BBC1 *Panorama*

"From Cradle to Grave: Broken Promises"

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"From Cradle to Grave: Paying for the Future" 29 January

On welfare in a state

For some people, state support for those in need is going out of fashion. We met a selection of them in the first of two programmes from the *Panorama* team on the future of the welfare state. We were told that costs are spiralling out of control, that many of those on benefit are too lazy to look for work, that benefits are far too generous, and even that the welfare state is contributing to family breakdown, making it easier for people to walk away from problems that they once would have had to sort out.

But others are not so sure. While some interviewees painted a picture of feckless individuals lazing about at the taxpayer's expense rather than looking for one of the many jobs available, could it be that those who fall off the ladder of education and employment descend into a vicious downward spiral with little hope of recovery? *Panorama* went to Hastings to find out. With 16% male unemployment, it is one of the most deprived towns in the south east of England. The human dimension of the statistics emerged from behind the Edwardian facades as we met a series of young men descending into long term dependence and premature death.

Jon, aged 16, had left home after endless rows with his stepfather. Ineligible for benefit, he was searching for work but Hastings offered only a few low paid jobs, none of which he was qualified for.

Chris, also 16, had at least managed to obtain benefit although it gave him only £36 per week to live on. It was 11 am and the noodles he had just eaten would be his last meal until the next day. Later he would be in a drunken sleep on cheap cider, his only means of escaping reality.

Tam lived next door, alone, "smoking [his] life away". A trained shopfitter, he had been looking for work in Scotland and all points south to Hastings. But after two years without work and on drugs, his prospects were receding fast.

David Wiggott wasn't available to be interviewed. At the age of 22 he had been found hanging, with a leaflet on helping people back to work lying at his feet. His father reported how he felt people saw him as a scrounger, despite all his attempts to get a job.

We were left with little doubt that the welfare state had failed these young men. But what is the alternative? In the second programme, Patrick Minford, one of the Chancellor's wise men, gave us his answer. In future most people will buy insurance for

Will the state provide nothing in future?

pensions and health care and pay for school fees and almost everything the state now provides. To see this idea working in practice we moved to a middle class street in Richmond, south London. Here, a cross-section of company directors and bankers face an onslaught of junk mail and statements by politicians telling them that they have to provide for themselves as the state will not. But can they afford to? Until the man from the Pru came to visit, they thought they could. Offering a basic package for £1500 per month for a couple, that didn't include school fees, he conceded that ordinary people simply could not afford it.

As the residents of Richmond recovered from their shock we cut to the United States. Five million Americans live behind barbed wire, not in jail, but in wealthy estates from which the poor are excluded. One resident cannot see why even one of his tax dollars should be spent on welfare. The Governor of California agrees. He plans to withdraw all welfare from adults without children after two years. Back in Richmond, a new housing complex is being built, surrounded by high walls and patrolled by security guards, and the existing middle class residents, who are excluded, are unhappy.

These programmes were profoundly depressing. Government policies are leading to a society where perhaps 40% of the population will live in grinding poverty, 5% will be locked behind high walls terrified of the masses outside like the French aristocracy before the revolution, and the rest will be permanently insecure in low wage service jobs, struggling to pay expensive private insurance subscriptions.

It is left to Will Hutton, author of the best-selling book *The State We're In*, to provide an alternative to this nightmare. He reminds us that most of our European neighbours understand the need for everyone

to hold a stake in society. After all, it has allowed them to outpace Britain's economic growth and give their elderly populations decent pensions. The *Panorama* team showed that we do need to rethink the British welfare state. But it is not that we cannot afford it. Rather we cannot afford not to have it. If the middle classes think they can do better by withdrawing into a private world and pulling up the ladder behind them they are mistaken. We either swim together or we all sink. I fear we are still sinking.—MARTIN MCKEE, reader in public health medicine, London School of Hygiene and Tropical Medicine

Diagnosis and treatment on the information superhighway

No touch technique

The consultation is undergoing a bigger revolution than the one caused 300 years ago by the invention of the stethoscope. For centuries, doctors have held surgeries and outpatient clinics, their patients sometimes travelling hundreds of miles for a specialist opinion. The advent of new communication technology now means that future generations of doctors and their patients may never meet, except through the information superhighway.

Along it, a doctor can receive clinical details about patients, as well as photographs, x rays and scans, offer diagnoses, and suggest treatments. If the information is made available on the Internet, 30 million people can join in the consultation. One recent case has generated wide interest in implications of the technology.

Zhu Ling is a 21 year old college student

living in China who presented with alopecia and transient gastrointestinal distress. She then developed a peripheral neuropathy, had a respiratory arrest, and went into a deep coma. After a brief period in hospital she recovered and went back to work at the industrial chemistry laboratory at Beijing University. However, she relapsed and was admitted to the Beijing Union Medical College Hospital with a working diagnosis of Guillain-Barré syndrome with incidental alopecia. As her condition deteriorated her diagnosis was revised to acute disseminated encephalomyelitis, but her doctors remained uncertain.

Four months after the onset of the illness, Bei Zhicheng, one of Zhu Ling's friends, sent an SOS message on the Internet asking for help. The message was sent to several destinations which are viewed by the international community. Two weeks later, Bei Zhicheng had received over 400 emailed replies. More than two thirds were from doctors; the rest were from Chinese students living abroad or non-medical well-wishers. Many of the messages suggested that the diagnosis might be thallium poisoning. Zhu Ling's parents arranged for the appropriate samples to be tested, and the results confirmed the diagnosis.

An international discussion took place on the Internet. When the medical experts from

around the globe reached a consensus on the appropriate treatment, an agreed protocol was taken by Bei Zhicheng to the doctors treating Zhu Ling.

Zhu Ling has now regained consciousness. Thallium poisoning is widely recognised to have been an important part of her clinical condition, but her slow and incomplete recovery is still the subject of much debate in cyberspace.

Zhu Ling's case illustrates the potential for diagnosis and treatment to take place over the Internet, but it also raises some serious problems. There is a real concern about confidentiality: not only were Zhu Ling's medical details made public, but there were also photographs of her taken before and during her illness. Although these photographs are accompanied by a suggestion that they should be viewed by professionals only, at the moment there are no restrictions to viewing them.

International agreements would help to standardise the doctors' legal and ethical obligations and establish which country's legal system would prevail in the event of an international consultation ending in a complaint. Both doctors and patients need know their legal position about this kind of consultation. British medical case law lacks precedents for transferring blame from clinicians to their instruments and systems

and on using electronic notes. Practitioners will need good advice about the best practice before such a case is brought.

There are also concerns about the effect that the new technology will have on the doctor-patient relationship. Physical examination brings something intangible to the consultation. Touch has a powerful placebo effect, and we have insufficient knowledge of the effect of removing it altogether from the consultation. A study from Kansas presented at the TeleMed 95 conference reported on a pilot study in which community nurses are using the new technology to provide remote teleconsultations for elderly patients. In nearly half the consultations, the patient said it would have made a difference in their care if the nurse had been able to be there in person. The nurses, in contrast, were completely satisfied and had no complaints.

The Zhu Ling Internet web site claims: "The beauty of telemedicine is that the best medical resources can be delivered to a remote site anywhere in the world throughout the information superhighway." As exciting as that sounds, the ethical concerns and lack of legal precedents may present a more depressing scenario for the victims of telemedical accidents.—NAOMI CRAFT, *freelance medical journalist*

Zhu Ling's parents gave consent for publication of her case on the Internet.

PERSONAL VIEW

Inside the oven

Helen Rosenthal

When I was in hospital for removal of an adrenal carcinoma the most unpleasant experience was the magnetic resonance imaging scan. Despite written information and reassurances offered, I was completely unprepared for it. Why was it so traumatic?

I now understand my distress by setting it within the context of being terminally ill. I knew that the tumour was malignant, that it was large and producing high levels of cortisol and other hormones. It created terrifying rushing sensations. The metyrapone that I was taking to reduce my blood cortisol made me nauseous and dizzy. My legs were weakening. I was terrified that I would not live to see my children again. Any resilience I had ebbled away. I had already been processed through many high tech investigations. I knew that the scan would play a critical role in determining the size and position of my tumour. Successful surgery would depend on obtaining the best possible images. I had to stay calm.

After being wheeled through the familiar hospital passages, I was left alone. I felt abandoned. The glass screen separating me from the radiographers left me feeling on display. The bed glided slowly into the scanner, like a pizza into an oven, foreshadowing the imagery that has haunted me

since. Despite earplugs, the knocking sounds were overwhelming. Time seemed endless. The roof of the white tunnel was so close to my nose that I could not move. I tried using the breathing techniques I had learnt in preparation for childbirth. But in labour someone holds your hand.

***"The cheerful image of the
pizza oven soon
metamorphosed into
Auschwitz gas chambers."***

Eventually it stopped. I hoped the minutes of respite would let me face the subsequent bouts of imaging less fearfully. I tried to communicate with my husband and the staff. They had re-entered the room, but it was difficult with people who had not been through the experience themselves. The knowledge of what was to come did little to soothe me. I sobbed helplessly. The cheerful image of the pizza oven soon metamorphosed into Auschwitz gas chambers. This emphasised further the chasm between me, my husband, and the radiographers. As the remaining three eight minute sessions proceeded I felt that I might die inside the oven. But I was fearful of being considered neurotic. By then I was being begged by the radiographers and my husband to continue. I knew that my survival might literally depend on completing the session. Under those pressures I took some deep breaths and eventually it ended.

There was no opportunity to discuss what happened with the people who had witnessed, if not understood, my distress. I was unable to think of asking to see the images then or later. The more immediate sharing of knowledge and pictures of what is the patient's tumour might help to redress the imbalance of power between patients and doctors. It might also have helped me control the nightmarish imaginary forms that my tumour subsequently assumed.

I left feeling that I had behaved feebly, my confidence smashed. That I had been offered this sophisticated technique which is in considerable demand made me feel even worse.

In retrospect, this was a microcosm of the experience of knowing that I was dying. I have since talked to friends who have had similar scans at the same and at different hospitals. None of them found it easy. A general practitioner friend subsequently asked four of his patients how they found it. All replied "terrifying." More extraordinary is that the literature on scans suggests that my experience is quite common. Some patients are unable to complete the scan.

So a reduction in trauma caused by the scan is an important consideration. These suggestions might help: a dose or two of Valium perhaps; someone speaking to patients throughout—it may not always be easy for patients to respond, but the sound of another voice would help. There are other possibilities. And there needs to be an opportunity to tell how it was.—HELEN ROSENTHAL
lives in London