# reviews

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## The Evolution of Hypnotism

Derek Forrest, Anthony Storr

Black Ace Books, £29.95,
pp 383
ISBN 1872988377

Rating: ★★★

The story of hypnotism is a multilayered one, covering the birth of psychotherapy as well as considering the complex interactions between nature and nurture. It is also a political story. Many of the original mesmerists were signatories to the first declarations proclaiming the French revolution in 1789. Far from being surprising, this was almost to be expected in that mesmerism opened up the prospect that the social order was in some sense suggested and could be overturned. Mesmerism in its later guise of hypnotism contained a clear implication that many saints might be hysterics, leading the Catholic church to ban hypnotism until the middle of the 20th century. In the hands of Freud, mesmerism gave rise to psychodynamic psychotherapy in Vienna in the 1890s. Much of the upheaval of the 1960s seems to have owed its origins to forces rather similar to those that underpinned mesmerism and the French revolution, while the controversies about repressed memory in the past decade mirror the turmoil in Vienna in the 1890s.

The story told in *The Evolution of Hypnotism* has been covered previously by Henri Ellenberger and Alan Gauld among others. However, this tale can be endlessly told and needs repeated telling. The merit of Derek Forrest's history lies in the human dimension that he brings to the story. He is not concerned with trying to pinpoint what forces of history threw up and moulded mesmerism, hypnotism, or whatever, but rather is more taken with the human dramas that the interplay of these forces gave rise to. He brings Mesmer to life as well as his successors —Puységur, the Abbé Faria, Elliotson, Braid, and Charcot. This book is intensely readable; it combines the merits of historical scholarship with a plot that could come from a good Victorian novel. This is a book to seduce readers into psychotherapeutics.

It finishes with a sketch of 20th century developments that hints at the unsettling relevance of hypnotism for the present day. If genetics provides one of the twin poles between which modern medicine and much of human identity is slung, mesmerism—which quintessentially is about the "influence" that individuals can have on each other—provides the other. In a genetic era, it is vital that these other forces be understood.

**David Healy** *director, North Wales Department of Psychological Medicine, University of Wales College of Medicine, Bangor*

CD roms

## Video Casebook: Medicine—The Toy Boy and The Burgundy Car

Andrew Levy

Blackwell Science, £14.95,
pp 176
ISBN 0632 051 221

Rating: ★

It is not entirely clear for whom this work is intended. Ostensibly it is a problem based learning exercise in clinical reasoning supported by a factual explanation for each clinical problem. Levy suggests that it is intended for undergraduate medical students. Learning is tested at the end of each scenario with multiple choice questions. However, it falls short of the mark.

I have seen this kind of approach done much better elsewhere, with a stepwise, interactive approach used in the resolution of the problem and video used to enhance the learning points. In this case the video clips—shot in a "cinema verité" style popular with some US television series shown on Channel 4—are short, often irrelevant, and so heavily edited that they fail to achieve the stated aim of being the "next best thing" to listening to and observing a patient.

The CD Rom material often duplicates the textual material and frequently fails to enhance it. It is not truly "interactive" (as suggested) in that the user is only a menu browser, moving from one item in each case (video, then duplicated history, factual notes, multiple choice questions) to the others. The electrocardiograms in case 14 are different in text and on screen, but one of them is an unlikely representation of myocardial infarction in evolution. The cases chosen do represent a wide variety of the workload of internal medicine and general practice, but the video clips that are more than "mug shots" (swollen joints, rashes, etc) are often duplicated in the text and would have just as easily been represented only there.

Publishers recognised some time ago that works of the "Dungeons and Dragons" type engage the reader by offering alternatives in problem solving that are exciting—choice of a particular decision or route can result in abject failure or triumph. In learning texts, that format can be exceedingly successful. This work, I believe, fails to engage either types of knowledge, such as application and analysis, or problem solving techniques, such as framing the right question, rapid generation of multiple hypotheses, and use of analogy. There is little scope for creativity or lateral thinking.

We are shortly to enter the era of hypermedia, in which, by intense interaction, the user forges constructs of his or her own to circumvent a problem. In doing this, the domains of hierarchical, linear, fragmented, or "network" knowledge are engaged. Levy's clinical passion and technological zeal stand out, but this work may already be dated.

**Martin Talbot** *director of undergraduate medical education, Central Sheffield University Hospitals*

***Reviews are rated on a 4 star scale (4=excellent)***

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# Clouding the AIDS issue

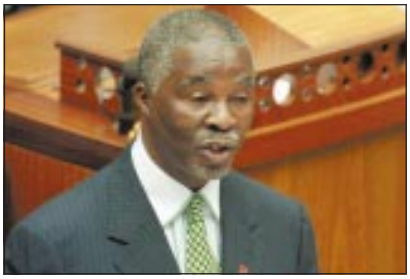
South Africa's president, Thabo Mbeki, is once again at the centre of a medical and scientific storm over the issue of HIV and AIDS, attracting a great deal of criticism from the media. The last time it occurred it was over the announcement of a "miracle cure" for AIDS, which turned out to have no medical value whatever and proved to cause only harm to patients illegally receiving the drug. The inventors of the cure, Virodene, bypassed all the research protocols and controls at universities and went directly to the then minister of health, Nkosazana Dlamini-Zuma. Dr Zuma presented the pair and their claims to a cabinet meeting, and they were hailed for their "discovery."

In the debacle that followed, Mbeki, then the deputy president, was thoroughly convinced by the "researchers." He was so taken by their case that when a financial squabble broke out among the "research team" he personally intervened, arranging early morning secret meetings with Zuma to organise a peace meeting between the warring parties. The episode had considerable fallout, with the head of the Medicines Control Council losing his job, in part because the council had refused to allow clinical trials of the miracle cure.

The phenomenon now seems to be recurring. The president has reopened a 20 year old, dead and buried, scientific debate through the media about whether HIV causes AIDS. It first appeared in the public consciousness through the columns of a small circulation, investigative magazine called *Noseweek*, which ran a series through several editions raising all the old debates. The issue was carried further by the minister of health, Manto Tshabalala-Msimang, who, in a television appearance, started a campaign against GlaxoWellcome's drug zidovudine (AZT). It then emerged that an international group of scientists was to be called together to investigate all the scientific issues about AIDS. This group would include well known "dissidents," such as the Californian microbiologist Peter Duesberg, and would explore questions including whether HIV causes AIDS.

It has been almost impossible for journalists to ascertain what the president and his health minister actually believe. At the end of last week, however, their views became clear in a series of articles and letters in several newspapers. Mbeki believes that AIDS is not caused by HIV, that those who seek to ridicule this are themselves not thinking broadly enough, and that multinational drug companies seek only to profit from the disease. The local scientific community, according to the print media, is appalled by his views.

The president's spokesman, Parks Mankahlana, writing in the influential daily paper *Business Day*, attacked Mbeki's detractors, particularly the pharmaceutical and medical insurance companies, whose shareholders, he postulated, would benefit from the AIDS crisis in South Africa. "The international panel of scientists," he wrote, "must strive to give us answers to all the unknowns. It must attempt to unravel the mysteries of the HIV/AIDS virus."


OBED ZILWA/AP PHOTO

**Thabo Mbeki fuels AIDS controversy**

A rejoinder was published later in the week by GlaxoWellcome's local chief executive officer, whose company had borne the brunt of the attacks by Mbeki and Tshabalala-Msimang, both of whom are adamant they will not buy zidovudine for pregnant women. Phillip van Niekerk, editor of the newspaper *Mail & Guardian*, said on a national radio programme that the attack on pharmaceutical companies almost suggested that the companies had manufactured the disease in order to make money. Zidovudine had become the focus of media attention because the government decided not to supply the drug to stop vertical transmission of HIV from mother to offspring or for women immediately after rape. Both rape and AIDS babies were obvious points for media attention.

It has become necessary for journalists to look for coding in the words used by Mbeki and Tshabalala-Msimang when they make public announcements. The publicist working for the AIDS "dissidents," Anita Allen, has told journalists that she has spoken to the president and health minister, that they agree with her views, and that they will, in speeches, refer to poverty when talking about AIDS. It seems that the dissidents' argument is that the opportunistic infections previously attributed to AIDS are actually caused by poverty, not HIV infection and AIDS. On cue, both Mbeki and Tshabalala-Msimang have referred to poverty when talking about AIDS.

Since almost no journalists are able to talk directly either to the president or to the minister of health, most have been left to interpret second hand reports. Among these was an interview given to the state broadcaster, the South African Broadcasting Company, on its early morning radio current affairs programme by another Californian dissenter, David Rasnick. He surprised listeners by saying that President Mbeki had telephoned him in the United States to discuss his views and solicit his support in Mbeki's fight against zidovudine. The *Mail & Guardian*, *Financial Mail*, *Sunday Times*, and *Sunday Independent*, all influential weekly newspapers, have run articles speculating on the need of the president to take such an odd line in the face of 20 years of research.

**Pat Sidley** *BMJ correspondent, Johannesburg, South Africa*


WEBSITE OF THE WEEK

**Men's health** Men die on average five years younger than women, and last week the public health minister Yvette Cooper said she wanted to do something about it (see news p 961). The tricky bit seems to be matching what men worry about (and will pay for), and the actual problems that they are likely to run into in later life.

Men's health seems mainly to exist as a consumer concept. Unlike gynaecology, andrology has never really broken out of the ghetto of sperm studies, but what there is on the net can be accessed at http://platon.ee.duth.gr/~intermed/infobase/zoumpos.htm. It's a thin haul.

The *BMJ*'s reviewer of consumer magazine *Men's Health* observed that, although the title says health, its real fascination is with sex (www.bmj.com/cgi/content/full/310/6976/406). Not much has changed, and this month's home page features fitness ("Make your biceps bulge"), sex ("Which woman wants you?"), and health ("Navigate the salad bar") (www.menshealth.com).

None of which really addresses the problems that Yvette Cooper wants us all to engage with—men's high death rates from trauma, suicide, and coronary artery disease. The preventable elements of these diseases are largely determined by social pressures, and kicking against them is hard.

BBC Online makes a fair stab at addressing the important issues at www.bbc.co.uk/health/mens/index.shtml: there's the previously reviewed "Life countdown counter" to focus the mind and advice on stopping smoking, sensible drinking, and stress and depression. It's worth noting the high quality of the external links from this site. In a world full of "ecommerce" metaphors, it has become an almost unquestionable truth that "Once the visitor has arrived, you don't let them go" (as if people don't know how to work their browsers). But the BBC links you straight through to excellent external content with no fuss—which is how it should be.

**Douglas Carnall**
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PERSONAL VIEW

# Medical tourism can do harm

We are expatriate doctors living at 3900 metres in the Mount Everest region of Nepal and running a health care system serving a population of 10 000. The area is remote, mountainous, and roadless, with the villages scattered along high valleys. Over the past 32 years a health system of one hospital and eight health clinics has been established so that most residents are within an hour's walk of a health clinic or hospital.

The area is popular with tourists. Last year 19 000 visitors came into the Sagarmartha National Park where Mount Everest, the hospital, and five of the eight health clinics are located. Inevitably, there are many doctors and other healthcare professionals among them.

Although the presence of the hospital is well publicised, many doctors touring the area hold ad hoc clinics along the trail. They often conduct these clinics just a 100 yards from the local village health clinic. At a time when we are developing the skills of the local resident health workers and increasing the confidence that the local people have in them such misdirected good will undermine progress in the existing health system.

It is inappropriate arrogance to assume that anything that a Western doctor has to offer his less developed neighbour is progress. These tourists are often working outside their trained specialty or have little concept of how that specialty applies to Nepal. They frequently don't understand local illness presentation, culture, or language. They often offer inappropriate treatment because they think they "must give something." The consultations are often one off, with little possibility for follow up and the local health providers are left to pick up the pieces with no record of the consultation. If an unregistered Nepali doctor on holiday in the United Kingdom offered general medical consultations in a shopping centre there would be a public and professional outcry. The problem is extended when applied to nurses, paramedical staff, and medical students.

Furthermore, legally these doctors are on difficult ground. The Nepal Medical Council is striving to develop and maintain a professional body and requires all doctors who practise in Nepal to register with the council. For certain services, such as family planning, practitioners are required to have Nepali training certificates. This is setting a standard of medical professionalism that is required and respected in the West so it should be respected in Nepal.

We are seeing the development of medical tourism—exotic travel to a developing region with a brief opportunity to practise medicine on local residents. This seems to occur on two levels. Firstly, doctors travel independently to areas that seem to have no system of health care and while there perform good acts. We see this regularly with trekking doctors who give residents short courses of antibiotics, which is fine until you consider tuberculosis control and resistance. Recently, a chest physician gave one of our long term psychiatric patients an injection, but we don't know what it was. On the other hand, the acts performed in a life or limb threatening emergency are justified, but there should still be follow up with the nearest local provider.

> Can you realistically treat chronic disease after a single consultation?

The second level, which is more alarming, is the development of adventure holidays sold to groups of doctors specifically for the purposes of research or providing health care. The most recent example was an American group of two subspecialists and a selection of house officers and medical students who actively sought out patients along the trail without making any prior contact with the hospital and health posts along the way. They brought an ultrasound machine and a microscope. Can you realistically treat chronic disease after a single consultation? But working with the senior doctors we might have used the equipment and instruction with lasting benefit.

> Consider whether you are treating the patient for your own good or for theirs

Medical work overseas can be constructive. It takes little effort to find out what health care exists in an area and for doctors to work with or refer to the local system. For more long term work there are numerous agencies in the United Kingdom and in other countries which recruit doctors to work in developing countries.

A fundamental principle of medical training is "first do no harm." If as a doctor you cannot resist the lure of medical tourism and insist on the casual or opportunistic treating of local residents, consider whether you are treating the patient for your own good or for theirs, and whether your actions may actually do more harm than good.

**Rachel A Bishop and James A Litch** *codirectors and physicians, Kunde Hospital, Solukhumbu District, Nepal*

SOUNDINGS

# *I saw Satan fall like lightning*

I was called recently to a patient who had collapsed in the carpark after church. This is a good place to collapse, implying a previous life of probity and devotion.

The bystanders are likely to be helpful. Collapsing outside a bar late at night, by contrast, you are unlikely to get a lift home from a friendly drug dealer; a better class of people attend church, although they may be more fastidious about mouth to mouth—perhaps not a bad thing. The doctor also feels more obliged to attend; there is something deserving about a church carpark. This collapse, we infer, is unrelated to debauchery.

I drove out at once, but some dogooder had already taken the patient to the surgery. And, returning to the surgery, I found, with a certain fatal satisfaction, that the entourage had inevitably returned to the church.

Eventually, a few laps later, I hounded the patient to earth. Invigorated by the chase, she was at first unwilling to accept cardiac pulmonary resuscitation, but a crowd had gathered and, as Pierre said in *War and Peace*, the common good is the only kind there is. Pleasing the mob always comes first, and saying all was fine would have been inconsiderately detumescent; doing nothing was too hard a proposition, the power was intoxicating, put a beggar on horseback and he'll ride to hell.

So, instead a symphony; excited oohs as I whip out the shock blanket like a magician's rabbit; somebody shouting, "Don't move her!" (because the conventions must be observed); the triumphant clash of the defib paddles as I flourish them theatrically on high; the patient's futile protests, "I'm fine, no really I am, really"; the crowd moaning and crooning and swaying with pleasure until the ambulance arrives, rabbits transfixed by the weasel's dance.

I accepted the plaudits modestly, mindful of La Rochefoucauld's maxim, "To refuse praise is to be praised twice." And as I led her up the steps into the ambulance, its interior lambent like a little piece of heaven, a ghostly Roman slave appeared at my elbow, whispering, "Remember thou art mortal, remember…" And I said, "Who the hell are you?"

The patient infarcted and died in the ambulance.

[Any resemblance to patients living or dead is entirely coincidental]

**Liam Farrell** *general practitioner, Crossmaglen, County Armagh*