Firstly, I would advise any general practitioner who has not already done so to consider providing written contracts of employment to his ancillary staff. Of course, I would also advise the doctor to exercise great caution before rushing into the surgery with a bunch of written contracts. Such a gesture can be easily misunderstood, creating, rather than avoiding, problems.

Secondly, if care is taken in preparing the contract it will take full account of existing employment law and clarify many matters where there is uncertainty on both sides. The draft contract, which will appear in a later article, takes full account of existing state law. It even takes account of health and safety legislation by including a policy statement on health and safety at work. (The Health and Safety at Work Act requires every employer of five or more staff to prepare a written statement of his general policy, organisation, and arrangements for health and safety at work.)

Finally, the BMA's regional offices can provide specialist advice and help to BMA members on how to introduce written contracts among ancillary staff. This service has already been widely used by members, and many general practitioners have already made use of the draft contract provided in a subsequent article.

Why is there so much employment law?

When I discuss employment law with doctors and explain its implications for general practitioners I am very often asked why there is so much employment law. My answer refers to the various influences that have contributed to its growth. (About 10 new Acts of Parliament have been implemented since the mid-1960s, establishing over 20 new rights for the individual employee.) Successive Conservative and Labour Governments have tried to influence the behaviour of unions by devising laws that would encourage them to act more reasonably and responsibly. As a quid pro quo for restrictions on closed shop agreements—for example, picketing, secondary boycotts, certain union—management have provided legal ground rules covering such matters as dismissal, employment rights, health and safety at work. Three important episodes illustrate the "trade off" between these two sets of objectives: *In Place of Strife* and Mrs Barbara Castle's proposals for legislation; *Fair Deal at Work* and the 1970 Conservative Government's Industrial Relations Act; and the 1974 Labour Government's Employment Protection Act.

But this plethora of legislation is not merely one side of an equation designed to contain the challenge that unions pose for governments. Governments have also believed that the more formal and equitable approach to industrial relations and personnel matters required in these enactments would quickly reduce the number of disputes by improving industrial relations. Of course, there were other influences—comparisons with established international standards, for example, the Equal Pay Act and Sex Discrimination Act; the influence of legislation on other subjects such as the Race Relations Act; and the commitment of governments to a climate of increased job security, for example, the Redundancy Payments Act and Industrial Training Act—that would encourage employers to relax restrictive practices and accept changes in working practices and new technology.

The law has been designed, however, to alter the personnel practices and policies of large organisations where unions are already well established. The special position of the small employer, whose circumstances are considerably different, has been mostly ignored by legislators, but the 1980 Employment Act has made some very important concessions. Many of these ground rules—the rights of the employee and the duties of the employer—apply irrespective of the size and resources of the organisation or firm.

It should be remembered that most of this law has the support of both major political parties. Both have contributed to

its growth and both now accept it as a permanent feature of the industrial relations environment. Only on a few issues such as the closed shop, picketing, and strike ballots is there a main divergence of opinion between Conservative and Labour governments. Such a divergence has become a problem for some people who have preferred to ignore the legislation have done so on the wholly erroneous assumption that the tide would rapidly recede after the change of government in May 1979. In fact, quite the reverse seems to have occurred: the body of employment legislation is still growing, as is evident from the 1980 Employment Act.

What significance does legislation have for the small employer?

Because governments have been heavily criticised for ignoring the problems of the small employer, some thought has now been given to the significance of the legislation. The previous Government made a survey of the problems of the small employer, which showed that the legislation had had a very limited impact. Only one small employer in 10 had had a case of unfair dismissal brought against him in the past two years. The survey also showed that small employers have very few disputes and problems. When asked, "What would you say have been the main difficulties you have faced in the past year in running your business?" employment legislation and health and safety regulations were hardly mentioned.

These findings could be said to vindicate those who have preferred to ignore the legislation and carried on regardless, believing that too much fuss has been made about the risks for the small employer, and that this survey gave a realistic perspective to it. This view may be acceptable to many employers who prefer to remain ignorant of the legislation (though ignorance of the law is no defence if legal proceedings should arise), but there are good reasons for being more cautious. Firstly, the survey's evidence was gathered about three years ago, and it is reasonable to assume that the climate of industrial relations has continued to change since then; more employers are becoming aware of the employment rights, and the process of unionisation is now penetrating general practice at an increasing rate. About eight union activities compete for members—among them the National Union of General Practitioners, NALGO, NUPE, COHSE, MATSA, (GAWU) clerical and executive section), and ACTS (TGWU clerical and executive sections)—all the effects of changes in Health Service industrial relations still reverberate in this field.

I have focused on the need for a written employment contract because this offers an easy remedy for the many doctors who prefer to keep employment law at a safe and decent distance. In a later article I will provide a draft contract that should suit the circumstances of most general practitioners, together with advice on how it might be introduced.

Avoid litigation by good management

I must emphasise that the overriding aim should be to avoid litigation. When doctors ask for help with problems concerning their ancillary staff they often mistakenly look for legal solutions to problems that are caused simply by their failure to manage their staff effectively. For example, one doctor asked if the law could help him to persuade his receptionist to provide him with

*APEX, Association of Professional, Executive, Clerical and Computer Staff; ASTMS, Association of Scientific, Technical and Medical Staff; NALGO, National and Local Government Officers' Association; NUPE, National Union of Public Employees; COHSE, Confederation of Health Service Employees; MATSA, Medical, Technical and Administrative Supervisory Section of the National Union of General and Municipal Workers-GMWW; ACTS, Association of Clerical, Technical and Supervisory Staffs (of the Transport and General Workers' Union-TGWU).

Beyond the Surgery

General practitioner as social anthropologist

Cecil G HELMAN

Most social anthropologists these days do their research in remote areas of the non-industrialised world. They live for a year or two in tiny jungle villages or isolated settlements studying small-scale tribal societies. Gradually, by inquiry and observation—the process of "participant observation"—they build up a picture of the tribe's culture, its customs and rituals, its political and economic structure, and they learn to view the world through tribal eyes. Later they return to their universities laden with ideas and artefacts and try to relate their findings to more complicated Western societies in which they live.

As an anthropologist my "tribe," as it were, is somewhat less exotic: it is my own patients and those of neighbouring GPs on the fringes of north-west London. There are no tropical forests there, no parkland squawking in the jungle, no crocodiles, no bamboo huts or cooking fires. Only rows of semi-detached houses containing suburbanites, with mortgages and marital problems, neat front gardens, and a Main in every driveway. But even in this sedate setting there are rich pickings for the medical anthropologist with an interest in medical folklore.

Medical anthropology

Medical anthropology is a fairly new branch of social anthropology. It is the study of how people in different groups or cultures explain the causes of illness, the types of treatment they believe in, and whom they turn to if they do get ill.¹ The subject includes more than a list of exotic medical practices from faraway lands; any culture's theory of illness and its treatment are greatly influenced by its view of the world in general and of misfortune in particular. Illness is only a special type of misfortune, part of a wider spectrum of adversities which, in some societies, are all said to have the same cause. For example, when one has a traffic accident, loses money on the stock exchange, and gets a violent toothache all in the same day one may ascribe it to something called "a streak of bad luck," as though there were a single causal force or agent; similarly in other societies all these bad events happening together may be taken as proof that the victim has been "bewitched" by some malevolent person. Medical anthropologists study these various beliefs and how they affect patients' behaviour; they compare the differing views of health and illness of different societies and also of different groups (say, doctors and patients) within one society. Problems of communication between general practitioners and their patients in an English suburb² are as much of interest to the modern medical anthropologist as, say, some exotic childbirth ritual in Outer Mongolia.

My own interest in the subject began several years ago. I remember, in Africa, seeing a grossly infected wound on a patient's leg. Among the purulent matter were a number of

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small dark bristles. I found out later that the wound was originally a dog bite and that these bristles were hairs cut off the offending animal. The patient, it appeared, had taken quite literally that old saying: "The hair of the dog that bit you." He had caught the dog, cut off its hair, and rubbed it into the wound with highly purulent result! This bizarre incident—and many others—led me gradually to medical anthropology. I had always been fascinated by folklore, old myths and legends, and curious superstitions, especially those relating to health and disease. But to look at these beliefs and their clinical significance required a more academic approach. Two years after my housemanship, the usual locums, and a short spell as a ship's doctor in the Med, I enrolled as a full-time student at University College London and graduated in social anthropology. For almost seven years I have been a full-time GP, but have been also since 1977 an honorary research assistant in anthropology at University College, and a co-founder of the British Medical Anthropology Society.

I find that general practice, even full-time, offers an excellent setting for medical anthropological research, in my case into the clinical significance of folk beliefs about illness and health.³ The two types of data gathered by anthropologists—"hard" or statistical data and "soft" or personal observations and open-ended interviews—can both be gathered by an astute GP working in any area where there is a wealth of folklore beliefs about illness.

The importance of these beliefs is that they affect the behaviour of patients, and of those around them. One classic study on this theme was done by Dr Louella Snow, of Michigan State University. She analysed the folk beliefs about menstruation and fertility of working-class women attending a city clinic in the United States. She found a variety of odd ideas about the uterus and its function, which clearly had an effect on the women's health. For example, some women viewed the uterus as a hollow organ that is tightly closed between menstrual periods, while it slowly fills up with tainted blood, then opens to release this blood at the time of the period. This belief led these women to assume that they were most likely to get pregnant just before, or during, or just after a period "before it is tightly closed again." As a result they could not see the logic of taking contraceptive precautions at other times of the month. They also believed that a woman could not contract venereal diseases during pregnancy "because the uterus is closed and the germ cannot enter."

Colds, chills, and germs

A prime aim of medical anthropology is the improvement of health care, and the beliefs and behaviour of patients obviously may have important clinical implications. So far I have conducted and published two research projects on this theme.⁴ The first⁵ was a detailed examination of folk beliefs about "colds," "chills," and "fevers," to find out the concepts and premises that lay behind the old aphorism "Feed a cold, starve a fever." Over four years I asked several hundred patients, as

a cup of tea twice a day, morning and late afternoon. (At the time I met the doctor he was actually making tea twice daily for his receptionist.) This doctor had not established contact with a manager 14 years earlier when he first contacted that his receptionist should no longer undertake this task as part of her job only a few days after she started work. At the time he did not like to say anything believing it would cause unpleasantness. And he hoped that the difficulty would improve. But the question of who made the tea was just a symptom; it was the problem of their working relations that had been unsatisfactory from the outset, and these had deteriorated further over the years. The law as such had little to offer this doctor in the way of a remedy. The problem had been going on for too long, and it needed more than legal action to put it right.

This example is typical of many cases where BMA advice is sought. It illustrates some of the advantages of a more formal approach to the employment of staff. It shows how a firm foundation for good working relations. The written contract also describe the disciplinary procedure that would be involved if performance in the job was unsatisfactory.

The prescription of a more formal approach to such matters, relying on properly agreed and documented contracts, might be

regarded as oversteering to something of minor importance. But this is simply not so. Relations between the doctor and his receptionist may seriously undermine his efficiency as a practitioner. And where there is only a small number of staff, the problems are often more difficult to deal with.

In my experience many of the problems of general practitioners are caused by poor selection procedures when staff are first appointed, inadequate supervision, and a reluctance to act decisively when staff are found to be unsatisfactory. Of course, for the general practitioner who employs only a few staff it is pointless to recommend formal procedures drawn from the practices of large organisations for the recruitment, appointment, and discipline of staff. But in other offices there are staff who are not only a nuisance but also a danger to the practice. Basic commonsense principles should be applied to these matters. The general practitioner should take great care to recruit the right staff; they should serve a probationary period (say, nine months) with effective procedures for assessing their performance, and the general practitioner should not hesitate to take firm action if their performance fails to meet the standard required.

This is the third of six articles on employing staff.

Another time we went to a seaside town to see a practice. A smooth doctor said to me, "I'm no businessman," which is a classical start. "I'm no businessman," he said, "but it would help you a lot if you purchased the house containing the practice. Because I don't think you can afford the main surgery, but I'll rent the accommodation to you." We went to see the beach surgery, which was a ghastly little suburban house. He was going to London. He was a single-handed general practitioner and had no right to do this at all because it was an executive council vacancy, which if he left would be advertised. What he was going to do was take on a partner, and once he'd got him installed he'd move up to London. The condition would be that once you were in he would resign and you'd move into the next.

We went for another interview with three doctors in a nursing town. They had a list of only about four or five thousand, and I wondered how on earth three doctors could survive. One doctor was leaving and he was the usual racket that you had to buy his house and he would have been a list of only about four or five thousand. It was an enormous house—about eight or ten bedrooms—the middle of a row of small houses in a beach street, and bright, light, a fine house. We looked at this, and we said, "No one can afford the house; how are we going to survive here? What is there to do?" And, of course, the truth was that the other two doctors—the two who were left—had got private incomes and didn't bother about the practice much, so the junior did all the work. The junior, who'd been with them for some time, had also got some private income and he was just pulling the strings. The other two thought it would be nice to have a third man to do all the work again, and so they advertised.—KEN DICKINSON, general practitioner, Birmingham.

Clinical Corrie

All was a Chaucer illusion who spent the war years in Jersey under German occupation. During that time, when he was in his 20s, he had a right occlusal for what he was told was a malignant tumour of the testis. I first saw him as a patient in the 1960s, when he took on the job of wardens at one of the local old people's homes. After since his operation his scrotum had been very swollen with a "bryopholous-like" appearance. The penis was almost buried in the swollen disease. I arranged for him to see a surgeon in London, but no treatment was offered.

Six or five years after I had first seen him he came to see me with a smile on his face. Two days earlier he had been to a foot and mouth clinic. The doctor had said to him, "You've got a foot and mouth, but don't worry, it's not serious, it's just a virus. The back fence to get a better view—and had lost his oedema. In some way, whatever was obstructing the flow had been unblocked. I never found out why.—STUART CANNON, general practitioner, London.

We will be pleased to consider for publication other interesting clinical observations made in general practice.—Ed, BMJ.

well as locally recruited surgery staff, a number of key questions such as, "What is a cold?" "Is a chill?" "Is a fever?" "What do you mean by a germ?" and so on. At first these questions drew puzzled frowns ("He's an odd 'un", that doctor; doesn't even know what a germ is!") but gradually the patients got used to it, and in the end they were able to answer the extra questions.

By this ethnographic technique I built up a picture of patients' lay beliefs about these conditions. The research revealed a host of unexpected and exotic beliefs. For example, "germs" of the vast majority of patients have never seen "a germ" nor have they any perceptual evidence for its existence. For most of them "germs" remain a hypothesis, a folk theory of causality, much like the "spirits" said to cause illness in some Third World societies. The stated attributes of "germs" were as follows: they are living, invisible, malevolent entities. They have no free existence in nature, and exist only in or among people. All "germs" are "bad," and distinction is made between "germs," "bugs," and "viruses." They are thought of as occurring in a cloud of tiny particles, or as a tiny invisible "insect." Germs causing gastrointestinal symptoms seem to be more "insect-like," for example, "a tummy bug"—but others, Germs have personalities which are expressed in, and can be recognised by, the symptoms they cause. ("I've got that germ, doctor, you know—the one that gives you the dry cough and the watery eyes"—or "the one that gives you diarrhoea, and makes you bring up.") Germs seem to be single in their effect; you are only attacked by one germ at a time ("I've got a germ, doctor"). They select their victims randomly, and therefore the victim is blameless and can mobilise caring relatives around him.

This is very different from "colds" and "chills," which are byproducts of one's personal battle with the environment, and usually result from doing something "fally," such as "going out in the cold after a hot bath," or "standing in the rain after a haircut." The "germs" enter the body by its orifices, the natural breaks in its defences, then move on to attack other parts of the body ("It began as a sore throat, but then went down to my tummy") and causes a fever. Sometimes fevers occur in a "dry" form—for example, pyrexia with a dry cough—sometimes in a "wet" form, where the pyrexia is accompanied by excess body fluid in the form of phlegm, mucus, saliva, diarrhoea, or sweat; the aim of folk therapy seems to be to move the patient from the "dry" to the "wet" state and thereby expel the "germs." "Flu" are often used to effect this expulsion; patients with "dry" coughs are told to "sneeze their cough," "hawn" or "loosen" so that they can "cough it off my chest," and so continue to demand cough lozenges. Wilks⁶ has noted that an estimated six million gallons of cough mixtures are prescribed every year under the National Health Service; could it be that part of the demand for these mixtures is that they are seen by patients as somehow "loosening" and then "washing out" the offending germ from the patient's chest?

Always go late at night

I once had a patient who was grossly overweight, lived in filthy circumstances, had a few cars, and a transport driver who came on a Thursday with diarrhoea. His family read on the Friday and said he'd still got diarrhoea and some vomiting. I said, "Well, carry on with the health and medicine, but I know in the morning if it's not better, and I'll come and see him." And about 2 o'clock in the morning they rang up and said he'd got a lot more diarrhoea—he was trying to go to the toilet two or three times every hour. I said, "Right, I'll move him to the fever hospital; he's obviously got acute gastroenteritis."

The discharge letter said, "Dear Dr Dickinson, Thank you very much for admitting this man. When we opened him we found an acute peritonitis."

It is logical from the patient's perspective to demand antibiotic when they are told they only have "a virus." In the folk model no differentiation is made between bacteria and viruses; both are "germs" that must be washed out or killed in situ by antibiotics. In this case, as in others, the value of in-depth medical anthropology is that one can get clues to the underlying premises governing patients' health behaviour, and also to their attitudes to prescribed medical treatment. My second study⁷ dealt with this theme—that is, patients' perceptions of their psychotropic drugs. It revealed a wealth of lay beliefs about these drugs and their supposed effects, which bear little relation to those of the medical profession. Once again I have found that viewing medical treatment and diagnosis from the patient's perspective can be a valuable experience.

Making sense of a dangerous world

Lay views of illness deserve our serious study because they are patients' ways of making sense—however imperfectly—of an unpredictable and dangerous world, where disease and death strike in an apparently random way. Hence all the superstitions about "good luck" and "bad luck," about "knocking on wood," and all the other "just in case" remedies, from which even doctors are not immune. I think there may well be a partial return to these "old wives' tales" and self-medication as a result of the increased prescription charges, as well as a sense of disillusionment with over-technological medicine.⁸ If this drift back does occur then the medical anthropologist is well placed to analyse what has happened, and to help design a better health service for the future.

In the meantime, ask the next patient to come in, please....

References

- Helman CG. What is medical anthropology? *BMJ* 1980; 1:155-63.
- Lundy D, ed. *Culture, disease and healing: studies in medical anthropology*. London: Collins Macmillan, 1977.
- Helman CG. "Feed a cold, starve a fever": folk models of infection in an English suburban community, and their relation to medical treatment. *Medical Anthropology*, 1979; 8:107-37.
- Helman CG. Lay and medical attitudes to illness. *BMJ* 1980; 1:151-5.
- Stanton G, Webb B. *Going to see the doctor: the consultation process in general practice*. London: Routledge and Kegan Paul, 1975.
- Helman CG. Patient expectations and expectations of the doctor. *J R Coll Gen Pract* 1981; 31:107-12.
- Snow L, Johnson SM. *Modern day mass hysteria: some clinical illustrations*. *JAMA* 1977; 237:278-9.
- Wilks R. The treatment of cough in general practice. *Prescriber's Journal* 1974; 1:107-12.
- Helman CG. An anthropological view of the modern hospital. *BMJ* 1980; 1:137-41.

His appendix had obviously perforated two days earlier. The lesson I learnt from this is really very simple: if ever you get a call after eleven at night, go; it's always genuine. Whenever the message is you go, because patients never ring after midnight unless it's genuine. I felt as guilty that when I was only once out on any one—four or five times over—because they were still grateful to me I said they could stay on the night. I hadn't the courage to say no. And the cross I bore to go to the long drive to the hospital, it was my guilt.—KEN DICKINSON, general practitioner, Birmingham.

We will be pleased to consider similar interesting stories about general practice.—Ed, BMJ.

Searching for a practice

In 1956 it was hard to find a partnership in general practice, and with the current numbers of general practice trainees it is likely to become hard again in the next few years. In 1956 we were all much the same, just as trainees are now: we were all ex-Army, had all old obese obstetric jobs, and had all done traineeships. We were exploited by poor pay, long hours, having to cope with all the obstetrics, and the problems of house purchase. My experience of 1956 might be of interest to present-day trainees as they may well experience similar things.

My wife and I had a routine: every Sunday we would go through the BAP, select jobs, write out applications, and send them off enclosing a hand-written curriculum vitae. Every Sunday we would go and see the interviewers, and in those days they were very friendly.

On Monday, having been rejected for the job, we would have been told by a letter of refusal. Once an advertisement appeared for a practice in an attractive country town in Herefordshire. We went there and a pleasant and delightful Irish doctor showed us his home. It quickly became clear, however, that his aim was to sell this house, which was an old rectory standing by a beautiful church. We couldn't understand what this was all about: why he was offering to sell his house? We found that he was leaving the practice to his wife, who was the main coming in to purchase his house, and at that moment his partners didn't even know he was going. When I rang up the partnership the following week to discuss some of the terms they were horrified.

There was a doctor at Graston who did the same sort of thing. The senior partner put in an advertisement but the junior partner always managed to intercept him and tell him that he was not to buy his house, because they really wanted this partnership you need to buy my house because quite honestly unless I sell my house for the proper price I'm not leaving." And the senior partner, of course, wanted him out and was quite prepared to accept this sort of thing happening.