weeks. Specific interventions at and around conception[8] might reduce the frequency of others.

Yet while the numbers of infants being born with severe handicaps may be reduced, such births will continue to occur, and difficult ethical decisions will still have to be made. Doctors need not be ashamed of making them. The best defence to any criticism is that the decision to withhold treatment and let an infant die should be made openly. In such cases we believe that a paediatrician should get the agreement of a colleague to his assessment.[9] Next, and equally important, when the baby dies the death and the circumstances leading up to it should be discussed at the next clinical meeting of the division of paediatrics (or at the joint obstetric/paediatric meeting if that is the local alternative). By putting the deaths on record the treatment policy will be seen to be considered, consistent, and compassionate.

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Medical aspects of unemployment

Satisfying work is generally agreed to be necessary for health and wellbeing. Regular work provides the opportunity for channelling creative drives and promoting self-esteem and gives pride in achievement. Yet the possible effect of unemployment on health has been ignored to a remarkable extent by various authorities throughout the years. Evidence linking unemployment with psychiatric and physical morbidity has, in fact, gradually become available since the 1930s.

Eisenberg and Lazarsfeld[1] described the psychological response to the event of unemployment in three phases. The first response is one of shock and denial, followed by feelings of optimism and a long-deserved holiday—and such feelings will be enhanced if there is a substantial redundancy payment.

The second phase is characterised by increasing distress, as the man or woman comes to realise the harshness and seriousness of the problem, particularly after vigorous efforts to find work have been unsuccessful.

In the third phase the ex-worker has become resigned and dispirited and develops the "unemployed identity." He no longer looks for jobs in a regular manner but in a haphazard and casual way without any real hope of success. He has feelings of inferiority and submissiveness and of hopelessness about his ability to provide for his dependants.

Tensions, family quarrels, irritability, and depression are common, particularly in the second phase. Not everyone will go through all these phases. The degree of reaction will be influenced by the amount of satisfaction associated with the lost work and the significance of the loss of status and prestige. The cumulative effects of other stresses occurring during unemployment and the extent to which the loss of employment was seen as unjust or selective will also contribute to distress.

One of the few prospective longitudinal studies of the effects on health of unemployment was reported by Kasl and colleagues in 1975.[2] They found that physiological changes, including increase in blood pressure and the serum concentrations of cholesterol and urate, correlated with increased depression, irritability, and loss of self-esteem. These changes began during the time that redundancy was expected and the abnormalities disappeared only on or a few months after re-employment.

Harvey Brenner[3 4] has produced evidence from a time-series analysis that an association exists between mortality and morbidity rates and economic indices, including real income, unemployment, economic growth rates, and inflation, with a lag period of one to three years. He included suicide and homicide rates and admissions to psychiatric hospitals in his health indices in addition to mortality rates. Brenner's methods and conclusions for England and Wales[4] have recently been criticised in detail by Gravelle and colleagues,[5] who are exploring the possibility of assessing effects of unemployment on mortality, using more specific models and different statistical techniques.

Other recent studies on the effects of unemployment on psychiatric morbidity have been carried out by Fagin[6] and Cochrane and Stopes-Roe.[7] Fagin's pilot study of 22 families showed that their health deteriorated after unemployment, and that this deterioration was not confined to the ex-worker but also occurred in wives and children. The morbidity took the form of moderate or severe depression and the exacerbation of illnesses such as asthma, psoriasis, and gastrointestinal disorders. He also found that disabled people who had succeeded well throughout their working lives suffered an appreciable increase in distress and incapacity associated with their disability during unemployment. Children's school performance declined and their behaviour became disturbed. Marital relationships were often affected, and some of the families separated permanently after unemployment. In many of the instances the general practitioner was not aware of the breadwinner's unemployment.

Cochrane and Stopes-Roe[7] studied relations between mental health in women and marital state and employment. They found that women who worked outside the home had fewer psychological symptoms than those who were not in paid employment. This particularly applied to depression.

All these studies, then, confirm that work is conducive to mental and physical health and that unemployment may increase the risk of morbidity and mortality. Loss of work is indeed a major life event which requires adaptation and is inherently stressful. Holmes and Rahe[8] quantified life events by their social readjustment scale according to their power as stresses. In prospective studies they showed that there was a critical level of the number of life events experienced over a year that put that person at great risk of illness. Life changes have cumulative effects and may tax an individual's adaptive ability to the maximum. Holmes and Rahe[8] found that losing one's employment, changing to a different type of work, and retirement all ranked high on their scale of life changes. If additional stresses occurred, such as death or illness of a member of the family or marital separation, the additive effect was likely to lead to illness.

The evidence is sufficiently strong to warrant an intensive full-scale prospective longitudinal study on random and representative samples of the unemployed population, with a

view to assessing precisely the adverse effects of unemployment on psychological and physical morbidity. Of prime importance is the identification of high-risk groups and of ways of preventing them suffering the adverse effects of unemployment.

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A New Year gift from the BBC to all smokers

This year began with doctors and the BBC still arguing bitterly over the *Panorama* programme on brain death. Next year will start much more amicably when the BBC launches its series of six 10-minute programmes designed to help smokers to stop smoking. Called *So You Want To Stop Smoking*, the programmes will be broadcast on consecutive Sunday evenings on BBC2 at 5 45, starting on 3 January. More than two years' work, research, and thought have gone into their preparation. Given that the *BMJ* has sometimes criticised the BBC heavily, it would be churlish not to acknowledge the thought and care that have gone into making a programme which is aimed at cutting down the commonest cause of preventable morbidity and mortality in Britain.

Right from the beginning the programmes had clear objectives: they were to be aimed at smokers who wanted to stop smoking (particularly those in social classes IV and V, who are having least success in stopping); they were to help these people to stop and "stay stopped"; and they were to concentrate on the benefits to be had from stopping smoking rather than on the death and disease that result from continuing.

Two pilot programmes were designed to answer particular questions, among which were: who should present the programmes; how many presenters should there be; how should the programmes be organised; should they include cartoons; should there be pictures of "buckets of lungs"; should celebrities be used; should there be any humour; and should "vox pops" (media jargon for quick comments from people in the street) be used? After making the pilot programmes, the team showed them in 11 cities, always to two audiences—one a group of interested professionals and the other people from the "target audience"—that is, smokers who wanted to stop. On many issues the two groups thought quite differently, and the producer, Anne Jackson, had to interpret exactly what the groups were saying and arrive at some sort of compromise in making the final programmes. Mostly the decisions veered in the direction of what made an impact with the target audience.

Many of the target audience liked the doctors in the programmes to be older, behind desks, and wearing white coats; the professionals thought this very old fashioned. Most of the audience liked "buckets of lungs" and pictures of pathologists slicing cancers; the professionals thought this far too negative. The professionals, however, were all for humour, whereas the audience, although they did not mind a little, did not want too much humour as they thought it would undercut a serious subject. Everybody, however, liked people to identify with, "vox pops," cartoons (in small doses), and celebrities.

After the pilot run the team had a much clearer idea of how to make the final programmes. They are centred on four people who are trying to stop smoking: a young, newly married Aberdonian girl; a married woman in her thirties with teenage daughters; and a working class Londoner in his forties and his wife. These people have been carefully chosen from hundreds, not only for their ability to "come over on television" and the producer's confidence in their ability to stop smoking, but also because they fulfil carefully predetermined criteria of things like age, class, and number and type of cigarettes smoked. Critics might say that there should be an adolescent or an old person, but in six 10-minute programmes not everything can be covered and not every type of smoker can be individually catered for. But every single person who appears in the programmes—and with the "vox pops," the celebrities, and the experts there are a great many—is there for a specific purpose.

The programmes will be supported by an information pack, which viewers can write in for. This includes a booklet *So You Want to Stop Smoking*, which has been specially written and has the same positive emphasis as the programmes; a tabloid newspaper; a "contract" that the viewer can use with a friend or spouse; and a letter from the presenter, Dr Miriam Stoppard. There will be a splash of advertising, tee-shirts, badges, and posters—indeed, commercial radio stations are going to carry trailers for a BBC programme. One important result will be that the antismoking message will be seen as establishment rather than fringe.

All this furore is bound to have effects on general practitioners. Viewers will not be told directly to go to their general practitioners, but doctors—including a general practitioner—will be seen in the programmes, and viewers will get the idea that doctors can and should help. For this reason the publication of the Give Up Smoking kit, which has recently been sent to all general practitioners (26 November, p 1576), was brought forward. Every general practitioner will have it in his possession if and when patients arrive after watching the programmes.

General paralysis of the insane

We have all been conditioned over the years by every form of audiovisual aid to believe that "Guinness is good for you," and we see an extensive field trial of this beverage being carried out daily by our friends: so it may be something of a similar paradox if I were to suggest that in certain cases "Disease is good for you." Perhaps I could correct this and say that as a result of disease the world of letters, science, art, and even politics has gained something. Naturally I have in mind those two diseases tuberculosis and syphilis, with