as relevant in our highly technological age as it was when René Laennec invented the stethoscope in the early 1800s. Guidelines and protocols may guide assessments and treatment, but in the crucible of a patient interacting with his or her doctor, the art of medicine is often what makes the difference between a successful consultation and one that fails the patient.

Modern medicine does not offer much time for reflection. It's a pity because within each patient's narrative lies an opportunity to answer the key question: why is this person seeking medical help at this particular moment in time?

One of the attractions of Visceral: The Living Art Experiment, an exhibition currently on show at the Science Gallery in Trinity College Dublin, is the opportunity to reflect on that space where art and science meet. A series of provocations and puzzles challenges us to consider the implications of modern biotechnology. The philosopher Marshall McLuhan regarded artists as canaries in the coalmine of scientific research, alerting us to the possible ways in which new technologies might transform social relations. At the core of all the artistic explorations in this exhibition is a strong sense that human intervention with life processes needs cultural interpretation.

The works on show were developed in SymbioticA, a research laboratory for biological artists in the school of anatomy and human biology at the University of Western Australia. It is there that art and science have collided for the past 10 years, and this exciting new exhibition is the result. To dismiss it as being only for those interested in science would be a great shame to those of a more artistic persuasion, and vice versa. Some, looking for science or art in their traditional sense, may not be happy, but the interesting hybrid that has been created will delight and intrigue many.

Although we live in an increasingly interactive world, it can feel a little surreal whispering your worries to a microphone beside the semi-living exhibit of worry dolls. These dolls are handcrafted out of degradable polymers and surgical sutures, but each has been seeded with living cells that gradually replace the polymers. Partially alive, they are inspired by the dolls that are given to children in Guatemala to whisper their worries to, to help induce sleep.

*Silent Barrage*, another work, uses signals from a dish of brain cells growing at the Georgia Institute of Technology in the United States. The neurones communicate with a mechanical display at the gallery, and movement of the audience in Dublin sends a signal back to Georgia that alters the neurones' response.

The subject matter of this show is not obvious, and neither are the works on display. Media usually confined to the laboratory—human tissue, fish semen, and insects—are used, as are other scientific paraphernalia. This exhibition could have been interpreted as artists taking the science lab hostage, but they have pulled it off with great success. Although on one level the projects can be appreciated for their artistic merit and beauty, they also have arresting concepts behind them. Works such as *Proto-Animate20* and *Let One Thousand Proteins Bloom* are concerned with subjects that are very much at the forefront of medicine and science today. The artists have touched on everything from Alzheimer's disease to DNA coding and epilepsy.

**Art and science, though at first glance seemingly different, are both deeply rooted in humanity**

The beauty of this exhibition is that it can be appreciated on a visual level too. There is the almost oriental feel of *Host*, with its jars of live crickets suspended on long plastic stalks, bathed in green and blue lights, not to mention the sumptuous, if tiny, gold sculpture that is *Midas*.

Art and science, though at first glance seemingly different, are both deeply rooted in humanity, and Visceral shows that they can learn from each other. Science can too often be bogged down with facts and pragmatism. There can be a noticeable lack of abstract thinking that is needed to answer the new questions facing modern science. Likewise it can give gravitas to the big ideas now emerging in the art world, showing detractors that it is no longer just art for art's sake but for science's too.

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PATRICK BOLGER

**Living doll: mannequins seeded with human cells will listen to your worries**

STEVEN POTTER LAB, GEORGIA TECH, ATLANTA

**Nervous breakdown: participants in Dublin interact with neurones in the US**

BETWEEN THE LINES **Theodore Dalrymple**

# A villainous doctor

As Herbert Kinnell pointed out in the last Christmas edition of the *BMJ*, Agatha Christie's novels have a lot of doctors, an inordinate number of them murderers (2010;341:c6438). In *Cards on the Table* (1936) Dr Roberts is not the only villain of the piece, but he is certainly one of the villains of the piece.

The story is convoluted, but to object that it is implausible is like objecting that the story of *Little Red Riding Hood* is implausible. Fairy stories are not to be confused with social realism, any more than revolutions are to be confused with dinner parties. Indeed, in Christie's novels dinner parties are not to be confused with dinner parties.

Mr Shaitana is a foreign socialite in London who, like many rich people with not much to do, likes flirting with evil. He holds a dinner party, inviting not only Hercule Poirot and Superintendent Battle of Scotland Yard but also four seemingly respectable people whom Mr Shaitana, but no one else, knows to have committed murder. Before the evening is over one of them has killed the host for fear that he is about to be exposed.

Among the four is Dr Roberts. When he arrives he "did so with a kind of parody of a brisk bedside manner. He was a cheerful, highly-coloured individual of middle age. Small twinkling eyes, a touch of baldness, a tendency to *embonpoint* and a general air of well-scrubbed and disinfected medical practitioner. His manner was cheerful and confident. You felt that his diagnosis would be correct and his treatments agreeable and practical."

**If only we'd paid more attention to Miss Christie we should have had revalidation a long time ago**

I don't think anyone would write a passage like this nowadays. No doubt if it referred to a male member of the profession the touch of baldness and the tendency to embonpoint could stay but not, surely, the twinkly cheerful confidence. These days Dr Roberts would have had a hard day staring at the computer screen and entering data, and he would drag himself in rather than enter briskly.

**Christie: wrote a doctor whodunnit**

Some years ago Dr Roberts was thought by one of his patients to be having an affair with his wife and was threatened with exposure to the authorities. Dr Roberts disposed of the patient by putting anthrax in his badger hair shaving brush and of his wife by giving her typhoid rather than vaccinating her against it when she proposed to go to Egypt.

It is he who kills Mr Shaitana; he also kills one of the other suspects with an intravenous injection of N-methyl-cyclohexenyl-methyl-malonyl urea.

In investigating Dr Roberts's background Superintendent Battle questions his receptionist, Miss Burgess, about the death rate of his patients: "'From the statistical point of view, it would be interesting to know how many deaths occur among a doctor's practice per year. For instance now, you've been with Dr Roberts some years—'

"'Seven.'

"'Seven. Well, how many deaths have there been in that time off-hand?'

"'Really, it's difficult to say.' Miss Burgess gave herself up to calculation. 'Seven, eight—of course, I can't remember exactly—I shouldn't say more than thirty in the time.'"

Ah, if only we'd paid more attention to Miss Christie we should have had revalidation a long time ago: though, of course, no one claimed that Dr Roberts was actually incompetent.

Theodore Dalrymple is a writer and retired doctor

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# MEDICAL CLASSICS

## Eyes Without a Face

A film in French (Les Yeux Sans Visage), first released 1960

*Eyes Without A Face* boasts many staple ingredients of the horror film: an old dark house, a pretty female victim (or four), and an evil genius doctor (and a sidekick with a spoiled identity). Yet this film is the antithesis of dismissible. From the subtly disconcerting opening credits to the surreal final shot, the director, Georges Franju, draws the viewer into a cinematic liminal space where lyricism, cruelty, misery, agonised ambivalence, and tenderness comingle with a grand guignol horror.

The plot is simple, though its components are not: the pre-eminent surgeon Dr Genéssier has crashed his car and in so doing destroyed his daughter Christine's face. He keeps her cooped up in his private cottage hospital outside Paris. A full face mask and the removal of all reflective surfaces protect her—and us—from seeing the extent of the damage inflicted. Meanwhile, with the help of a female servant he kidnaps young women to serve as "donors" for face transplantations, chillingly depicted, that never quite succeed. These women are human sacrifices on the twin altars of his medical hubris and sense of guilt. Dr Genéssier is both haunter and haunted, while Christine lives a hellish half life, desperate and hopeful but horribly appalled by proceedings. It's an unusual doctor-patient relationship for sure.

If it is these tensions that generate the film's narrative power, then it is through the expert use of the tools of his trade that Franju fashions an unqualified masterpiece: the black and white photography oozes atmosphere; the locations are choice; and the performances are perfectly calibrated. But it is perhaps the film's soundtrack that supplies its knockout punch. Part of it is occupied by sardonic musical themes that lend a nightmarish air, and there are disturbing natural sound effects. Mostly, though, there is much silence: we are accustomed to relying on dialogue to propel a story, and its frequent absence forces us to engage with this film differently. We have to watch patiently and absorb cumulatively. (A side effect is that the film seems slow to some people, even though it lasts only 90 minutes.)


Franju first showed his fascination with what goes on behind exteriors in an early film, the astonishing 20 minute documentary about Paris abattoirs called *The Blood Of Beasts*; and in *Eyes Without a Face*, in which the relation between identity and appearance is so central, he found the perfect vehicle for it. Eyes are the window of the soul—particularly in the cinema—and the title primarily refers to Christine, whose mask has cutouts for her eyes. But there is an ironic parallel: when the doctor dons cap and mask to perform his awful operations, he too has "eyes without a face."

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# Explaining the unexplainable

FROM THE FRONTLINE
**Des Spence**

When I started in general practice there were no nurses, no blood test results, and no radiographs. Just me in a demob suit, a broken thermometer, and a stethoscope prop. I struggled to cope with 10 minute appointments as the list of possible differentials scrolled in my mind. I saw potential pathology in every consultation because everything was vague—neurology, chest pains, headaches, aches and pains, dizziness, bladder symptoms, and fatigue. The history never hung together and changed at each time of telling. Then, of course, there were the common conditions that never appeared in textbooks—peeling feet, nasal crusting, and all the rest. The vertigo of uncertainty gave me chest pains.

The other general practitioners laughed and joked, kept to time, and rarely investigated or referred. I asked them how they did it. "If the symptoms don't make any sense then there is nothing wrong with them." "Remember, frequency of attendance is inversely proportional to likelihood of pathology." "Referring the anxious only makes them more anxious." "Medicine is just magic and misdirection." "Everything you were taught in medical school is wrong." "Look for normality, not pathology." "Do nothing, but with style."

And with the insight of time I realised that they were right. I saw how a small minority of patients with multiple and changing symptoms dominated the workload, not just in general practice but in hospital too. Recently we have rebranded these patients as having "medically unexplained symptoms," but these problems are as old as Hippocrates. And these patients are different from the "worried well," spawned from hysterical health promotion campaigns, because these patients have chronic, persistent, and changing patterns of symptoms. It isn't to dismiss these patients, because their symptoms are real to them, but there is no underlying pathological process. Estimates indicate that a quarter of consultations are for unexplained symptoms, but experience suggests this value is higher (*BMJ* 2008;336:1124).

Practising medicine is not playing *House*; however, medical schools are still intent on teaching porphyia not corns and equipping doctors with pathology blinkers. This leaves many doctors simply unable to recognise patients with unexplainable symptoms. And doctors are being denied the opportunity to gain insight into unexplained symptoms because of the increasing breakdown of continuity of care. This has led to ever increasing investigations, polypharmacy (most notably analgesics), and unnecessary interventions and admissions, which in turn consume vast quantities of resources and, worse still, reinforce patients' health behaviour. The most unexplainable and unforgivable aspect is why there is so little research and teaching on this topic.

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# The need to teach inspiration

THE BIGGER PICTURE
**Mary E Black**

I don't know my place. I never have. This has been both a strength and a weakness. I am driven more by curiosity and an interest in talking to people and understanding how they work than in moving smoothly through the levels of social or class convention or staying within the defined limits of a medical problem.

I came to England in the 1980s, on a tidal wave of Irish junior doctors facing unemployment and few training opportunities at home. In comparison with the family hierarchies ruling Irish medicine, England was a free market. I was astonished by the open and generous help gladly given by senior colleagues, and hard work, delayed childbirth, and optimism led to many opportunities. I also learnt to take risks. The legacy was confidence—I transgress with relative ease.

The week before last I spent the afternoon at Mossbourne Community Academy in Hackney. This former sink school in northeast inner city London, closed as an abject and violent failure, now blossoms, an example of how a school can be if it is well run and decently funded. This is a good place: the children are happy; the staff are engaged; order reigns. Through glass fronted classrooms and down bright corridors festooned with students' work and inspiring banners, learning oozes. The health science hopefuls in the sixth form are worth meeting and will take any opportunity given and then magnify it. They asked awkward, smart questions.

UK medical schools, once the private playgrounds of wealthy sons, have over the years broadened admission to the able, then women, then anyone. But the scandal of enormous hikes in university fees in the United Kingdom threatens to obscure efforts to open the top universities to a wider range of children, and the UK is examining how applicants clear that first bar of academic eligibility.

The England I love is asking such questions. The republic of Ireland meanwhile has barely started, and admission to medical school is based on numerical scores in the school leaving certificate examination and the health professions admissions test. This keeps the competition for places fair and open, but it only partly tackles the lack of a level playing field.

However, no matter how entrance criteria for university are adjusted to measure scholastic and medical school potential, children still need contacts and guides. Coaching, encouragement, and work experience are available to well connected children but need to be created somehow for those who may not find it in their immediate environment. This is exactly what Mossbourne does. What all children need are more signposts for boundary crossing—signs that say, "Look: there is a door in that wall, and you can walk through," "That territory can be yours," and, above all, "Why not?"

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