Visual broadcast in schizophrenia

Although doctors are trained to classify psychotic symptoms (for example, as delusions or hallucinations) within a standardised mental state examination, it is likely that some symptoms will defy such classification. Hence, if the mental state examination is not supplemented by patients’ verbatim descriptions of their experiences, then novel symptoms may go unrecognised and potentially untreated. We have recently cared for a patient whose case reinforces the importance of this point.

A 38 year old man with long-standing paranoid schizophrenia suffered a relapse characterised by prominent auditory hallucinations, persecutory delusions and thought broadcast. Rather, we want to emphasise that one’s own thoughts have become accessible to others). Following admission to psychiatric hospital, he described a previously unrecorded symptom. He explained that he preferred not to bathe because, during bathing, images of his naked body were being transmitted to and seen by others. The basis for this belief was an experience during which he became aware of his own visual perceptions diffusing out of his head, so that whatever he saw was simultaneously seen by millions of other people. The experience was not confined to occur during bathing, but the patient was most embarrassed in that situation hence the symptom became apparent. Examination by an ophthalmologist revealed only mild short-sightedness. No abnormalities were found on clinical examination. Standard blood tests were normal.

The symptom that we describe demonstrates clear similarities with thought broadcast in that the visual images escape passively and are broadcast and shared with others. Rather, we want to emphasise that one’s own thoughts have become accessible to others.

We searched Medline for earlier reports of ‘visual broadcast’ (1966–2004; terms: ‘visual’, ‘vision’, ‘perception’, ‘broadcast’ and ‘schizophrenia’), but found no related citations. Multiple sources describe thought broadcast, but these do not provide a link with visual perception.

Although ‘visual broadcast’ is previously unrecorded (as far as we are aware), it is not our intention to report a ‘rare’ or ‘obscure’ symptom. Rather, we want to emphasise the importance of listening to patients’ verbatim accounts of their psychiatric symptoms. We argue that disorders of the mind can produce diverse and, perhaps, patient-specific symptoms whose essence can only be captured by patients’ own descriptions of their experiences.

The identification of ‘visual broadcast’ in our patient enabled the clinical team to incorporate this knowledge in his management plan. With reassurance, he was able to resume bathing whilst receiving inpatient treatment for acute schizophrenia; his willingness to bathe is a helpful marker of overall improvement in his mental state.

**References**

2 Schneider K. Clinical Psychopathology. New York: Grune and Stratton, 1959
practitioner, social anthropologist, ex-ship's doctor, researcher, and published writer. It provides the reader with a wonderful magi-
cal, mystery tour of stories from his career thus far. It is only available in South Africa 
at the moment (www.kalahari.net) but available via the usual easy routes in our global world. I am told publishers are sought 
in the US (likely) and the UK (perhaps).

The book is composed of three parts and 
these mark the three phases of Helman's 
expansive career. What are these stories and 
what or who are they for?

The stories are invariably about patients 
and memories of patients collected over the 
last 27 years of clinical practice. There are 
links and resonances with other works—for 
example, Dostoyevsky—and this juxtaposition 
works particularly well when they appear.

The chapters, with almost familiar names, 
such as “The Rusty Ark” and “Deformation Professionnelle”, are mostly short and suc-
cinct, not pithy but compellingly thought 
provoking. The ones I liked best are those 
mired in what is often the daily grind of 
general practice, the patient with psychosis 
(Mrs P), or a lady so bitter from a lifetime of 
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general practice, the patient with psychosis 
(Mrs P), or a lady so bitter from a lifetime of 
whom she is afraid of yellowing 
An autumn leaf”. The last and poignant 
chapter, “The Brass Plaque”, brings the 
endeavour to a close with the removal of 
the aforementioned plaque from the front 
door of his surgery in North London. 

It is not all about patients, for example one 
of the tales is a highly personal tale of the 
workings of our clinics in the UK. Having 
fallen, following a hard day’s work the author 
ends up on the opposite side of the fence and 
the full force of an under-resourced, under-
achieving National Health Service (NHS) 
hospital comes down on him like the pro-
verbial ton of bricks. His insights are devas-
tating, powerful, and rather sad, considering 
that he is a local general practitioner (GP).

I have been in practice myself now for over 
20 years and the revelation to me is that 
many of the patients in the Suburban Shan-
am are instantly recognisable. The grumpy but 
good old lady who has seen better times in 
the days of the Raj, the man who has lost 
touch with reality, and the sad bereaved 
old woman should be familiar to those in general 
practice. Is this so amazing I ask myself, or is 
there something in these stories that the 
anthropologist/physician can relate to, in 
a way that is perhaps unique? Or is it that these 
are archetypal GP/patient interactions and 
thus are instantly memorable?

Helman’s thematic context is familiar—he 
has written such narratives before—and the 
antireductionist, medicine in a crisis flavour 
is counterbalanced by the wholesome, some-
times utterly real and true to life tales of “Mr 
G” or just plain “Suzie” and “Glady’s”. 
The question is, are these views consciously 
overstated or do they represent (his) reality? 

If I had one comment it would be that 
the more management or educational side 
of doctoring is ignored, since these too 
have their stories and narratives, perhaps 
illustrating the complexities of how health 
systems work or do not as the case may be. 
Reflection in whatever sphere is no bad thing 
and this may be key learning from such a 
book as this. Rather than merely emphasise 
its educational value, I would rather say that 
the book is a sheer pleasure and I would 
recommend a slow, deliberate read, pref-
ervably while on holiday with all senses suitably 
relaxed, dimmed and destressed.

Helman’s book is a strong addition to a 
body of work by increasingly high calibre 
authors who write about medicine from the 
inside. These include Oliver Sacks and 
Richard Selzer as well as the relatively new 
kid on the block, Atul Gawande. All these 
authors chronicle their lives, and those of 
patients and their families, as doctor, sur-
gon, parent, carer, traveller or just plain 
observer. Helman’s account is always 
personally deep rooted, intellectual, and 
instantly understandable.

As I have already stated the book is 
excellent and will add to the burgeoning 
body of knowledge—perhaps Helman’s book 
will be used in the mandatory medical human-
ities modules in years to come. It will enable 
students to learn that medicine is about 
stories as much as anything else but it will 
teach them also that it is the seeing, 
experiencing or just believing those stories 
that makes them come alive. The book comes 
as close as one can get to real embodied 
experience without actually being there.

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Hacettepe medical humanities 
student congress

The Hacettepe Medical Humanities Student 
Congress will be held May 26–27, 2005 at 
Hacettepe Congress Center in Ankara, 
Turkey. There will be three conferences on 
the three main topics of the program. The 
Speakers are pioneers in their subjects. After 
each conference, the related short commu-
nication sessions will begin. We will have 24 
presenters at each session. There will be 315 
posters for ‘Medicine and Art’, 96 posters for 
‘Medicine and History’, and 72 posters for 
‘Man and Medicine’. The best poster in each 
category will receive an award. During the 
congress, groups of students and faculty mem-
bers will perform in concerts and there will 
be painting and photography exhibitions of 
the work of students and faculty members.

The Student Congress is the last step of the 
medical humanities section of the Good 
Medical Practice Course at Hacettepe. 
The course was added to the medical curriculum 
in September 2004. It was designed to rest on 
a base of communication skills training, and 
includes sections on clinical skills, physical 
examination training, ethics, professional-
ism, medical humanities, medical decision 
making, evidence based medicine, and clinical 
visits. The goals of this course are to help 
the students achieve the skills and attitudes 
of a good doctor and become competent in 
caring for and communicating with patients.

It is a vertical program in the first 3 years of 
a 6 year medical course. It is a small group 
activity (12–14 students in a group); each 
group has a tutor and meets one half day bi-
weekly throughout the year.

Each group rotates through the sections of 
the program. There are appropriate learning 
activities for each section, appropriate for-
mative evaluations at each step and a sum-
mative assessment at the end of each year.

There are three topics: ‘Medicine and Art’ 
for the first year, ‘Medicine and History’ for 
the second year and ‘Man and Medicine’ for 
the third year. In the first year, each student 
prepares an individual project on literature, 
music, cinema, drama, dance, opera or 
sculpture. In the second year, groups of 3–4 
students prepare a project on history, reli-
gion, belief, law, archaeology, or architecture. 
In the third year, groups of 3–4 students 
prepare a project on philosophy, sociology, 
ethics, biology, sports, genetics, or technol-
ogy. In the first session of the program at 
Hacettepe, the concept of medical humanities 
and examples from related articles are 
discussed. The students organise the groups 
and try to find a topic in the first session. Two 
weeks later, they give their proposals. They 
then have 2 months to prepare the first 
reports. At the first report session, they 
present their projects to their group members 
(each group consists of 12–14 students) and 
they all decide which project will be pre-
sented as a short communication at the 
congress; the other projects will be presented 
as posters. They have another 2 months to 
present the final reports. Each project is to be 
presented as a portfolio that includes the final 
project, self-assessment reports of the stu-
dent, documents and portfolio assessment 
reports of the students. The congress begins a 
couple of weeks after the final reports are 
submitted.

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