Why the modern day eunuch remains invisible

PERSONAL VIEW Richard J Wassersug, Tucker Lieberman

Let’s study emasculation. No, we don’t mean the loss of political power. That’s a metaphorical sense. We mean the real thing: the removal or chemical destruction of a man’s testes. And here we refer not to the manufacturing of courtiers in Constantinople, nor to the construction of a caste of opera singers, but to modern day emasculations.

Although to many people castration signifies a barbarism that disappeared with the demise of the Ottoman empire, the Chinese dynasties, and the castrati movement in European music, there are surely more men living with removed or functionally arrested testes today than at any other time in history. A minority either identify as women and have sex reassignment surgery or sought castration simply to suppress their libidos. By far the majority, though, are prostate cancer patients, and it’s this group that we focus on here.

Chemically shutting down or surgically removing the main source of testosterone—the testes—can slow the spread of prostate cancer. Castration, of course, has extensive side effects. A castrated adult male will lose muscle but gain fat. He can expect hot flushes like those that women have at menopause. He will lose body hair, and his penis will shrink. Erections will be rare and weak, if they occur at all. He will be sterile.

Castrated men also often experience changes in cognitive function and affect, although the nature of those changes is poorly understood. Recent reviews of the topic have yielded contradictory results.6,11

Right now, in North America, as many as 600000 patients with prostate cancer are coping with the effects of medical emasculation.12 But unless such a man tells you what has happened to him, his physical and mental changes may not be apparent to you. Most of those patients are on a short term course of androgen suppressing drugs and believe their testes to recover; and even with short term use the effects are not always completely reversible.13

Inaccurate, antiquated, and negative stereotypes of castrated men—implicitly illustrated by the misuse of the term “eunuch” to indicate a completely powerless person—are perpetuated because of society’s general ignorance of contemporary castrations. The language of emasculation remains pejorative and shameful.14

Fearing such shame, many patients hide their medically modified morphology and deny that they feel any different.15 Thus they remain invisible,16 and their condition is poorly understood.

Emasculation is arguably as distressing for men as mastectomy is for women. Nevertheless a search in PubMed on “castration” and “mastectomy” matched with various words indicative of psychological effects indicates that mastectomy has received over 50% more attention in that domain. Data from open ended discussions with men taking androgen deprivation treatments show that many are distressed yet can’t fully articulate how they feel about the changes they are experiencing.17 In trying to preserve residual masculinity, most are reticent on the subject of their transformation.

It is crucial that the psychosocial impact of castration receives more attention so that those who are androgen deprived can be helped to adapt to the changes they experience, whatever those changes may be. Recognising the side effects of any medical treatment is a prelude to developing effective coping strategies. This is particularly true when the treatment affects the personality.

Although emasculated males may continue to present outwardly as men, they must come to terms with their diminished biological maleness. How they adapt to such changes is inevitably influenced by social context. As long as society remains largely unaware of who is emasculated and how common castration is, we can expect little curiosity about its consequences. Thus there is a paucity of scholarship on modern day emasculation. This lack of research is regrettable, as it hampers efforts to help medically emasculated men overcome the more emotionally challenging side effects of their treatment and leaves androgen deprived patients little or no social context with which to accept the changes they experience.

So where should you go to learn more about the psychosocial effects of androgen deprivation? Despite the fact that eunuchs have been the most common gender variant throughout history, they are rarely mentioned in university courses. Even when castration is discussed in the field of “gender studies,” it tends to be metaphorical, as exemplified by the title of Germaine Greer’s famous book The Female Eunuch.

The only academic terrain in which contemporary castration is regularly explored is in departments of urology, where physicians are trained to do orchidectomies and administer castrating drugs to patients with cancer.

Even there, physicians shy away from using terms such as “castrated,” “emasculated,” and “neutered,” because they sound like what they are: mutilating procedures with profound psychological and social impact. Typically physicians relabel androgen depriving treatments, including orchidectomy, as “hormonal therapy.” This may make it easier for them to diminish, if not dismiss, the consequences of the treatment—easing their own angst, if not that of their patients. This, however, leaves the scholarly exploration of emasculation in academic no man’s land.

Genital ablation has never been merely a metaphor. Everyone should be aware that a multitude of men are either chemically or surgically castrated for a variety of reasons in contemporary Western society. Until doctors, scholars, and researchers are forthright with their language, the emasculated will remain invisible. This invisibility, in turn, castrates the study of emasculation.

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The sibyl is faulty

The way that research is currently configured, there is enormous pressure if not to deceive then certainly to game the system, writes Julian Sheather

Every age has its sources of wisdom, those to whom we turn for a little light in the abiding darkness: the oracle at Delphi intoxicated by volcanic gases; shadowy priests whispering behind the grille; or ascetics and gurus in their mountain fastnesses. Ours, though, is unassailably the age of the expert. With science regnant, it is to her disciples we instinctively turn. What, asks David Freedman in his combative new book, is the status of their collective wisdom? The interesting thing turns out to be not the answer, which is given in the title, but what lies behind it. Wrong: Why Experts Keep Failing Us—And How to Know When Not to Trust Them is a brisk interrogation of the extraordinary fallibility of even the most lauded and garlanded of our contemporary experts.

Freedman is catholic in his choice of targets—no discipline is spared—but he does have a lot to say about contemporary health claims. He introduces us at the outset to John Ioannidis, professor of medicine at Tufts University, who specialises in assessing the likelihood that the results published in medical studies are false. It turns out that even when focusing on research published in the most prestigious medical journals, two out of three studies are likely to be unreliable. And when it comes to randomised control trials—the absolute gold standard—one out of four has subsequently been refuted; and, Freedman says, that rate could be higher but nobody has tried to refute more than half the rest. And yet the findings of many of these studies appear daily in the media as the nearest thing we have to health gospel. So what is going on here?

We are in the midst, it would seem, of a collective dance of error, and the problems begin early on with the very structure of research. Career researchers are under enormous pressure to get their research published in prestigious journals. These journals are more interested in positive than negative findings—it is just so much more interesting to read about researchers establishing a link between, say, a particular behaviour and a specific disorder than about the numberless possible links that have been discounted—so consequently there is pressure on researchers to come up with findings that support the study’s hypothesis rather than refute it, so called “publication bias.” There is a problem here, though, for, as Freedman points out, the more novel and exciting the hypothesis, the more likely it is to be published but the less likely it is to be right. Setting to one side outright fraud, the way research is currently configured puts enormous pressure on scientists if not to deceive then certainly to game the system.

When imperilled research findings make their way into the mainstream media, things get much, much worse, but this is less to do with researchers and more to do with our preferences as consumers. High quality research often comes hedged with qualifications and disclaimers, but these are not newsworthy and are frequently omitted in the passage from scientific journal to news stand. News outlets recognise that consumer taste in health stories is for clear, confident advice, preferably involving small actions that will contribute large benefits—hence the enthusiasm for miracle weight loss diets. Apparently, we particularly favour findings that are both optimistic and in accord with our underlying prejudices. Put simply, consumer taste is par excellence for precisely the least trustworthy findings.

Given Freedman’s breathless exposure of so many sources of contemporary scientific error—I haven’t mentioned the effect of commercial sponsors, the perils of peer review, the habit of assuming causes where there are only correlations, and the limitations of animal models—what, if anything, can be said on the positive side? In addition to a nice appendix asking whether or not he might be wrong himself, Freedman leaves us with a few pointers to the kinds of research that might repay attention. Good advice, he writes, “will be complex, it will come with many qualifications, and it will be highly dependent on conditions. Because of all the ‘ifs,’ ‘ands,’ and ‘buts,’ it will be difficult to act on. Because our beliefs tend to be simplistic and optimistic, it will be probably be incompatible with them. In other words, good expert advice will be at odds with every aspect of the sort of advice that draws us to it.” And although such sober advice is unlikely to induce euphoria in the reader, I’m not sure that the Delphic sibyl, high on her volcanic vapours, could have done better than that.

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Unsyphilised behaviour

It is said by his most important biographer that after he reached middle age Henrik Ibsen (1828-1906), the great Norwegian playwright, never read anything other than the Bible and newspapers. It did his plays no harm.

He wrote *Ghosts* in 1881. The plot turns on what was then called hereditary syphilis. Oswald, son of Mrs Alving, returns from Paris, where he has lived for some years as an artist in Bohemian circles. He has been told by a great specialist there that he has that dread disease; and it emerges that he contracted it from his father, the now dead Captain Alving (who clearly died from neurosyphilitic dementia), who lived a secret dissipated life, which hereditary syphilis is only a symbol.

Two questions come to mind as one reads *Ghosts*. Can syphilis be transmitted by the father alone? And can the mental symptoms that Oswald shows (severe headaches and loss of concentration and willpower) be the first manifestations of congenital syphilis at such a late age? Oddly enough, eminent physicians of whom I asked these questions were unable to answer.

The great specialist whom Oswald consulted in Paris is almost certainly based on Alfred Fournier (1832-1914), who first attributed tuberculosiis to syphilis (before the spirochaete had been discovered) and was also among the first to recognise the long term neuropsychiatric consequences of the disease.

Shortly before *Ghosts* was published Fournier wrote a book, *Syphilis and Marriage*, in which he stated quite clearly that syphilis could be passed on by the father alone, without there having been any signs of it in the mother. This was in accordance with the law enunciated by Abraham Colles (1773-1843), the surgeon whose fracture we all know, who wrote: “I have never seen or heard of a single instance in which a syphilitic infant (although its mouth be ulcerated) sucked by its own mother, had produced ulceration in her breasts; whereas very few instances have occurred where a syphilitic infant has not infected a strange, hired wet-nurse.”

In other words, mothers of syphilitic infants could be infected with and develop immunity to syphilis without clinical signs or symptoms. Mrs Alving was one of those mothers, and so it appeared that Oswald inherited syphilis from his father alone.

Fournier also supplied the answer to the second question. In his huge book *La syphilis hereditaire tardive (Late Onset Hereditary Syphilis)*, published five years after *Ghosts*, he states: “Hereditary syphilis can do what acquired syphilis does, that is to say to express itself after a long interval, indeed at a mature age.”

Even in his depiction of Oswald’s symptomatology Ibsen is correct, according to the clinical science of his time. Fournier says: “One symptom that serves as the first manifestation of hereditary cerebral syphilis is headache.” This is just as in Oswald’s case, followed, as Fournier describes, by an inability to concentrate. It seems that Ibsen knew his Fournier.

Sixty four years after Fournier’s book, Charles Dennie and Sidney Pakula, in their massive tome *Congenital Syphilis*, confirmed all that Fournier and Ibsen had written. Fournier estimated that in the middle years of the 19th century 15% of the French population had syphilis. Were it not for the discoveries of Wassermann, Ehrlich, and Hata, it appears that syphilis would have been an even greater threat than it is now.

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FROM THE FRONTLINE
Des Spence

What junior doctors need

Jeremy Vine was inflaming the middle aged masses on BBC Radio 2 the other day, this time over the reduction in junior doctors’ hours to 48. The profession was getting fired on the airwaves yet again. Looking back through the rosy retrospectoscope, older people wonder what is becoming of society and despair of the current generation. But this new generation is our children, and young doctors are merely younger versions of ourselves caught in a medical system not of their making.

So what of the past? We worked one in four nights and normal hours during the day. There was no induction, no mentoring, and little senior supervision, and we often made decisions beyond our ability and training. The care of patients was put at risk. To begin with we made mistakes, but these were mistakes that could be prevented by education. The pay was poor, but the long hours made up the money. Indeed, many of us did additional sessions because money was tight, and we were grateful for the work. We had almost no sickness absence; this was no machismo culture, but we felt like comrades in arms in a clinical conflict zone. Study leave was getting the day off to sit your exam.

We worked in teams, and our next jobs depended on our references, because there was little formal career structure. There was some bullying, but no one complained. Our retribution was to deride the bullies in the junior doctors’ mess. This was a flawed system, long on experience but short on education.

Today we see the reaction. Multidisciplinary working, shifts, induction, supervision, mentoring, e-portfolios, union meetings, ever more doctors, structured training programmes, maternity, paternity, and family leave, part time training, antibullying policies, equality, structured interviews, human resources departments, and proper pay: surely this protected generation has it all. But the stories leaking from hospitals are of the end of medical and surgical firms, locums, unfilled posts, no continuity, dysfunctional rotas, and absenteeism. A haemorrhaging of happiness, goodwill, and professionalism: this is a flawed system long on education but short on experience. There must be a better way.

Currently many senior doctors still work more than 48 hours, so junior colleagues should likewise be free to work longer, up to 65 hours. The Working Time Directive must be renegotiated, and this should be supported by the BMA. The practice of medicine and surgery cannot be learnt, only experienced. Good judgment comes from experience; experience comes from bad judgment. So we should allow junior doctors to earn self respect and assert professionalism in the front line once again.

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“Outside the Box”

Trisha Greenhalgh

I was recently invited to attend a media training day by our corporate affairs department, which all universities have these days. Conscripts had two things in common: we did research in controversial or sensitive areas, and we were incapable of converting profound academic insights into pithy soundbites.

Our trainer was a feisty woman whose pedigree included seven years as assistant editor of a leading national tabloid newspaper. I calculated that she could have been the person who ran the front page story that was based loosely (and I do mean loosely) on a piece I had written in this column on abortion, but I thought it unwise to confront her about this.

She explained that the making of scientific news occurs in a tight 24 hour cycle, beginning with an analysis of the day’s press releases and leading, through follow-up phone calls and drafting of outlines, to a shortlist of pieces to be considered by the section editor in late afternoon. Pieces selected to run are sharpened and by evening will be set out on the page under bold, five word headlines.

All this means that the phone call that interrupts your clinic at 11.30 am must be answered with two short sentences—what you’ve discovered and why it matters—before 2 pm, or you will lose the opportunity for your painstaking five year research study to become news. In the absence of superlatives (“biggest,” “best,” “first”) and unequivocal numerical data (“one in four schoolchildren”) you are likely to end up “spiked” (rejected by the editor) or relegated from the news (front) pages to features (the bits at the back that only your elderly mum reads).

In one exercise we were each sent into the corridor in turn to await a phone call from Francesca of the Daily Blurb, with no warning of the topics to be raised. In the afternoon we progressed to a role play of a live television interview. “Professor, I understand that you’ve just done a sex change on a minor. Are you planning on doing any more?”

After four takes, the trembling endocrinologist managed to produce a coherent lay explanation of how the management of congenital adrenal hyperplasia differs from gender reassignment.

Here are some take home tips. Prepare two or three key messages and learn them by heart. Use the politician’s trick of shifting the agenda (“I can’t comment on that, but what I do know is”). And finally, of course, nothing is “off the record.”

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