claim for unfair dismissal can be heard by a tribunal, the employer must establish that dismissal took place. Dismissal occurs when: (a) the employer terminates the contract with or without notice; (b) a fixed-term contract expires without being renewed (a claim cannot be made if the contract is for one year or more and the employee has previously agreed in writing to forego his right of complaint); (c) the employee resigns in cases where the employer's conduct shows intention not to be bound by the terms of the contract of employment or where the employer has broken a fundamental term of the contract of employment. This is often described as "constructive dismissal," and occurs when the treatment of an employee by the employer is so unpleasant or intolerable that the employee feels compelled to resign.

THOSE WHO CANNOT COMPLAIN OF UNFAIR DISMISSAL

The general rule is that employees who have not completed 52 weeks' continuous employment with their employer (where from 1 October 1980 the employee was not continuously employed for more than two years and at no time during that period did the total number of employees exceed 20, or who have reached normal retiring age for their employment (or if there is no normal retiring age, have reached 65 for men or 60 for women) cannot complain of unfair dismissal. But any employee working for an employer with 20 or less staff does not

have the right to complain of unfair dismissal during the first two years of service, unlike other employees who have the right to complain of unfair dismissal after one year of service. However, there is no qualifying period of employment or age limit for those complaining of unfair dismissal on account of trade union membership or activities.

FAIR AND UNFAIR DISMISSAL

Dismissal can only be fair if the employer can show that the reason for it was one of these:

- a reason related to the employee's capability or qualification for the job;
- a reason related to the employee's conduct;
- redundancy;
- a statutory duty or restriction that prevents the employment being continued;
- some other substantial reason that could justify the dismissal. The employer must also show that he acted reasonably in the circumstances in treating that reason as sufficient to justify dismissing the employee. But the tribunal will take account of the size and administrative resources of the employer's undertaking.

Dismissal for redundancy may be unfair if the employee was unfairly selected for redundancy. Dismissal on account of pregnancy will, in most cases, also be unfair. Dismissal will

Individual employment rights

Right	Legislation	Eligibility (length of service in weeks)
(1) To be given a minimum period of notice—based on length of service—of termination of employment	Employment Protection (Consolidation) Act 1978	4*
(2) To be given written particulars of terms of employment	"	13*
(3) To receive equal pay with a member of the opposite sex doing similar work	Equal Pay Act 1970	Immediately
(4) Not to be discriminated against on the grounds of marriage or sex	Sex Discrimination Act 1975	Any stage from advertising of job
(5) Not to be discriminated against on the grounds of colour, race, nationality or ethnic or national origins	Race Relations Act 1976	Any stage from advertising of job
(6) Not to be unfairly dismissed	Employment Protection (Consolidation) Act 1978 and Employment Act 1980	2 years or less than 21 employees
(7) To receive a guaranteed payment when no work is available	Employment Protection (Consolidation) Act 1978	4*
(8) To receive payment when suspended on medical grounds—in certain specified industries only	"	4*
(9) Not to be dismissed on pregnancy grounds	"	52*
(10) To receive payment for absence due to pregnancy or maternity	"	104
(11) To return to work after absence due to pregnancy or maternity leave	"	104
(12) Not to have action—short of dismissal—taken against him because of trade union membership or activity	"	Immediately
(13) To have time off—with pay—for carrying out trade union duties or for approved industrial relations training, if trade union is recognised for collective bargaining purposes	"	Immediately
(14) To have time off for trade union activities if trade union is recognised for collective bargaining purposes	"	Immediately
(15) To have time off for public duties	"	Immediately
(16) To have time off—with pay—to seek alternative work or to arrange training in a redundancy situation	"	104*
(17) To have protection in case of employer's insolvency	"	Immediately
(18) To receive on request a written statement of the reasons for dismissal	"	26*
(19) To have an itemised pay statement	"	Immediately
(20) To have paid time off for antenatal care	Employment Act 1980	Immediately
(21) To have a protected period of notice and for his trade union—where recognised by his employer for collective bargaining purposes—to be consulted in a redundancy situation	Employment Protection Act 1975	Immediately

Note: *Employees working 16 hours or more per week are eligible. After 5 years' continuous employment, employees working 8 hours or more a week are eligible. If dismissed for certain inadmissible reasons—that is for reasons of trade union membership or activity—there is no length of service qualification. (BMA copyright)

also normally be unfair when it is for being a member of or for taking part in the activities of an independent trade union, or for not being a member of a trade union which is not independent.

REMEDIES FOR UNFAIR DISMISSAL

- reinstatement (the employee is to be treated in all respects as though the dismissal has not occurred);
- re-engagement (the employee is to be re-employed but not necessarily in the same job or on the same terms and conditions of employment);
- compensation.

WRITTEN STATEMENT OF THE REASONS FOR DISMISSAL

Employees who have been dismissed and who have completed 26 weeks' employment have the right to receive from their employers on request a written statement of the reasons for

dismissal. Employers are required to comply with an employee's request for such a statement within 14 days of the request being made.

A final note of reassurance

For the most part, employers rarely experience the problem of dismissing staff. Most ancillary staff are loyal (devoted to their doctors) and provide a very high standard of service. No problems have ever arisen or are likely to arise in the future. In these circumstances where there is an entirely happy and satisfactory working relationship the doctor should be most careful not to upset it by providing conditions of employment where none have been supplied previously. The sudden and unexpected introduction of a degree of formality into the working relationship could so easily be misunderstood. So do please consider the possible psychological impact on your staff of any action you may decide to take.

This is the final article on employing staff.

Sex Problems in Practice

Non-organic causes of sexual problems

ELIZABETH STANLEY

Until quite recently it was thought that all sexual problems were purely the expression of deep intrapsychic conflict arising from traumatic experiences in infancy and childhood, which only prolonged psychoanalysis could resolve. Fortunately, it is now understood that most sexual difficulties are far simpler in origin and can be resolved using brief forms of intervention that require little more than common sense once the causative factors are understood.

The most important causes of sexual problems are (a) ignorance, (b) cultural taboos and myths, and (c) poor communication skills: sometimes a problem is initiated by a specific precipitating factor with these other causes acting as perpetuating factors. Once sexual failure of any kind has been experienced a vicious cycle of fear of failure may begin. The diagram illustrates the causes of sexual failure and the treatment strategies of education, "permission giving," and teaching communication skills, coupled with the use of the "ladder concept" and sensate focus, which will be described in a later article in this series.

Ignorance

Many patients think that they are well informed about sexual matters, but the school playground as a source of learning has its limitations. Some, acknowledging their ignorance, have been too inhibited to seek the information they need. Others may have acquired accurate information at an intellectual level, but

past conditioning may have prevented the emotional acceptance and healthy integration of this information into their lives. Conflict resulting from feelings that are at variance with facts is not always immediately recognised by the patient but needs to

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be identified since such conflict is one of the major factors contributing towards sexual problems. Even if appreciated, there may be a reluctance to disclose such irrational feelings for fear of seeming foolish to the doctor. If in our history taking, however, we ourselves recognise that our patients' feelings about "factors outside the sexual relationship" are themselves, no matter how irrational these feelings may seem we can then assist our patients to articulate and put into perspective such confusing dilemmas.

Many of the commonest areas of ignorance have already been dealt with in the first article in this series. Ignorance about female genital anatomy and masturbation, however, are so important that they deserve further discussion.

FEMALE GENITAL ANATOMY

Few women who present with sexual problems have ever looked at their vulva with a mirror or explored their vagina with their fingers. They have little idea of how they are put together "down there," and many otherwise intelligent women, especially those with vaginismus, have irrational and bizarre fears and fantasies about what they are like "inside." Fear of the unknown is of course one of the most potent sources of fear and can be very inhibiting to sexual responsiveness.

There is also much ignorance about the anatomical relationships of the urethra, anus, and vagina, and many women are convinced that their normal leucorrhoea is some abnormal and "dirty" form of discharge—another somewhat inhibiting idea when it comes to intercourse. The commonest attitude of women with sexual problems towards their genital area is that it is a dirty, untouchable, and unmentionable part of the body. For the woman simply to articulate such feelings is in itself therapeutic, and such a measure, combined with straightforward but sensitive educational procedures, can help that woman to develop a more positive and healthy attitude towards this very important part of her own body. Lack of adequate personal hygiene can undoubtedly give more realistic grounds for some of these feelings and may also need to be discussed.

The clitoris is one of the most misunderstood and misused parts of the human anatomy. Few women with sexual problems, and even fewer of their male partners, know exactly where and what the clitoris is. Sometimes they can identify the head of the clitoris, but do not appreciate that for most women this can be painfully hypersensitive to direct touch. They do not realise that the clitoris also has a shaft which, although covered by skin and not so easily recognisable, is usually the part that is most pleasurable to be touched directly. Only the woman herself can know just how and where she wants to be touched at any given moment, however, and she will usually have to tell her partner of any specific needs. Often neither partner appreciates the contribution direct clitoral stimulation can make towards sexual arousal, and many feel that it is perverted or abnormal for the woman to reach orgasm in this way. In part such attitudes may stem from Freud's belief that "clitoral" orgasms were "immature" and "vaginal" orgasms were "mature." This notion has now been abandoned by most people in the light of the research of Masters and Johnson, which showed that all orgasms were clitoral in origin, since the afferent arc of the orgasmic reflex is triggered by stimulation of the clitoris, whether directly or indirectly. Direct stimulation can occur through the use of fingers, tongue, vibrator, etc. Indirect stimulation occurs during intercourse when the hood of the clitoris and the skin covering the shaft is pulled rhythmically backwards and forwards due to its connection with the labia minora and the movement of them that occurs during intercourse.

MASTURBATION

Acceptance of masturbation as part of our developing sexuality and as a continuing option for sexual expression throughout

adulthood may be disputed by many who hold certain orthodox religious convictions but is disputed by few of those who treat sexual problems.

Patients who present with sexual problems guilt about masturbation is almost universal, although this may at first be denied since many people have now read somewhere that masturbation is a normal, healthy activity, so making it difficult for them to admit to such an irrational but nevertheless very real feeling. At worst, masturbation is thought of as perverted and disgusting, and even, although unnecessary if you have a sexual partner. Even in 1981 there are still those who believe that it makes you go mad, stunts your growth, toughens "the skin," and makes you unable to respond sexually with a partner, etc. Few patients value masturbation as simply one form of sexual expression, which can be enjoyed not only on one's own but also can sometimes be shared with one's partner, giving as much pleasure to both as any other shared sexual experience.

Cultural taboos and myths

Three main taboos contribute towards most sexual problems, but they may not be immediately apparent to the doctor because, as in the case of masturbation, the feelings evoked by these taboos are often irrational and conflict with the patient's conscious thoughts about the problems. Awareness of the importance of helping the patient to get in touch with and express such feelings, combined with sensitive handling of the interview, however, should enable most patients to recognise and express such irrational feelings when they exist.

The first important taboo is on female genital sexuality. Even in this supposedly enlightened era the prevailing message most women receive as they grow up is that "Nice women don't do it," or "The only women who do it are whores, tarts, used goods, and other kinds of bad women." A common problem arising from this message is that of the woman who enjoyed sex before she was married, although probably paying her price in guilt, but who finds that after marriage this enjoyment disappears. One explanation for this is as follows: "Before I was married I was a bad woman because I was doing it, and because I was bad I could enjoy it, but now I am a nice, respectable married woman I can't enjoy it because nice women don't do that sort of thing." I have never yet met a woman who could not identify to some extent with this nonsensical conflict, and appreciate its relevance to the sexual problem. Once this taboo is clearly identified and put into words, the woman is then in a position to reject it with a helping dose of "permission" to do so from the doctor. Men, on the other hand, are usually given all the permission they need to be sexual. The message they receive as they grow up is that the more women they "lay," the bigger and better they are as men; but this may have adverse repercussions later by creating unnecessary and destructive performance pressures.

The second important cultural taboo is on the open expression by men of their emotional feelings. "Good, strong, virile men don't show their feelings," is the prevailing message received by the growing male. On the other hand, women in our culture are allowed to express their emotional feelings. For most people, although perhaps more for women than for men, the ability to share sexual feelings is intimately related to the ability to share emotional feelings. Unlike the views held by some of the more rigid behavioural therapists, it is not my belief, nor my experience, that sex can be isolated from the emotional side of the relationship and simply be treated as a "behaviour" that can be "trained."

The third taboo is on male sexuality. Men in our culture receive much less encouragement than women to develop their sensory awareness, especially that of touch. This may cause marked inequality in the apparent need for foreplay, which has such an important role in sexual arousal for women, although the extent to which it can also enhance the man's sexual pleasure may be underestimated.

If we put these taboos together we can appreciate the absurdity of many relationships. Typically the man feels good about his genital sexuality but is uncomfortable with open expression of emotional and sensual feelings, while exactly the converse is true for his partner. An important component of treatment is to minimise these destructive imbalances by "giving permission" to the woman to value her genital sexuality and to the man to value his emotionality and sensuality.

Four myths must be mentioned. The first is that men are naturally endowed with precise knowledge of what to do to please a woman, and another related myth is that sex should never have to be talked about, especially during lovemaking. Thirdly, it is commonly believed that the man's role should always be active and the woman's passive, regardless of how much either may wish to be otherwise at times. Finally, there is perhaps the most destructive myth of all illustrated by the complaint, usually in a long-term relationship, that "If you really loved me, you should know how I feel *without* my having to tell you"—with all its implications regarding inadequacy of communication.

Poor communication

One of the practical outcomes of ignorance, acceptance of cultural taboos, and belief in myths of the kind described is a breakdown of two particular aspects of communication necessary for establishing a good sexual relationship. The first of these is simply a failure to let one's partner know what one likes and dislikes during lovemaking. The need for this may seem too obvious even to state, but failure in this respect is a common factor causing sexual problems, and indeed may also be the one of greatest significance, especially early on in a relationship.

The second form of breakdown is inadequate or inappropriate communication of emotional feelings. This relates mostly to the more "difficult" feelings such as weakness, helplessness, pain, confusion, and vulnerability, but particularly anger. It may seem surprising to mention these more negative feelings first, but the expression of positive feelings, no matter how genuinely they are felt, can be remarkably difficult while these more negative feelings are withheld or are shared only in a destructive manner. Anger that is repressed can be an even more potent inhibitor of sexual responsiveness than destructively expressed anger, though neither are to be recommended. Both may occur within a relationship that, in the couple's own estimation, is essentially sound. The statement, "We never have rows," should raise doubts rather than allay fears about the couple's ability to deal with anger in a healthy manner. It increases rather than decreases the likelihood of repressed anger being an important contributing factor to the sexual problem. Conversely, some couples admit to constant rows, but this does not necessarily reflect a fundamentally poor relationship, although it may mean that they have never learnt how to express anger in a constructive way that allows for mutually satisfactory resolution of conflict. Indeed, sexual problems may often be more quickly and easily resolved by those couples whose rows occur frequently rather than never.

Precipitating factors

Sometimes sexual failure in a relationship previously regarded as satisfactory is precipitated by a specific event such as getting drunk, being made redundant at work, the discovery of a partner's infidelity, or can be traced back to some traumatic sexual experience in childhood. Although such an event may at first be seen as the sole cause of the sexual problem, its resolution (even if possible) is rarely sufficient to reverse the sexual failure.

One then has to look for other causes, or, perhaps more accurately perpetuating factors, which are almost invariably found in the areas of ignorance, cultural taboos and myths, and poor communication skills. Once sexual failure has occurred, for whatever apparent reason, the importance of these other areas becomes unmasked and it often emerges that the sexual relationship had previously been satisfactory only to the man, with the woman having been unwilling to admit her earlier dissatisfaction to him.

Fear of failure

Once sexual failure has been experienced for whatever reason or combination of reasons, a vicious cycle is established of failure leading to fear of failure causing further failure, and the more frightened a person is of failure the more likely he or she is to fail subsequently. None the less, failure can only be defined in relation to ideas of success, and an inappropriate idea of what constitutes successful sex often sets the vicious cycle in motion. Among hundreds of couples describing to me their idea of successful and normal sex, an erect penis entering a lubricated vagina giving orgasm in both partners, preferably simultaneously, is a typical picture. Anything short of this achievement is perceived as failure, and if this is the expectation of success in a long-term relationship, there will be many experiences of failure.

Viewing "successful" sex thus also puts an undesirable emphasis on "performance" and "goals" rather than on simply sharing pleasure, regardless of the respective levels of intensity. This can put both partners under considerable pressure to "perform," regardless of how they are actually feeling, which can lead to attempted pretence of pleasure when it is not really being experienced. Of course, sexual "failure" is far more obvious in men than in women, and usually far more immediately devastating for the man.

The reassessment of the concepts of "normal," "successful" sex is an important aspect of treatment which will be dealt with in a later article in this series.

Reference

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We all make mistakes

One weekend I was on duty for six doctors. I'd had a very hectic time and was exhausted. On the Sunday night I'd been out two or three times, but at five in the morning the phone went. A woman said would I come and see her husband who'd got a lot of back pain, and I said, "It's really necessary? How long has he had it?" "Oh, he's had it on and off for some weeks."

"Has a doctor been to see him?" "Yes, he's been to see him and he's given him the red tablets."

I thought the red tablets were phenylbutazone, and I said, "Has he had any?" "No, no."

So I said, "We'll give him two and let Dr Othello know in the morning," and went back to sleep.

Next morning Dr Othello phoned me up and said, "Ken, you know that fellow with the backache who didn't visit last night?" "Yes, he's obviously osteoarthritic and you've got him on phenylbutazone."

"Well, actually he suffers from angina which always relates to his back, and he's had a rather vicious coronary."—KEN DICKINSON, general practitioner, Birmingham

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