The truth is that an emotionally vulnerable person given appropriate cues and suggestions can reconstruct all sorts of "memories" in the minutest detail—and believe them implicitly. Unfortunately, many people have been sent to jail on the basis of such "memories."

Tens of thousands of families have been ripped apart by allegations made by people swept along in the "recovery movement," which in the United States means among other things "recovery weekends" and "recovery gift catalogues"; every bookshop there has an entire section devoted to "recovery and abuse." I know of one family whose adult daughter, after therapy, "recovered" a vague and non-specific memory to do with an erect penis—disembodied and apparently ownerless, it has to be said. What did she do? She accused her father of being the owner of this dim and misty penis, called him an abuser, and cut herself off from him absolutely. Needless to say, his life fell apart, just like the numerous examples shown in *Divided Memories*. One enraged father in the programme successfully sued his daughter's therapist for implanting memories, but this was scarce recompense for a ruined life.

This is all, of course, very bad news for those children and adults who really have been abused; and recent events in Belgium, Britain, and elsewhere bear witness to the fact that organised sex abuse rings do exist. Adults and children may be frightened or ashamed to tell what has been done to them, and winkling out the truth is a complex and distressing business, farragoes such as the Orkney scandal notwithstanding.

But it seems neuropsychologically highly improbable that years of abuse can be so massively repressed that a person remembers nothing of any of it. And it is most certainly neuropsychologically impossible for abuse at the age of 6 months to be remembered episodically, as some "survivors" have claimed.

So I think that someone had better give Dr Jarman a lesson or two on neonatal cognitive development. But then, we are not exactly sure how the brain works 2000 years before birth. Hmm, maybe we'd better hold off on speaking to him until we find out a bit more about this.—IAN ROBERTSON, *neuropsychologist and writer, Cambridge*

PERSONAL VIEW

The great hijack

Bernard Rabinowitz

It is over 40 years since I qualified as a doctor and 35 since I was awarded the fellowship of the Royal College of Surgeons of England. As a student I read with enthusiasm about the revolution wrought by Pasteur, Jenner, and Lister. Later I was stirred as polio was defeated, diphtheria became a rarity, and smallpox vanished. We were taught and in turn passed on to our students the principles so decisively developed by these great men.

Any epidemic imposes obligations on the doctor. We must diagnose, isolate, localise, and treat. An overriding concern is the protection of the uninfected. That is the modern and proved way to limit and end an outbreak of an infectious disease. Indeed, it is a catechism for even our junior students.

In the early 1980s some hundred or more people who were immunocompromised came to light in the homosexual community in the United States. A diagnostic test was developed and an infecting agent was identified. Then modern medicine was made to run for cover. A positive test labelled the carrier as a homosexual. That community, generally erudite, articulate, and eloquent, was prominent in the arts, the media, and often in public life. The fear of possible labelling was real and immediate. It hit interested parties in the administration, which handed down speedy and even panicky legislation mandating secrecy and confidentiality and prohibiting testing without consent.

The medical profession remained obediently silent as this disease emerged as a lethal, spreadable infection. We, the doctors, were told that the standard approaches to an infectious disease would land us in court. Our professional bodies raced, with politically correct zeal, to endorse the criminalising of normal diagnostic protocols. With heavy ethical breathing we had endorsed the first legally protected epidemic in medical history.

Some of the jargon then and now bears looking at as we balance on the wobbly ethical platform. The sanctity of confidentiality is a prime example. We have never respected confidentiality at the expense of the common good. The profession has never permitted the rights of an individual to compromise the community. Would any doctor who sees a patient known to have epilepsy driving a school bus keep quiet? Would a person with angina be allowed to pilot an airliner? Doctors employed by insurance and building societies have never felt constrained to protect the secrecy of the person with tuberculosis or hypertension who is now refused a mortgage loan. Yet with AIDS the rights to secrecy of a tiny minority were deemed ethically more important than the rights of the huge uninfected majority.

"Obligatory tests for HIV, as in other countries for other diseases, should precede marriage and pregnancy"

The medical voices raised in protest at our feeble acquiescence were blasted with the labels of callous, unethical, and not compassionate. Our profession forgot its heritage and its duty. It abandoned its science and its obligation to apply it. As the years passed, young people died in their hundreds, then thousands, and soon, as heterosexual contacts spread, the figures will be millions. Secrecy and confidentiality have served the epidemic well.

What might we have achieved had we identified, labelled, and campaigned? The epidemic would not have been stopped, but millions of people who now have HIV would not have contracted the virus. Homosexuals and carriers identified as such would have had to live with whatever exposure ensued. The HIV infected developing world is, like the developed West, battling with the ethical nonsense formed in the United States 15 years ago. Earnest doctors, people who know better, are shackled by fear of prosecution if they identify a person with HIV. Yet ethical debates have never arisen on cholera, tuberculosis, or lassa fever. We even indulge the indefensible practice of anonymous testing without consent to gain statistics. Those identified as positive are not informed.

Medical law endorses the patient's right to refuse a test for HIV—a test that could be vital in an emergency or other cases. The law demands that the surgeon should proceed or risk prosecution. Can you envisage a scenario where a patient presents for, say, a hip replacement, or a partial gastrectomy and tells the surgeon that he or she cannot take an *x* ray examination of the chest or do renal functions but must do the operation anyway?

In years to come the profession may well label these past years as the great hijack. As doctors we can still save millions. We must be free to test, diagnose, and label. Families, lovers, and contacts must not be denied information. Obligatory tests for HIV, as in other countries for other diseases, should precede marriage and pregnancy. All patients; blood, organ, and sperm donors; schoolchildren; medical students; surgeons; boxers; rugby players; and anyone in an occupation where blood can be shed should be freely tested as and when indicated with no specific consent required. The person with AIDS will become an accepted feature of society. The hijackers have facilitated a worldwide disaster; I would urge that we speedily do what we can to minimise it.—BERNARD RABINOWITZ *is a retired surgeon in Johannesburg*