Visual broadcast in schizophrenia

Although doctors are trained to classify psychiatric 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 broadcasting. Rather, we want to emphasise the symptom by which 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 occurring 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 the importance of listening to patients’ verbatim accounts of their psychotic symptoms. Multiple sources describe thought broadcast, but these do not provide a link with visual images. 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 occurring 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 importance of listening to patients’ verbatim accounts of their psychotic 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 represented a new and hopeful marker of overall improvement in his mental state.

M D Hunter, S Mysorekar, P W R Woodruff
The University of Sheffield, School of Medicine & Biomedical Sciences, Academic Clinical Psychiatry, The Longley Centre, NGH, Norwood Grange Drive, Sheffield S5 7JJ
Correspondence to: Michael Hunter, The University of Sheffield, School of Medicine & Biomedical Sciences, Academic Clinical Psychiatry, The Longley Centre, NGH, Norwood Grange Drive, Sheffield S5 7JJ;
md.hunter@shef.ac.uk
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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
Professionelle”, are mostly short and succ-
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
disappointment that she is afraid of yellow-
ing “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 devast-
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 Shaman
are instantly recognisable. The grumpy but
grand 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
anti-reductionist, medicine in a crisis flavour
is counterbalanced by the wholesome, some-
time utterly real and true to life tales of “Mr G” or just plain “Suzie” and “Gladys”.
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, prefer-
ably while on holiday with all senses suitably
relaxed, dimmed and distressed.
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-
geon, parent, carer, trainee, 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
array of such works. I am sure that future
students 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
about as close as you can get to real embodied
experience without actually being there.

Melih Elcin

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, professionalism,
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
prepare final reports. Each project is to be
prepared 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.

http://mh.bmj.com/