*re*views

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ART

Body Art: Marks of Identity

American Museum of Natural History, New York, until 29 May 2000

(see www.amnh.org/exhibitions/bodyart and www.discovery.com/exp/humancanvas/humancanvas.html)

Every time you shave, put on make up, or squeeze into tight jeans in an attempt to alter your appearance you are unwittingly following in the footsteps of your ancestors, who devised equally ingenious ways of doing the same thing. Now a history of our ancestors' methods of painting and piercing their bodies over the past 30 000 years is on display in a wondrous, imaginative, and sometimes frightening exhibition at the American Museum of Natural History. "There is no known culture in which people don't do this, whether permanently or temporarily," said Ellen V Futter, president of the museum.

Why do people alter their bodies, sometimes painfully and permanently? Enid Schildkrout, curator of the show and chair of the museum's division of anthropology, thinks there are many reasons: "To be human. For beauty, as a sign of change or rebellion or conformity, to show status, to mark a moment, to be able to wear a certain ornament, to identify with spirits or ancestors or deities, to show group membership, to show gender distinctions."

Organised in six major sections, with several short films, the exhibit traces body art through history, showing the techniques, the tools, the results, and the way other cultures looked at body art that was strange to them. Among the techniques shown are body painting (including henna decoration and makeup), body shaping, piercing, scarification, and tattooing. The earliest signs of human interest in self decoration appeared 30 000 years ago, when handprints, ochre deposits, and ornaments are found alongside cave paintings. Thousands of years later, in ancient Egypt, humans were grinding natural substances—malachite, lead, and antimony—into eye makeup for both men and women. In the show are a makeup palette and dispensers like modern mascara tubes, inscribed with the names of the donors, who may have handed them out at festivals, much like the free samples at modern department stores.

More recently, Nuba men in the Sudan painted their bodies as traditional signs of changing status—from boy to adolescent to adult—and also to win favour from their wives and wives' families, until European photographers and tourists came and paid to see the art. Then body painting became more profitable, but less meaningful to the society.

Body art reflects what one society believes is beautiful, expensive, noble, religious, or of high status. An outside society may react quite differently to beards, tattoos, black teeth, or oddly shaped bodies. When Westerners, mostly Americans, came to Japan in the mid-1800s, Japan had been a closed society for about 300 years. The Japanese commented on the extravagant facial hair of the American men and the strange clothing—hooped skirts—of the women. Americans found strange the Japanese habit of women beautifying their teeth by painting them black.

When meeting other cultures, Westerners focused on the absence of clothes and the use of body painting and scarification or cicatrisation, in which substances are rubbed into cuts to produce raised scars, often in a decorative or symbolic pattern. The exhibit suggests that body art links an individual to a society, group, or class. In 18th century Japan, for example, elaborate full body tattoos were taken up by those on the margins of society—labourers, firemen, and gangsters. In the Marquesas Islands of the Pacific, men were elaborately tattooed from head to foot, beginning during adolescence. The tattoos showed courage because tattooing is painful, wealth because the tattoo expert was expensive, and beauty because tattooing made the wearer attractive to women.

Among the Maoris of New Zealand, facial tattooing involved deep, grooving cuts in the face, severe enough that the exhibit includes elaborately carved feeding funnels for use by those recovering from facial tattooing. For modern devotees, the exhibit includes a warning from the New York City Department of Health: "Tattooing is an invasive procedure that can result in serious skin and blood infections. Where procedures involving penetration of the skin are not correctly performed, they can be means of transmitting organisms that cause diseases like AIDS, hepatitis B and hepatitis C."

AMERICAN MUSEUM OF NATURAL HISTORY

Ready for marriage? Decipher the body art

Some body art practices may have had a medical intent. For the 4000 year old "ice man" found in the Alps, tattooing may have been meant to ease pain. He had tattoo marks near his spine and on his legs, near where *x* rays have revealed joint degeneration. Body art may mark life's changes. An African woman's beautiful beaded corset in coral, blues, and white was worn while she stood all day with a pitcher of water on her head as a sign she was ready to endure the rigours of married life.

Non-Western societies shaped babies' heads into longer, flatter, more aristocratic shapes—easy to do when children's heads are relatively malleable, up to about age 7. Until this century, Chinese women suffered foot binding to produce deformed tiny feet thought to be beautiful. Western societies to this day are attempting to shape women's bodies—in appearance if not in reality. The show includes corsets from the late 17th century and undergarments up to the present. These garments are designed to temporarily reshape women's bodies into the currently desirable form. People may also practise body art to reinvent themselves, to become something different through art. "Western society is more tolerant of body art now than it was during the colonial period, when it was associated with tribal cultures. We're seeing a revival," says Dr Schildkrout.

Janice Hopkins Tanne *freelance journalist, New York*

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

Medical Retina CD Rom

N H Victor Chong, Susan M Downes, et al

BMJ Books, £116.33
ISBN 0727912739

Rating: ★★★

Opening a new medical CD Rom is an exciting and slightly daunting experience. The slim silver disk emerging from the case might contain the equivalent of an *Encyclopaedia Britannica* or merely represent a small handbook. You hope that you will be able to navigate around the program without having to ask your children or computer literate colleagues for help, and that your PC will have enough horsepower to browse the CD without interminable waits for images to appear. You want to avoid getting lost within the program and be able to escape back to the contents page easily without needing a ball of string.

Do not worry, because this CD works, and the authors deserve to be congratulated. They have set out to capture the spirit of the Fluorescein Conferences established by Professor Alan Bird at Moorfields Eye Hospital, which are justifiably world famous, and to present the material in the browser style of an internet page rather than a traditional book layout. This approach is successful, and readers will be delighted to meander through it, exploring common and more esoteric retinal diseases, and relax while Professor Bird eloquently comments on the conditions.

The CD will have a limited market appeal, however, being most suitable for ophthalmic trainees and those with a particular interest in retinal diseases. It is a little too specialised for the non-ophthalmologist, who may be puzzled by the lack of images and detail on diabetic retinopathy. Although this is a subject of a BMJ CD in its own right, inclusion of diabetic retinopathy and its treatment would have enhanced this CD's overall appeal, particularly to physicians and optometrists. The case selection is otherwise extremely comprehensive, and the quality of images is excellent with only a few exceptions. The animations of laser treatment of choroidal neovascularisation work well but would have been enhanced by some practical advice on laser power settings or even short video sequences of actual treatment. The section on electrophysiology is clear and comprehensive but yearns for the more dynamic presentation that animation could provide.

Anyone who has used the internet will have no difficulty navigating through this CD, and its makers have enthusiastically embraced the multimedia capabilities of this medium. The program itself ran without a hitch on Windows 95, 98, and NT4, but it does require an internet browser such as Internet Explorer or Netscape. Run it with ease on a current Pentium or equivalent processor set up for internet access, but don't embarrass your old 486.

Hamish M A Towler *consultant ophthalmologist, North East London Eye Partnership, Whipps Cross Hospital, London*

The Mind within the Net: Models of Learning, Thinking and Acting

Manfred Spitzer

MIT Press, £16.65, pp 360
ISBN 0 262 19406 6

Rating: ★★★★

We are told that the 1990s are the decade of the brain. With the unravelling of the human genome, there are few great scientific challenges except, perhaps, understanding the origin of the universe and consciousness. This new book seeks to provide a greater insight into the workings of the mind through neural networks (for once, the "net" in the title does not refer to the internet). Neural models may help us understand phenomenology as diverse as why children need to have structured play and why schizophrenics may experience auditory hallucinations. The book brings together an eclectic range of materials from medicine, psychology, psychiatry, neurobiology, and neural network theory.

The book is extremely well written and easy to read with plenty of fascinating titbits. How can the word "fish" be written as "ghoti"? What has Beethoven's ninth symphony got to do with the size of a standard CD Rom? Does it make any difference if one learns to play a stringed instrument before the age of 12? I particularly enjoyed the historical perspective. For example, I was surprised to discover that it was the great English scientist Sir Francis Galton who first used the method of word association in a series of introspection experiments, well before Sigmund Freud and Carl Jung. Spitzer should also be commended for the way he presents real research data. Many popular science books explain the results of research in general lay terms without empirical data. The excellent figures for this book present clear summary data, with detailed legends providing any necessary explanation. There is also an impressive array of references and a useful glossary.

Appropriately, Spitzer leaves the final chapter to more philosophical thoughts. In this age of artificial intelligence, he is cautious about what neural networks can and cannot achieve. Can computer models really tackle the complexity of such phenomena as emotions and personality—the essence of being human? Ultimately, neural networks are models or simplifications of an organic process. As such, they enable us to test hypotheses and dissect out processes that could not otherwise be examined. These models do not have to represent biological reality. If a neural model could really reproduce how the brain works would it still be a model? I leave the last comment to a cited quote from James McClelland, a leading figure in neural network research: "All my models may be wrong, but some of the principles we have discovered using them may be right."

Yoav Ben-Shlomo *senior lecturer in clinical epidemiology, Department of Social Medicine, University of Bristol*

Hit parade

These articles scored the highest hits on the *BMJ*'s website in the week of publication

NOVEMBER

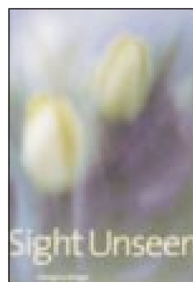
1. **ABC of complementary medicine: Unconventional approaches to nutritional medicine**
   1999;319:1419-22
   31 713 hits
2. **Fortnightly review: Medical management of menorrhagia**
   1999;319:1343-5
   21 763 hits
3. **How many, how old, how soon?**
   Education and debate 1999;319:1350-2
   21 546 hits
4. **ABC of complementary medicine: Hypnosis and relaxation therapies**
   1999;319:1346-9
   20 154 hits
5. **ABC of complementary medicine: Massage therapies**
   1999;319:1254-7
   20 061 hits
6. **Why do babies cry?**
   Editorial 1999;319:1381
   15 110 hits
7. **Recent advances: Management of self poisoning**
   1999;319:1414-7
   13 363 hits
8. **Science, medicine, and the future: Virtual colonoscopy**
   1999;319:1249-52
   12 995 hits
9. **Shopping around the internet today and tomorrow: towards the millennium of cybermedicine**
   New technologies issue 1999;319:1294
   9488 hits
10. **Reducing vertical transmission of HIV in the UK**
    Editorial 1999;319:1211-2
    9071 hits

Sight Unseen

Georgina Kleege

Yale University Press, £16.95, pp 233
ISBN 0 300 07680 0

Rating: ★★★



Close to the top of every guru's list of exhortations is the advice that doctors should listen more to their patients. Here is your chance to do what you are told and enjoy the process. *Sight Unseen* offers a fascinating and scholarly glimpse into a specific impairment (blindness) and, more importantly, provides unique insight into the complex relation between normal function and impairment.

This is not an autobiography but a book about blindness per se, by a writer who is blind, on how the severely visually impaired see the world and how the sighted perceive the blind. According to Kleege, in a sighted world blindness is seen as the enemy and linked with ignorance, confusion, indifference, and ineptitude, not forgetting its legal and sexual connotations. This reductive view disturbed me. Indeed, I almost abandoned the book before reluctantly recognising that I did not have evidence to the contrary. Blindness is simply a different way of perceiving, as exemplified by H G Wells's wonderful story "The Country of the Blind," in which blindness is the norm and sight is troublesome.

The visual experience of severely visually impaired people is described in moving detail and vividly drives home how little information about real life function we glean from our patients. Kleege is a highly visual blind person, and her description of viewing a Matisse exhibition is a joy to read, powerfully emphasising that there are so many ways of appreciating art. For lovers, eye contact is the real business, but to the blind person it is a complete mystery—so Kleege has learned how to fake it. She also explodes much of the myth about eye contact, which has less to do with eyes than one might suppose.

Reading, of all activities, distinguishes the sighted from the blind. It is humbling to learn just how much extraordinary, painful effort is required for a blind person to undertake visual reading. To a sighted person, reading braille seems to be difficult and laborious, yet, intriguingly, Kleege describes it as natural and pain-free, and even skim reading is possible.

Sight Unseen is an enjoyable, sometimes disturbing, but always thought provoking read that gives a unique client insight into impairment. It also indicates the complexity of developing patient centred outcomes. Unintentionally (I think), it highlights that disability care requires robust interprofessional links. When these are defective and fractured, care and support are delayed or just don't happen, so it often falls to the affected person to unravel the maze and initiate action. This is illustrated by Kleege, who gained access to braille only after many years of refusal by experts and by becoming a self made expert herself. This is a wonderful book; whatever your discipline, there is something here for you.

Alistair Fielder *professor of ophthalmology, Imperial College School of Medicine, London*

WEBSITE OF THE WEEK

NHS Direct Online The website of the moment is undoubtedly NHS Direct Online (www.nhsdirect.nhs.uk/main.jhtml)—so much so, that on the day of the launch many users (including me) found that the only contact they could have with this self help system was a server error message. Network overload happens when many people try to do the same thing at the same time—trying to use a mobile phone in a traffic jam is the classic example. On the web it's known as the slashdot effect after the eponymous website www.slashdot.org, which brings new developments on the web to a worldwide audience of nerds: when they all arrive at once for a look at a linked site, servers get overwhelmed. In health care it is unusual for everyone to get ill at the same time, so, after the initial hype of the launch has died down, access to the server should be quicker and more reliable.

If you have a diagnosis, say "schizophrenia" or "alcohol," then the site works very well. A sensible quantity of straightforward information appears rapidly after a search, with links to external organisations interested in the condition. The site has not solved the natural language problem—a search for "cold" brings up information about food safety and refrigeration rather than upper respiratory tract infection—but it is the decision analysis software that will prove most controversial. Superficial testing suggests that it is simplistic and errs on the side of caution, which is appropriate; without proper evaluation, however, claims that it saves lives seem premature.

And now we have a new health inequality to add to a long list. The prime minister himself launched the service in Bootle, but, as local general practitioner Kailash Chand pointed out to the *Sun* newspaper, "Tony Blair must be living in Cloud Cuckoo Land if he thinks people like these have access to the Internet. Some don't know where their next meal is coming from."

Douglas Carnall
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Pre-hospital Paediatric Life Support

Eds F Jewkes, P Lubas, K McCusker

BMJ Books, £22, pp 203
ISBN 0 7279 1419 7

Rating: ★★★★
(if you do the course)

Measuring 125×85 mm and weighing in at 0.8 kg, this is no pocket reference book for those who find themselves resuscitating a child before the ambulance arrives or en route to hospital. This is the text book written primarily for the prehospital paediatric life support (PHPLS) course, one of the more recent additions to the growing number of didactic courses on resuscitation.

The authors have varying backgrounds, including paediatric accident and emergency, the ambulance and paramedic service, and anaesthesia. The book has 24 chapters and appendices logically arranged through introduction, life support, medical illness, trauma, and practical procedures.

Who will benefit from reading this book? It is accessible only to health professionals, being written in technical medical English rather than plain language and simplified concepts easily understood by parents, teachers, and children themselves. This medical text highlights the differences between children and adults and teaches a logical, ordered approach to the initial management of a severely ill or injured child. However, it is of limited value unless read by a practitioner stimulated by the anticipation of an impending PHPLS course. On successful completion of the course, the book may become a reference (the line drawings photocopy wonderfully on to acetate sheets for overhead presentations), but the core knowledge will be firmly in place.

The book can be easily and quickly read, and it is well illustrated and indexed. The meat in the sandwich is the middle section on life support and the management of a seriously ill and injured child; to find fault would be to nitpick; it is excellent. I am puzzled somewhat by the section on practical procedures; I suppose it is necessary in preparation for the course, but there is only one way to learn practical procedures and it's not from a book. My favourite chapter is "Scene Management," which gave me some insight into the work of paramedic colleagues and made me grateful for my controlled hospital environment. Will someone please tell me the answer to example 1 at the end of this chapter?

This book will give any healthcare professional some instruction in the early management of a critically ill child. When read in conjunction with the PHPLS course it should provide practitioners with the skills and confidence to manage such patients and to work as members of an effective team.

Ian Barker *consultant anaesthetist, Sheffield Children's Hospital, Sheffield*

PERSONAL VIEW

Is an apology called for?

Dr David Moor had many friends and patients to support him during his trial for murder for providing analgesia for a dying patient in 1997, and most people were relieved by his acquittal. Another general practitioner, however, has been less fortunate.

In 1995 a nurse reported Dr Ken Taylor to the police for refusing to continue to prescribe Fresubin, a nutritional supplement, to an 86 year old woman with terminal cerebrovascular disease, who was being cared for in a nursing home. She was unable to feed normally so the supplement was being squirted into her mouth with a syringe. Her family found this "horrifying to watch, agony really." They did not object to the feeds being discontinued and thought that Dr Taylor took good care of their mother, who died eight weeks later.

The Crown Prosecution Service decided not to charge Dr Taylor, but referred him to the General Medical Council. As a result he was suspended from practice, and the *Times* published three articles: "Doctors told nurses to starve widow"; "GP guilty of letting patients starve"; and "Relatives fear rising tide of euthanasia."

The leading accusations in the minutes of the GMC's professional conduct committee were: "You gave instructions to the nursing staff that fluids should be administered every two hours during the day; the Fresubin should be stopped; Mrs X should not be disturbed during the night apart from general nursing care; you did not think it would be helpful to sit Mrs X out of bed. You gave these instructions knowing that the intake of food or nutritional supplements is essential for the continuation of life; the withdrawal of Fresubin … would or might hasten death; [and without] conducting an adequate examination … of the patient yourself, seeking a specialist or second opinion, arranging specialist or other investigations, seeking prior approval from the court *when you should have done so* [my italics], without adequately seeking or heeding the views of the nursing staff."

Dr Taylor was found guilty on three main counts: "not examining the patient," "not seeking a second opinion," and "not adequately seeking and heeding the views of the nursing staff." He had been looking after Mrs X for four years, so I do not know what a new examination could have shown. On the issue of a second opinion, the BMA's guidelines, *Withholding and withdrawing life prolonging medical treatment*, were not published until June 1999, so that at the time of Mrs X's death and the hearing there was no official advice about the management of patients with irremediable advanced disease. I am a consultant geriatrician and could have been charged a hundred times with Dr Taylor's crime. Consultants and GPs are repeatedly told that they have ultimate responsibility for their patients—this is reinforced by the BMA's guidelines.

We are, therefore, left with the third count. There is nothing in the GMC minutes about what passed between Dr Taylor and the nurses, other than that the deputy matron said that she did not agree with his instructions and "would have no part in carrying them out." Why was no comment been made about the danger of nurses not obeying medical instructions? Many nurses think that nutrition is primarily their responsibility although nutritional supplements are classed as drugs.

> The GMC seems to be in danger of becoming a kind of medical inquisition

The BMA's guidelines accept that continuing to give dying patients food and drink by artificial means may not always help them, and that they may be discontinued. Numerous studies have emphasised the burden of futile treatment and the dangers of forcibly feeding dying patients. A review in the *Lancet* in 1996 of tube feeding patients with stroke concluded that for almost all conscious patients "a dedicated attempt should be made at feeding by hand." Whether squirting liquid food into the mouth is "feeding by hand" is doubtful. All too often tube feeds and supplements are used for patients who are reluctant to feed because they are quicker. Giving nutritional supplements to an unwilling patient could be considered an assault. The GMC's conduct of this case is worrying. Not only has it put a doctor in the modern equivalent of the stocks, but unchallenged it could seriously affect medical practice in Britain. If the courts had decided to charge Dr Taylor it is likely that he would have been acquitted, and, as in Dr Moor's case, doctors might have been helped and the public educated. By handing him over to the GMC, whose job should be to promote understanding and good medical practice, doctors and patients and their families have been frightened out of their wits.

Inflated by the fears and influence acquired from the Bristol case where three doctors were found guilty of serious professional misconduct after the deaths of babies undergoing cardiac surgery the GMC seems in danger of becoming a kind of medical inquisition, accountable only to itself, dedicated to stamping out heresy or freedom of thought and action in any form. Is an apology called for?

Mary R Bliss *consultant geriatrician, London*

SOUNDINGS

No regrets

South Armagh is gaily festooned with army bases. For security reasons these bases are supplied exclusively by helicopter, and the helicopters have to travel in threes to protect each other against ground to air attack. This all makes our skies very congested and noisy, but it's an ill wind; we can often call in these helicopters for the urgent transfer of critical patients to hospital, usually either as a result of a road traffic accident or somebody getting kicked in the head by a cow. I've travelled in them a few times, and it was exciting at first; the noise, the speed, the fun of leaning over the pilot's shoulder and pretending to vomit or yelling, "I love the smell of napalm in the morning."

But the novelty soon palls; it is a bumpy, cramped ride, and when you arrive and hand over the patient's care the hospital staff will patronise you, however tactfully.

One minute you are solely responsible for a patient's life, looking death right in the face, desperate eyes clinging to yours, and the next you are just another Joe wandering the hospital corridors waiting for a ride home. Such an abrupt change of role is curiously unsettling.

We used to have the added excitement of expecting to be blown out of the air at any moment but now even that little thrill is gone, though it is a thrill I am happy to forgo. To paraphrase Trollope, the troubles have delighted me for long enough.

I'm not sure a political solution is really all that vital. As the level of education improves and the standard of living rises and more people travel the world and achieve a sense of perspective, the stupidity of creeds based on slaughter and deceit becomes more obvious; economic imperialism will solve our problems in the end, though in a society where Darwin still has vociferous opponents, it may take some time, as Captain Oates said.

So if a political settlement expedites matters even better. I've seen my share of bloody messes, and I'm sick of it. Young lives wasted and ruined, dead faces staring sightless. Fresh blood gleams and newly shed tears glint, but only for a heartbeat. Then the blood clots and turns dull and rusty and the tears dry and disappear.

The wounds still gape, but eventually even they will heal; I just want to forget.

Liam Farrell *general practitioner, Crossmaglen, County Armagh*