ABSTRACT. This paper outlines a widely-held conception of illness, related to perceived changes in body temperature — 'Chills' and 'Colds' on one hand, 'Fevers' on the other — in an English suburban community on the outskirts of London. The relationship between this folk model, and that of the local family physicians is analysed, to show how biomedical treatment and concepts, particularly the germ theory of disease, far from challenging the folk model, actually reinforce it. Remedies which cannot be scientifically and biomedically justified are nevertheless prescribed by the physicians to meet their patients' need to 'make sense' of biomedical treatment in terms of their folk model of illness. At the interface between physician and patient, biomedical diagnoses and treatment are more 'negotiable' than previously realised — and this has important implications for the delivery of health care.

INTRODUCTION

Much of the research in medical anthropology has dealt with folk beliefs and practices relating to illness, in the non-Western and non-industrialised world. An area of research that has been largely neglected is the persistence of such folk beliefs in the West, particularly in an urban context. Most studies of indigenous medical systems in Europe and North America have dealt with those of ethnic minorities or of relatively isolated rural communities in those regions. There is often an implicit assumption that in the cities, at least, most adults are familiar with the allopathic or biomedical model of disease of the medical profession, and that except for a few elderly or uneducated people, or those who follow 'alternative medicine', its basic premises of cause and effect in disease are largely accepted. The public, after all, have been exposed for many years to information about modern medicine via books, the schools, the popular press, radio and television, and health education pamphlets produced by the government; in Britain particularly, since the formation of the National Health Service in 1948 — which guaranteed free and unrestricted access to medical care — there has been prolonged contact with doctors and with their ways of thinking. Nevertheless, many folk concepts of illness remain unchanged. The purpose of this paper is to explain why such beliefs persist, and to describe how biomedical treatment and concepts (for example, the germ theory of disease), although originating in a different conceptual system, are easily incorporated into the folk
model without challenging its basic premises. In fact, they may serve to reinforce it. This is particularly true in the context of family medicine, and I hope to show how in this situation—at the interface between general practitioner and patient—the biomedical model of disease is ‘adapted’ in such a way as to ‘make sense’ in terms of the folk model of illness. As a result of this process it can be shown how many of the diagnoses and treatment given by family physicians cannot be justified in purely scientific or rational biomedical terms; but only in terms of the patients’ need to ‘make sense’ of this treatment in terms of their folk beliefs about illness. This has important implications for the delivery of health care, and indeed for the whole notion of what does or does not constitute a ‘treatment’ in medical terms. Eisenberg (1977) has noted how physicians employ both everyday and biomedical models in practice, even though these are not logically compatible; that is, in our society “clinicians mediate between medical models of disease and popular models of illness, just as do the patients who employ concurrently the services of herbalists, shamans, and doctors. The resolution of the tensions between contradictory models occurs in practical action” (1977:19). The process of resolution or adaptation is described by Stimson and Webb (1975) in the context of consultations in general practice in Great Britain. They see such consultations as a process of negotiation between doctor and patient, whereby each tries to influence the other regarding the outcome of the consultation, the diagnosis given, the treatment prescribed. Their evidence suggests that “there is so much room for variability in diagnosis, even with seemingly ‘hard’ information such as the results of X-ray photographs, that diagnosis is not the cut-and-dried scientific exercise that it is often made out to be” (Stimson and Webb, 1975:37). What they fail to stress is that this negotiation is not only between individuals, but between two systems of thought, lay and professional, folk and biomedical; that is, between two seemingly incompatible systems for the explanation and alleviation of misfortune. For the interaction to be successful to the patient, there must be agreement between doctor and patient on certain key concepts, and on the physician’s interpretation of the patient’s problem; according to Fabrega (1975:972) “it is probably an agreed upon social consensus which includes the practitioner and the sick person (or his surrogates), that is required for a medical action to be judged as beneficial or helpful”. When it is attained, this consensus has its effect on both folk and biomedical models of ill-health, as will be shown. In particular, my research suggests that the folk model is more functional and more resistant to change, than had been realised, and that there are various explanations for this.

This paper—which arises from my own experience as a family physician—describes a folk model of illness in an ordinary English suburban community on the outskirts of London; it outlines certain widely-held beliefs about illness related to perceived changes in body temperature in such a community—beliefs
which can be summarised in the phrase "Feed a Cold, Starve a Fever", and which to some extent are common throughout the British Isles. Although the suburb is now part of the great metropolis, it is a study of the 'ethnomedicine' of the area, which in Hughes' definition is "those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine" (1968:88). It is also a study of the effect of these beliefs on the diagnoses and treatments given by the general practitioners, the local representatives of biomedicine, to their patients.

SOURCE OF DATA

The material was collected in a four-year period since 1973, during which time I have worked as a general practitioner or family physician for the British National Health Service in Stanmore, Middlesex. It is based on my own experience, as well as on interviews with patients, district nurses, receptionists, and with seven of my general practitioner colleagues who practice in Stanmore, or in the neighbouring suburb of Edgware. The quotations used in the paper are from those interviews. In addition I have used published material on drug prescribing under the N.H.S. from a number of sources.

Although technically in the county of Middlesex, Stanmore is a peripheral suburb of London, at the edge of the 'green belt' of open countryside. It is about 12 miles from the centre of Westminster. Until 1936 it was open countryside and marshland, but in that year the 'Laing Housing Estate' of detached and semi-detached suburban houses was built. The inhabitants were drawn either from London, or from the surrounding villages in Middlesex, with a small number from abroad. Many of the present-day inhabitants, in their 60's and 70's, moved into the area as young couples in the 1930's; while others are their descendants, or new arrivals mainly after the last war. It is a predominately middle-class suburban community, with strong values of order, balance, and social respectability. The area is in no way isolated from the rest of London; it is served by the same bus routes, Underground network, and other facilities, as well as the same newspapers, and radio and television programmes. Most doctor's surgeries, or clinics, in the area are located in ordinary houses converted for this purpose. There are several large hospitals only a few miles away.

GENERAL PRACTICE IN GREAT BRITAIN

Under the British National Health Service the entire population has access to free medical care, at both general practice and hospital levels. Each patient belongs to the 'list' of a general practitioner in their area, though there is some choice as to which doctor's list they can join, provided it is still within the area.
Consultations between patients and family physicians are free of charge, and take place at specified times at the surgery, or by house-call for emergencies at other times. A small fee is paid by the patient for each item of drugs prescribed by the doctor; the fee is paid directly to the pharmacist who dispenses the drug. It is estimated (Levitt, 1976) that there are about 26,000 general practitioners in Britain, and that each one has an average list size of 2347 patients. Levitt estimates that about 75% of symptoms are treated by the patients themselves, without going to a doctor (1976:95), but of those who do seek professional medical treatment for ill-health, the NHS general practitioner is the first point of contact for about 90% of these people (1976:97). The general practitioner is therefore the main interface between biomedical concepts and lay beliefs about illness. The majority of the patients seen by a general practitioner suffer from minor complaints, with no risk to life or permanent disability; in the studies quoted by Levitt (1976:95) 62% of the conditions seen commonly fall in this group. Only about 13% are major, life-threatening conditions, and these are mostly referred for hospital treatment. In general, the conditions of ill-health to be described below fall into the category of minor complaints, yet they form a large proportion of the workload of the average general practitioner.

'Illness' and 'disease'

The analytical distinction between illness and disease is one that has been made by several authors (see Eisenberg; 1977, Fabrega, 1973:91–93, 218–223, and 1975:969–975; Cassell, 1976:47–83; Mitchell, 1977:17–19; Lewis, 1975:146–151). In general, the term ‘disease’ has been used to describe the pathological processes and entities of the biomedical model; diseases are defined "on the basis of deviations and malfunctions of the chemical and physiologic systems of the body" (Fabrega, 1975:971). What constitutes 'normal' physiological and chemical variables is clearly defined within a fairly narrow numerical range, and is assumed to be shared by all members of the human species. Each disease in biomedicine is "an abstract biological 'thing' or condition that is, generally speaking, independent of social behaviour" (1975:969); that is, every named disease has its own particular personality and life history, and these entities are largely independent of the personal attributes of the patients suffering from the disease. To the Western-trained doctor, therefore, the aim of therapy is primarily the identification and treatment of named diseases, using the scientific paradigm and definitions of modern biomedicine: which is the culturally-specific system of the West for explaining and treating ill-health. By contrast, 'illness' is an altogether vaguer term, embodying the patient's subjective perception, or sometimes the perception of those around him, of a condition of impaired well-being. Fox (1968), Fabrega (1973) and Foster (1976), all of whom have
studied the medical systems of the non-Western world, point out how illness in those regions has many dimensions: social, moral, psychological, as well as physical. Explanations for ill-health are part of wider systems for the explanation of misfortune, which usually embody a variety of aetiologies; for example, in Prince’s study of the Yoruba (1964) misfortunes, including ill-health, can be caused by natural agents (diet, insects, worms etc.), preternatural agents (witchcraft, sorcery) or supernatural causes (gods, Orisas, ancestors); and Foster (1976) also divides folk aetiologies of illness into ‘personalistic’ systems (illness due to the active and purposeful intervention of an agent, whether human or non-human), and ‘naturalistic’ systems (where illness is explained in impersonal terms, as being due to natural forces or conditions, such as cold, damp, and so on) (1976:773–781). In these societies there are culturally-specific systems for explaining illness in these terms, and there are as many of these systems as there are different cultural groups. In dealing with what therefore constitutes ‘illness’ here in the West, the literature is less helpful. Fabrega (1975:973), Cassell (1976) and Eisenberg (1977) have all pointed out that in the West it is possible to feel ‘ill’ without having an identifiable disease in biomedical terms, and to have a biomedically-defined disease without feeling ill (for example a raised blood pressure, or early carcinoma). Biomedicine can be seen as the world-view of a professional sub-culture, the medical profession. Contrasted with this, is the patient’s perspective of subjectively experienced ill-health; in Eisenberg’s phrase “patients suffer ‘illness’; physicians diagnose and treat ‘diseases’ ” (1977:11). Diagnosis is therefore the ordering of the patient’s experience into the disease entities of biomedicine, but neglecting those that do not fall within the classification. In Cassell’s view, this removes biomedicine from its traditional healing role, for he sees illness in holistic terms as human suffering that includes disease, but has a much wider definition: one should “use the word ‘illness’ to stand for what the patient feels when he goes to the doctor, and ‘disease’ for what he has on the way home. Disease, then, is something an organ has; illness is something a man has” (1976:48). It is therefore a problem of two partially overlapping schemes of classification, whereby the symptoms and signs of illness/disease are grouped into pathological entities, in both folk and biomedical models. However, a major drawback of many studies of illness in the urban West, both in Europe and North America, is that folk beliefs about illness have not been studied as systems, but rather as a vague area of subjective symptoms and signs beyond the territory of biomedicine. It is not only in the non-industrialised world that folk models of illness have strong moral and social dimensions, both ‘personalistic’ and ‘naturalistic’ theories of aetiology, and which ask the question “Why me?” as well as “How?” In addition, folk theories of what constitutes ‘normality’ also form part of such models, and these definitions of ‘normality’ often bear little relation to the biomedical definitions.
A further point is that the rational and scientific nature of biomedicine, in practice, is often over-estimated. Fabrega (1973:218-223) for example, in his comparison of the Western biomedical system and the indigenous medical system of Zinacantan, gives the impression of biomedicine as a monolithic and quite inflexible system of beliefs and practices. However, not only is there wide variation in medical practices in different Western communities but also within the same country. My research indicates that in Great Britain, at least, biomedicine at the general practitioner level is more flexible than had been realised; and that due to the process of 'negotiation' at the consultation the 'operational' model of the general practitioners bears a closer resemblance to the folk model, in some respects, than to the official model of biomedicine that exists in the hospitals, medical schools, and medical textbooks. Eisenberg (1977:13) has suggested that the patterning of illness is influenced by medical concepts, but the reverse seems also to be the case — particularly in general practice, as will be described.

"FEED A COLD, STARVE A FEVER" – THE FOLK MODEL OF INFECTION IN STANMORE

The phrase "Feed a Cold, Starve a Fever" is a common aphorism in the area. It arises from a folk model, or scheme of classification, of illness which is widely accepted by the patients; and it relates to those conditions of impaired well-being which the patients perceive as disequilibrium, and regard as 'illness', and which concern perceived changes in body temperature — either 'hotter' than normal, or 'colder'. In general, these feelings of abnormal temperature change are purely subjective; they bear little or no relation to biomedical definitions of 'normal' body temperature as 98.4°F or 37°C, as measured orally on a thermometer. The conditions where the patients 'feels hot' are classified as Fevers, those where he 'feels cold' in his body are classified either as Chills or Colds. Both Fevers and Colds/Chills are states of being — both classified as abnormal — which, in the folk model have different causes, different effects, and thus require different treatments.

There are two important principles underlying this folk classification of 'illness-misfortune': (1) the relation of man with nature, i.e. with the natural environment, in Colds and Chills, and (2) the relation of man to man, which exists within human society, in Fevers.

To a large extent the area covered by the folk model — which I have set out schematically in Figure 1 — corresponds to that area of disorders which biomedicine classifies as Infectious Diseases: that is, acute or chronic inflammatory conditions where the causative agent is known to be either a virus or a bacterium. These disorders, which occur very commonly in general
**Fig. 1. The Folk Classification of common ‘Hot’ and ‘Cold’ Symptoms**

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<th>HOT</th>
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| **(1) Ear, Nose, and Throat**  
FEVER + NASAL CONGESTION OR DISCHARGE | **(1) Ear, Nose, and Throat**  
COLD + NASAL CONGESTION OR DISCHARGE, WATERY EYES, ‘SINUS’ CONGESTION |
| **(2) Chest**  
FEVER + PRODUCTIVE COUGH | **(2) Chest**  
COLD + NON-PRODUCTIVE COUGH |
| **(3) Abdomen**  
FEVER + DIARRHOEA AND ABDOMINAL DISCOMFORT | **(3) Abdomen**  
COLD + LOOSE STOOLS AND SLIGHT ABDOMINAL DISCOMFORT |
| **(4) Urinary System**  
FEVER + URINARY FREQUENCY AND BURNING | **(4) Urinary System**  
COLD + SLIGHT URINARY FREQUENCY BUT NO PAIN |
| **(5) Skin**  
FEVER + RASH + NASAL DISCHARGE OR COUGH |  |
| DRY  
FEVER + DRY SKIN, FLUSHED FACE, DRY THROAT, NON-PRODUCTIVE COUGH | COLD + SHIVERING, RIGOURS, MALAISE, VAGUE MUSCULAR ACHES. |

practice, include disorders known as: upper respiratory tract infections; influenza; coryza; bronchitis; pneumonia; sinusitis; urinary tract infections; gastroenteritis; childhood fevers (e.g. rubella); and several others. This classification overlaps, to some extent, the area covered by the folk model, but as will be described there are significant differences. Illnesses associated with temperature change are common in all sections of the population, as are the often associated symptoms of cough or rhinitis. Cough is apparently the commonest symptom complained of in general practice (see Morrell, 1972:297), and it is common even among those who do not consult the doctor: in Dunnell and Cartwright’s study (1972;11) 32% of adults reported “cough, catarrh, or phlegm” in a sample two-week period, while 18% had suffered from “cold, influenza, or rhinitis”. To describe the folk model it is necessary to adopt a diachronic approach: what follows is mainly the folk classification reported by older patients; those born during or since World War Two, while sharing the basic underlying classification, have introduced new elements, particularly with regard to the germ theory.
In Figure 1 I have listed the common groups of symptoms which relate to, or are accompanied by, perceived changes in body temperature. There are four diagnostic categories in all (see Figure 2); the basic division is between 'Hot' and 'Cold' conditions, but in addition there is a further division into 'Wet' and 'Dry' conditions. 'Wet' conditions are those where the temperature change is accompanied by other symptoms, and with a seemingly abnormal amount of 'Fluid' being present — either still within the body, or else emerging from its orifices; this 'Fluid' includes sputum, phlegm, nasal and sinus discharge, vomitus, urine, and loose stools. The symptoms here include nasal congestion or discharge, sinus congestion, productive coughs, 'congested' chests, diarrhoea, and urinary frequency. 'Dry' conditions are those where the abnormal temperature change is the only, or the paramount symptom — such as a subjective feeling of being cold, shivering or rigours on one hand — and a feeling of being 'hot', perhaps with a dry throat, flushed skin, slight unproductive cough, and possibly delirium, on the other. Skin rashes usually occur on the 'Hot' side of the classification. Other subsidiary symptoms — including pain — may occur in one form or another on both sides of the temperature division.

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Thus there are four basic compartments into which most common symptoms relating to temperature change can be fitted (see Figure 3): 'Hot/Wet' (Fever plus Fluid), 'Hot/Dry' (Fever), 'Cold/Wet' (Cold plus Fluid), and 'Cold/Dry' (Cold). Obviously these compartments are not watertight; there is always some overlap between divisions. In addition, not all conditions associated with abnormal temperature changes have been included; only the commonest, as encountered in general practice.

(A) 'Chills' and 'Colds'

These are explained as being due to the penetration of the environment — across the boundary of skin — into the human organism. They are part of the relationship of man to the natural environment; in particular to the idea of
FEED A COLD, STARVE A FEVER

‘danger without’ and ‘safety within’ the boundaries of the human body. The causes of these illnesses are areas of lowered temperature in the natural environment – either as damp or rain (i.e. ‘Cold/Wet’), or cold winds and draughts (‘Cold/Dry’). In general, ‘Cold/Wet’ conditions in the environment may cause ‘Cold/Wet’ conditions in the body, and ‘Cold/Dry’ may cause ‘Cold/Dry’ conditions of illness, though the division is by no means rigid. Dampness is considered dangerous in most situations, as is rain. Wind is dangerous if it is lower than body temperature, and is called a draught. Wind at body temperature, or above it, poses no threat, and is merely ‘fresh air’. Night air, though, whether warm or cold, is considered dangerous by many of the older patients; it is different in quality from day air, and often “the children get sick if you leave the bedroom windows open at night”.

These cold forces in the environment are impersonal, and not linked to any social relationships.

The protective boundary of the human being is skin, but also clothes. All areas of skin, though, if exposed to damp or draughts, can be penetrated by the cold (“the damp goes right through you”, “I was chilled to the bone”). The actual route of entry of the cold, is through the skin itself. Some areas of skin are more vulnerable than others: in particular, the top of the head, the back of the neck, and the feet. These parts of the body must be specially protected from draughts and damp. Colds were explained as occurring when any of these areas were inadvertently exposed to damp or draughts: e.g. after “getting one’s feet wet”, “walking around with damp socks on”, “going outside with damp hair”, “going out into the rain, without a hat on”, “stepping into a puddle”, “getting caught in the rain”, and so on. Among men, there is a particular sense of increased vulnerability to ‘head Colds’ after a haircut – when the back and top of the head are unprotected against environmental cold by their normal covering of hair.

I think it is significant, incidently, that the two most vulnerable areas to cold – the head and the feet – are, in a sense, the most public parts of the clothed body, and the parts most passive to being acted upon by the environment. I would argue that the hands and face, while both ‘public’, are considered less vulnerable as they actively manipulate the environment, and in a sense ‘join’ the person to the environment.

In addition to parts of the body especially vulnerable to cold, there are certain states intermediate between hot and cold environments, or between body temperatures, where the intermediate zone is considered most dangerous to the human being – as far as Colds and Chills go. For example:

(1) Body temperature changes, from hot to cold: e.g. “Going into a cold room (or outside) after a hot bath”, “sitting in a draught after a hot bath”, “walking on cold floor when you have a Fever” – all which occur within the home.
(2) Changes in environmental temperature, from hot to cold, on leaving the home (or other building): Older patients explained the increased incidence of Colds in winter as being due to a drop in body temperature when one leaves a modern centrally-heated house for the outside. Younger patients think this occurs because “the Germs breed more” in a hot, centrally-heated house. Other examples here are “going outdoors when you have a Fever”, “going out into the cold after a hot bath”, and so on.

(3) Changes in season: November (damp), and February (cold winds) are both considered dangerous months, but most dangerous of all is autumn — where the ‘hot’ summer is changing to the ‘cold’ winter.

(4) Changes in geography: One patient has explained that there are more Colds (‘summer Colds’) in summer these days because, since cheap air-flights and holidays became available 10–15 years ago, people return from ‘hot’ Spain or Italy to ‘cold’ Britain after their summer vacations, and in the change over of temperature they “catch Cold”.

In all these cases there appears to be an intermediate, dangerous zone, between hot and cold states — when the former gives way to the latter. This may reflect an underlying schematic dichotomy between ‘Hot’ inside (body, home), and ‘Cold outside (nature, the natural environment). Mary Douglas (1970) has pointed out how in many primitive classificatory systems, special dangerous qualities are ascribed to states of transition, marginality, or anomaly. She notes Van Gennep’s observation of the danger inherent in states of social transition (1970:116), but it would appear that this applies also to intermediate zones between changes in temperature, as described in the above examples.

Although Colds do not, at least in the view of older patients, originate in other people, they are caused — as one middle-aged patient put it — “by doing something abnormal”. That is, by putting oneself in one of the situations of danger or risk mentioned above. There is the strong implication of personal responsibility for the condition, which has been caused by one’s own carelessness, stupidity, or lack of foresight. You get a Cold when you “don’t dress properly”, “go outside after washing your hair”, “allow your head to get wet”, “walk barefoot on a cold floor”, “wash your hair when you don’t feel well”, and so on. Making oneself, or part of oneself, vulnerable to cold causes one to “catch Cold”. Colds, therefore, are a by-product of one’s personal battle with the environment. They are one’s own responsibility, and no one else could be blamed for them. If, despite adequate precautions such as proper clothing, etc, one still got a Cold, it was still your responsibility. Poor people tended to get more Colds as they are “less responsible”.

Once the cold has penetrated the boundaries of the human organism, it can travel. It can move from the damp head, down to the nose (causing a “runny nose”), the sinuses (“Sinusitis”, “a head Cold”), the chest (causing a slight cough — “a Cold on the chest”). It can travel even further downwards to the
abdomen, to cause vague abdominal discomfort and possibly slight loosening of the motions, or to "the bladder" to cause discomfort and slight frequency, but no burning sensation or fever. From damp feet it can migrate upwards to cause the "stomach Chill" or a "Chill on the bladder" already mentioned, or even further upwards to the nose, chest, or sinuses. All of these symptoms are accompanied by a subjective feeling of cold, shivering, and possibly by some muscular discomfort. In addition, a direct draught can also cause the Colds and Chills, but this occurs less frequently; usually a direct draught on the lower back (while "sitting in a draught") causes a "Chill on the kidneys" which is described either as a muscular pain in the lumbar region, or vague lower back discomfort, perhaps with some urinary frequency.

In general, Chills occur below the waist ("stomach Chill", "bladder Chill", "kidney Chill") and Colds above it (a "head Cold", a "Cold in the sinuses", "a Cold on the chest", "a Cold that's gone to my chest").

In the battle with environmental cold, one should strengthen one's own defenses by dressing warmly, avoiding draughts and damp, and building up the body's strength from within, by good food and patent 'tonics'. If you "did not eat properly" you were more liable to develop a Cold. People took tonics to "build themselves up" against the threat of cold; older patent tonics used included Parrish's Food, ViDaylin, Cod Liver Oil and Malt Extract, and Virol, and newer ones include Brewer's Yeast, Multivite, Haliborange, Sanatogen, and of course Vitamin C. As one patient put it – if you went outdoors after having taken a tonic "you felt warm inside"; the tonic was an ally in one's battle with cold. Most important of all allies and body strengtheners, though, was food.

Some people, who have been severely penetrated by cold in the past and were severely ill, may be left with a permanent "weakness" in that part of their body; a permanent gap in their defences against the environment. They may have a "weakness on the chest" and often wrap up that area particularly warmly when they leave the house. "Weakness" may also be familial and "run in families", or else constitutional, such as a "thin skin" which is abnormally vulnerable to cold penetration.

The area of Stanmore is known by the patients as a damp, dangerous area as far as Colds go. People in the area are reputed to suffer many respiratory infections and to be "bronchial"; this is said to be due to "dampness" retained by the clay soil in the area, which is the residue of marshes drained in the 1930's.

Treatment of a Cold or Chill is your own responsibility; it is your own problem, and is less likely to mobilise a caring community around you than a Fever. As in all Hot-Cold and humoral systems, treatment aims primarily to fight cold with warmth, and to move the patient from 'Cold' (or 'colder' than normal) back to 'normal', by adding heat in the form of hot drinks, hot-water bottles, rest in a warm bed, and so on; and in giving him the means to generate his own heat, especially by ample warm food ("Feed a Cold, Starve a Fever"), as
well as tonics and vitamins, which are also perceived as a type of nutriment. In addition, he must if necessary be shifted from the ‘Wet’ to the ‘Dry’ state — not by expelling or washing out the Fluids, but by drying them up. These Fluids are considered part of the body, and should be conserved, with the aid of nasal drops, decongestant tablets, inhalations, and drugs to solidify the loose stools. Older remedies used as decongestants include goose fat, Vicks, and Friar’s balsam. Pain accompanying these symptoms is to be treated by analgesics such as aspirin, anadin, paracetamol, and several others. By these various methods, both folk and medical treatments aim to restore the previous equilibrium, and a ‘normal’ temperature.

The only social dimensions of Colds and Chills are the implications of personal carelessness that they carry, and also for the social embarrassment of a red nose, rhinitis, bloodshot eyes, etc. “For appearance’s sake”, said one patient, “you get rid of them as soon as possible”.

(B) ‘Fevers’

Illnesses in this group are all characterised by conditions which begin with, or are accompanied by, a feeling of abnormally raised body temperature. In general, they are more severe, longer-lasting, and potentially more dangerous than those in the ‘Cold’ group. All are said to be due to the actions of entities known as ‘Germs’, ‘Bugs’, or ‘Viruses’. These terms are not used in the strict biomedical sense; to most people, who have never looked down a microscope and seen ‘a Germ’, and who who have no other perceptual evidence for their existence, Germs remain a hypothesis, a theory of causality. Although the terms are borrowed from biomedicine, folk theories of Germs are rooted in the folk classification of Fevers and Chills, rather than in modern microbiology.

When asked about the attributes of Germs most patients give the following description: Germs are described as living, invisible, malevolent entities. They have no free existence in nature, but exist only in or among people. They are thought of as occurring in a cloud of tiny particles, or as a tiny, invisible, single ‘insect’. They traverse the spaces between people by travelling in the air, or in the breath. Germs causing gastro-intestinal symptoms are seen as more ‘insect-like’ (‘Bugs’), and are larger in size than those Germs causing other symptoms. Germs have personalities; these are expressed in, and can be recognised by, the various symptoms they cause. (For example, “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”). The Germ, however, may only reveal its true personality in stages, during the course of the disease.

In their effect, Germs are single; you are only attacked by one Germ at a
time, which selects just you to attack ("I've got a Germ, doctor"). 'Your Germ' can infect other people, but part of it will remain within you until it is expelled, or you are cured. The same individual Germ cannot be in two places at the same time. Germs are amoral in their selection of victims, but once they attack they can only cause harm. There are no 'good' Germs, or 'normal' Germs; all Germs are bad, whether they are 'Bugs', 'Germs' or 'Viruses'. Viruses and bacteria are generally lumped together, and no attempt is made to differentiate them clinically.

The routes of entry of the Germs into the body are via the orifices; particularly the larger ones of mouth, nose or anus, though sometimes they can enter via the ears or the urethra. These orifices are the natural breaks in the body's defences and boundaries (cf. Douglas, 1970:145). The Germs can enter the mouth in a "moist wind", perhaps causing a painful throat en route; or through the anus from a dirty lavatory seat. In general, Germs that enter the body in this latter way cause diarrhoea and vomiting, and are usually termed 'Bugs', while the remainder of the Fevers are caused by Germs or Viruses (these terms are used interchangeably) that enter via the mouth, though this division is not absolute.

Once having entered the body, and crossed its boundaries, the Germ signals its presence by a Fever, and later by other symptoms. It can expand to inhabit several parts of the body simultaneously, or it can move in sequence from part to part ("It's gone to my lungs", "I can feel it in my stomach", "It began as a sore throat, but then went down to my tummy", "It's moved to my chest", "It's breaking out in the skin", or, as one patient with a peptic ulcer said, "I got the 'flu, but then it flew to the ulcer and that blew up").

The cardinal attribute of Germs is their externality. They originate outside the individual, but not outside human society. They may wander from country to country, or through a community, but they are always transported by people. Here, the inside/outside dichotomy can be seen to refer to dangers outside the organism, but which still originate in other people — not in the natural environment. In fact, Germ infection implies another person, and the social dimension of life. Infection with a Germ implies a social relationship (of whatever duration) with another person. Infection is an inherent risk in all relationships. Different types of relationship imply different types of risk, different types of infection. For example: measles, mumps, chicken pox, etc. indicate relationships between children (school or family); influenza usually occurs after sustained contact between adults — relatives, friends, neighbours, or workmates; urinary infections are sometimes linked to sexual relationships; and tuberculosis infection implies contact with 'unclean' people, such as slum-dwellers or recent immigrants. The risk, however slight, of Germ infection appears to be inherent in all relationships, but neither party is to blame for the infection. There is no malevolence or 'maleficium' involved. That is, the Germ
has its own volition, and cannot be directly controlled by its host. The victim of a Germ infection is therefore blameless; there is not the slight implication of irresponsibility found in Colds and Chills. The patient is the passive victim of a Germ that is “going around”, and his illness is not in any way linked to the moral order (with the exception of certain venereal infections). Because of this blamelessness, the person has a socially acceptable reason for withdrawal from all his social networks, work obligations, and so on.

Fegers create a caring community around the victim. Because Germs can be dangerous to contacts, one of the obligations of close relationships is to undergo these risks when called upon to do so. This is especially true of families with children, or with adults who become, as it were, ‘temporary children’.

Fegers attack especially the weak, the old, and the poor. With regard to the latter, there is a strong association with dirt (which is conceived of as concentrated, or condensed, Germs) and Germ infection, particularly in poorer people. To some extent this may be due to their type of social relationships, as well as to the dirt and disorder associated with poverty.

Germs can be ‘immunised’ against; the ‘immunising’ drug or chemical is seen as a force that is introduced into the patient’s body, with his permission, and resides there — ready to combat the Germ should it enter the body. It is, in a sense, an internal talisman against infection.

The Fegers that are covered by the classification above are those that occur most commonly in the population in Stanmore, and which are frequently seen in general practice (see Figure 1). They include such conditions classified biomedically as: influenza; bronchitis; pneumonia; pharyngitis; tonsillitis; urinary tract infections; some forms of gastroenteritis; and the childhood fevers — all of which are accompanied by a subjective feeling of being ‘hot’, as well as certain other symptoms. In all of these the Germ is conceived of as being within the body itself. Local skin infections, which usually do not cause a Fever, are therefore not included here.

As with Colds and Chills, Fegers may occur in either the ‘Dry’ or the ‘Wet’ state. ‘Wet’ fevers (‘Hot/Wet’) are the presence of a Fever, plus Fluid — whether as excess phlegm, sputum, nasal discharge, tears, urine, loose stools, or sweat. ‘Dry’ Fegers (‘Hot/Dry’) are characterised by merely “feeling Feverish”, perhaps with a flushed skin, dry mouth, and a slight cough. A rash may occur in either state and so may pain or discomfort.

In summary, Fegers and Germ infections seem to be associated with three qualities: (1) Externality — penetration of the body by an external, living entity. It is easier to conceive of the Germ as a living entity, I think, because it originates in living people, unlike Chills and Colds; (2) Heat — that is, the Germ itself is ‘hot’, and brings its heat into the body. It is also easier to conceive of a ‘hot’ entity being alive; and (3) Liquidness — the majority of Fegers seem to be
related to the presence of excess fluid. It is as though the Germ matures into a
‘hot liquid’ inside the body.

The treatment of Fevers, in the folk model, aims firstly to move the patient
from the ‘Hot’ state back to a ‘normal’ temperature, and secondly to move him
from the ‘Dry’ to the ‘Wet’ state (see below).

Methods of dealing with Germs – the living, malevolent entities who
temporarily invade and disrupt the body, or parts of it – fall into three main
categories:

(1) Expulsion: In all these methods fluids are used to “wash out” or liquefy
the Germ, so that it can be “washed out of the system”. Fluids are taken
in by mouth as a form of treatment, and the appearance of a more ‘Wet’
symptom indicates that the Germ is being diluted and “washed out”, usually via
the orifices through which it entered the body. Examples of this are:

— From the chest – the aim in chest infections associated with Fever is the
expulsion of fluid from the chest, carrying with it the infecting Germ – “getting
it off your chest”, “coughing up the muck”, “clearing the chest”, “getting it
(the phlegm) out of your system”, and so on. Patients often complain that their
cough is still unproductive and “dry”, that it “hasn’t broken” or “hasn’t
loosened” so that they can “cough it off my chest”. A variety of fluids are used
as expectorants here; including tea, honey, hot water, cough medicine, and other
liquids, and these also have a soothing effect on the throat. “I gargled with salt
water to get the catarrh out,” said one patient, “and I always swallow a bit of it
to loosen the cough”.

— From the bowels – especially in the presence of diarrhoea and vomiting
with the Fever. Here the therapy consists primarily of drinking lots of fluids, so
as to “flush out” the infection.

— From the urinary tract – especially if there is urinary frequency and pain
on micturition, accompanied by Fever – once again treatment consists of
drinking large amounts of fluid “to flush it (the Germ) out of one’s system”.

— Through the skin – usually by induced sweating. The appearance of sweat
fluid on the skin, which often accompanies a drop in the Fever, is taken as
evidence that the Germ or infection is leaving the body through the skin. The
aim of treatment, therefore, is to “sweat it out” or “sweat it off”. Various fluids
and other remedies7 are used for this purpose, including hot drinks, honey,
certain types of tea, as well as aspirins and other patent anti-pyretics, which are
always ingested with large amounts of fluid. The appearance of a skin rash is also
welcomed, as the Germ is now “showing itself”, and is on its way out of the
body; this is especially true in measles where the fever often drops when the rash
appears.

Germs can also be dealt with by:

(2) Starvation – as in the phrase “Feed a Cold, Starve a Fever”. I think the
implication of this advice to reduce the food intake of a feverish patient is that as the Bugs or Germs are living entities to starve their host is to starve the Germs, and they will eventually die or leave the body, and so end their possession.³

(3) KIlling the Germs in situ – since World War Two, and the discovery of the anti-microbial drugs, it is generally accepted by most of the patients that antibiotics and sulphonamides are the specific agents for killing the Germ in situ, without the need to expel or starve it. This is particularly true of those Germs causing high Fevers and severe illness, which do not respond to home remedies. The drugs are taken into the body as an external force to kill the Germ in situ, in a battle lasting up to ten days.

The signs of expulsion, death, or starvation of the Germ are a return to what is perceived as normal body temperature, a subjective feeling of being less ill, and the appearance of excess liquid being expelled from the body (as phlegm, nasal catarrh, urine, or loose stools), which then gradually dries up – as well as the disappearance of all other associated symptoms.

Germ infections imply, or bring into being, social relationships: as sources of infection, a caring community about the victim, and as an informal ‘community of suffering’ of those afflicted by the same type of Germ. Questions often asked of doctors or their receptionists in the area are: “Is there a Bug (like mine) going around?”, “Is there a Germ floating around?”, “Have you had anyone else in with the ‘flu?”, “Is there Chicken Pox in the area?” They are relieved if the answer is in the affirmative, and to find that they have “got something normal” and are part of a community of victims.

It should be noted that this description of ‘Germs’ as hypotheses, or theories of causality, of illness in the folk model in Stanmore, has a similarity to equivalent theories of disease causation in many non-literate societies, particularly with spirit possession.⁹ In these societies ‘spirits’ take the place of ‘Germs’ as causal entities of disease, and like them are invisible, amoral, malign, and capricious in their choice of victims. The victim is therefore blameless, and possession by these pathogenic spirits is a culturally accepted experience, and a way of mobilising a caring community around the ill person (see Lewis, I. M., 1971:66–99). However, a much wider range of disorders are caused by these spirits, than those included in the Fever/Colds model described above.

IMPACT OF THE BIOMEDICAL GERM THEORY OF DISEASE ON THE FOLK MODEL

There is an increasing difference, as regards the Germ explanation of disease, between older and younger patients in the area – especially those born during or since World War Two, who constitute the first ‘antibiotic generation’.
Although the bacteriological discoveries of Pasteur and Koch were made at the end of the 19th Century, the biomedical germ theory of disease seems to have only gained widespread currency among the lay public since the influenza pandemics of 1918/19. However, it is only since the last War, and the introduction of specific antimicrobial drugs, that the Germ theory has come to explain a wider range of illness in the folk model. A probable reason for this is that since the establishment of the N.H.S. in 1948, with its guarantee of free medical care to the entire population, more people consult doctors and for a wider range of disorders – disorders that they would previously have borne in what one writer calls “the imposed silence of poverty” (Inglis, 1964:18). This means that ‘Fevers’ and ‘Chills’ in the folk classification, that would previously have been treated by folk remedies alone, are now brought to N.H.S. doctors – particularly general practitioners – for diagnosis and treatment. Nevertheless, the basic conceptual system of the Fevers/Colds/Chills model has remained largely unaltered; Germs are still hypotheses, and there is little lay knowledge of their characteristics, or of the difference between Germs and Viruses, terms which are used interchangeably by the patients. The main differences between younger and older patients regarding the folk model, are as follows: the conception of Germs as active causative agents of illness has spread to include several (though not all) conditions on the ‘Cold’ side of the classification. Younger patients are more likely to blame ‘Germs’ or ‘Viruses’ for these conditions. Because Colds and Chills are due to these active agents, they can be killed, expelled or starved like the Germs causing Fevers. Hence the increasing demand, on the part of the patients, for specific ‘anti-Germ’ drugs and the pressure put on doctors to prescribe antibiotics for even minor viral infections. While a Cold is now often considered to be caused by a Germ, some sense of personal responsibility for the condition still remains; bad clothing, inadequate nutrition, exposure to damp or cold – all make you more vulnerable to Colds, as before. Nevertheless, on the ‘Cold’ side of the spectrum, the amount of personal responsibility for illness seems to have declined. At the same time, ‘Cold’ illnesses have become more social in origin, effect, and dangers; they now arise more from within human society, and create more of a caring community around the victim than previously. Colds and Chills are now dangerous to other people, especially children and the very old. Young mothers often ask “My child’s got a Cold; can she mix with other children?”, or remark “I didn’t go round to her place yesterday because her child’s got a Cold”. It seems that there is an increased sense of danger in human relationships, and they are now all tinged with a new anxiety, the threat of infection. Whether or not this new fear expresses or echoes other stresses in the social system, one cannot be sure. Nevertheless, in a small way, the threat of infection is used to avoid social contacts, or to mobilise a perhaps unwilling community around the patient. This ‘medicalisation’ of Colds and Chills extends also beyond the
original confines of the folk classification; for example, a wide range of mood changes, from aggression to depression, are now being ascribed by patients to Germ infection. In this medicalisation of internal moods, the folk Germ theory provides a useful escape route to the patient – "I'm feeling low and depressed. I must have picked up a Virus", or "He was rather aggressive on Sunday, and I wondered if he hadn't picked up a Germ"; so that, increasingly, the hypothesis of Germ infection is now being used to explain behaviour changes. Depression due to Viruses, is now added to "post-Viral depression", in the folk classification of younger patients. Also, both "stomach Chills" and "bladder Chills" are now increasingly being ascribed to Germ infection, except by the older generation; they are now often thought to be due to "a Germ in the water (urine)", rather than "a Chill on the bladder", or to a "stomach Bug" rather than a "stomach Chill" or "something you ate". In both cases, the infection requires active medical help to destroy or expel the Germ. In general, as the hypothesis of 'Germ infection' has spread to cover a wider range of illness and behaviour, illness has become more social and dangerous, and the process of seeking medical treatment for it is increasingly common.

CONSENSUS AND CURE

The social process that begins with illness, and hopefully ends with cure, begins with a state of discomfort or disequilibrium perceived by the patient, or by those associated with him. In the Fevers/Colds/Chills model, the basic minimum definition of 'illness' is a subjectively experienced change in body temperature, on either side of 'normal', and which is usually accompanied by other symptoms; so that the units of the folk model are clusters of symptoms forming what might be termed 'illness entities'. These are predominantly composed of subjective symptoms, while objective corroboration of the symptoms (for example, by measuring the body temperature with a thermometer) is less commonly called upon as an integral part of defining oneself as 'ill'. By contrast, the units of the biomedical model are named diseases, which are composed of symptoms plus objectively verifiable physical signs. At the interface between these two systems, a consensus must be achieved by doctor and patient regarding the interpretation of the patient's symptoms, and the treatment to be given. My research concentrated on the nature of that consensus, on the vocabulary used in consultations, and on the diagnoses and treatment given to patients by GPs in the area; particularly those patients suffering from symptoms within the Fevers/Colds/Chills model of illness.

It should be pointed out that apparently most patients suffer from some pathological symptom or symptoms, most of the time. In Dunnell and Cartwright's study (1972:8–13) 91% of adults in a random interview reported
that they had had one or more abnormal symptoms in the two weeks preceding the interview, while only 16% had consulted a doctor during that time. Most illness is treated by self-medication; it is estimated that only about one-third of all illness reaches a medical agency (1972:13). The remainder are treated by self-prescribed folk or patent remedies bought at a pharmacy. Self-medication is therefore much more common than drugs prescribed by a doctor, and also the illness seen by a doctor is only the tip of an ‘iceberg of illness’ in the general population. Only those cases of illness brought to the GP’s attention could be included, therefore, in this study.

DIAGNOSIS OF ‘FEVERS’, ‘COLDS’, AND ‘CHILLS’

The initial diagnosis of ‘illness’ is usually made by the patient himself, and expressed in the terms of the folk model (“I’ve got a Cold”), and is usually dealt with by self-medication. However, there is a hierarchy of advice as to the diagnosis, and the treatment required. This hierarchy includes friends and relatives, the local pharmacist, the doctor’s receptionist, and finally—in the minority of cases—the doctor; (see Dunnell and Cartwright, 1972:96–98—57% of adults questioned in their survey regarded the local pharmacist as a good person to ask advice when not feeling well). The threshold at which the doctor is consulted varies with individuals, and between social classes; the impression is that under the N.H.S. the threshold for consultation is dropping for most conditions. Diagnosis, as given by the GP, is the organisation of the patients symptoms and history into a named and standardised entity, the biomedical disease. The patient’s symptoms and experience pass from the private to the public domain, and become a recognisable part of the biomedical model of misfortune. For this to be acceptable to both sides, a consensus must be negotiated; diagnosis, as Fabrega (1975:972) has said, “is an attempt to establish a consensus for purposes of action”. No diagnosis would be acceptable to patients, it appears, unless it was to a large extent consonant with their world view, and particularly with their interpretation of illness. The impact of biomedical concepts on this world view are less than had been thought. Despite exhortations in medical textbooks, for example “D(ector) should never forget that P(atient) is already equipped with all kinds of ideas about the nature of disease. Many of these are stereotypes, and attacking them is an essential part of any therapeutic strategy” (Crystal, 1976:49), the language and concepts used by GPs in consultations with patients suffering from Fevers/Colds/Chills was in the idiom of the folk model, not the biomedical one. The patients usually presented lists of symptoms, often accompanied by questions like “Is there a Bug going around?”, “I’m feeling ill— is there a Virus around?”, “Have you had anyone else come in with a tummy Chill?”, “Is there Chicken Pox in the area?”, “Have
there been any children in recently with German Measles?”, and so on. The
answer from the GP was usually in the affirmative, and the patients were relieved
to find that there is a “Bug going around”, and they are blameless and not
socially deviant in their behaviour; they also no longer feel uneasy or unsure of
their condition, particularly as their illness is now a disease within the
biomedical world—and by definition capable of being cured, or at least
palliated. The diagnoses given by the GPs, which provided a unified expla-
nation of the patients’ vague feelings of illness or unease, were also couched
in the folk idiom; for example: “You’ve picked up a Germ”, “You’ve got a
’flu Bug”, “It’s a Viral infection”, “It’s just a tummy Bug—there’s one going
around”, “It’s just an ordinary Cold”, “I’m afraid it’s gone to your chest”,
“Your chest is clear now—the infection’s gone”, “You’ve got a Germ in the
water”, “It’s only the Chicken Pox”, “Oh yes, is that the one where you’ve got a
runny nose, watery eyes, and you lose your voice? I’ve seen a dozen already this
week”, and so on1. These explanations do not satisfy all patients; nevertheless
the majority find such diagnoses, although vague, a satisfactory diagnosis of their
condition. Even if a more precise and ‘biomedical’ diagnosis is given, it often
turns out to be also vague and non-specific. This is partly due to the fact that
diagnosis in general practice, where the average consultation time between GP
and patient is 5–6 minutes (Morrell, 1971:454; Marsh and Kaim-Caudle,
1976:132) is usually based on traditional rather than modern forms of
biomedical divination—such as listening, looking, feeling, touching, smelling,
and so on; and by numerous questions relating to the patient’s feelings,
experiences, and behaviour up to that point in time. A minority of patients are
referred for hospital investigations, such as blood tests or X-rays (also a form of
‘seeing’), or referred to specialists in out-patients departments. In general
practice precise differentiation between viral and bacterial infections is often
impossible to make (due especially to the time factor involved), or else
unreliable. Aetiological agents of infection are often loosely termed “Germs” or
“Viruses” by the GPs, when speaking to patients, rather than a precise definition
of the type of bacterium (e.g., Streptococcus, Staphylococcus) or virus
(Coxsackie virus, ECHO virus) responsible for the condition. Pressure of work,
and the self-limiting nature of many infections, makes it impracticable to always
undertake bacteriological or viral laboratory studies, such as throat swabs, blood
cultures, stool cultures, etc. The diagnosis “an infection” is commonly given,
without identifying the causative organism more precisely. Even if more precise
diagnoses are given, they are also often couched, as mentioned above, in what
to the patients seems a vague way; for example, “upper respiratory tract
infection”, “a viral infection”, “gastroenteritis”, “influenza”, “bronchitis”,
“urinary tract infection”, “chest infection” and so on. The effect of this
vagueness of diagnosis, from the perspective of the patients is, I think, to
confirm and strengthen the ‘illness entities’—clusters of subjective symptoms
and behaviour changes — that constitute the folk model of illness, rather than imposing precise biomedical ‘diseases’ on this lay model. This vagueness of diagnoses given extends also to the anatomical model used by both patients and GPs; in order to achieve a diagnosis based on mutual understanding, broad areas of the body are coalesced into: “a chest infection”, “a tummy bug”, “a cold in the head”, “gastric ‘flu”, “an infection in the sinuses”, or “a urinary infection”. So, to a large extent, as far as diagnosis goes, what might be termed the ‘operational’ model of the GP in practice bears a closer relationship to the folk model than to the official biomedical model of hospital medicine; and may therefore serve to reinforce that folk model. The entities into which the patients’ symptoms are organised in diagnosis often bear a closer resemblance to the symptom groupings of the folk model than to biomedically-defined diseases.

Much of this organisation of symptoms, in the area, is done not by the GPs but by their receptionists — who are often consulted personally or by phone by the patients at the surgery, and often they make the decision as to whether they are ill enough to justify seeing the doctor. In general, the doctors’ receptionists act as paramedical diagnosers and advisers, and reduce even further the number of patients who actually get to see the GP. In dress and manner they often mimic the doctors; wear white coats, speak in a voice of authority, and often make confident diagnoses on minor complaints based on their years of experience in the practice.

To some extent diagnosis itself is a cure; especially in those conditions likely to be self-limiting, and where the patient’s unease is a marked feature of the condition. This phenomenon was well put by one Phineas Parkhurst Quimby, a famous folk-healer, born in New England in 1802 — “I tell the patient his troubles, and what he thinks is his disease, and my explanation is the cure. If I succeed in correcting his errors I change the fluids in the system, and establish the patient in health. The truth is the cure” (Rose, 1971:62). From my own study and experience, it would appear that in general practice the ‘language of truth’ in most consultations was the idiom of the folk model, rather than that of the biomedical model.

**TREATMENT OF ‘FEVERS’, ‘COLDS’, AND ‘CHILLS’**

Treatment commonly prescribed by general practitioners for disorders within the Fevers/Colds/Chills model can also be seen to ‘make sense’ within the conceptions of that model. More important, though, is that many of these prescribed treatments cannot be fully justified in scientific, biomedical terms; it is almost as if, in some cases, the patients are treating themselves, using the doctor as a source of folk remedies — rather than a pharmacy, or a supermarket. An important aspect of any GP consultation under the N.H.S. is the handing over to the patient of the E.C.10 prescription form, which is then handed to a
local pharmacist in exchange for the prescribed drugs. The majority of patients attending a GP are given such a prescription for one or more medicines. In a sense, many GPs regard all patients who consult them as being, by definition, in some way 'ill'; even if it is only the 'illness' of over-anxiety. This attitude is expressed by one Professor of Community Medicine (Marinker, 1976) — "A patient is not necessarily someone who has a medical problem; he is rather someone who comes to ask a doctor for help. It is the act of asking, or in the case of those who cannot ask for themselves, of being presented to the doctor, that constitutes that relationship of which we call one half doctor and the other half patient" (1976:18). A result of this over-medicalisation of the population is that more and more minor illnesses that were explained by folk models, and treated by folk remedies, are now brought within the sphere of biomedical treatment. Nevertheless, as the examples below indicate, the biomedical treatment itself can be incorporated into, and be explained by, the folk model itself; and thus helps the patients 'make sense' of the treatment given. Examples of this are:

(1) General Advice (From Doctors or Receptionists)

"Drink a lot of fluid", (for influenza, cystitis, diarrhoea);
"Stay in bed, and keep warm: take warm drinks"; (for a Cold);
"Don't smoke now, or it'll go down to your chest", (for a Cold);
"The rash is a good sign; it shows that the infection is coming out of the system", (measles);
"Yes, there is a tummy Bug going around. Starve yourself and take only sips of water for 24 hours; otherwise, the more you feed it (the Bug), the more it'll enjoy itself and cause diarrhoea and sickness". (Advice given by a receptionist to a patient with diarrhoea and vomiting).

(2) Cough Medicines

According to Wilkes (1974: 98–103), a Professor of Community Care and General Practice, an estimated six million gallons of cough mixtures are prescribed in Britain every year under the N.H.S. (this excludes the vast quantity of self-prescribed patent cough medicines sold over the counter). Of the about sixty million N.H.S. prescriptions written every quarter, about 5% (i.e. 3 million prescriptions) are for cough mixtures. In a winter quarter they can form the single largest group of drugs prescribed, exceeding antibiotics, tranquillisers, and antipyretics. At the same time, most medical authorities cast doubt on the pharmacological effectiveness of cough medicines; in some views this is negligible. Wilkes (1976: 98–99) discounts their therapeutic value, except as reassurance, particularly in coughs likely to be self-limiting, as most are. He
suggests instead a hot or sweet drink, which will be just as effective; (most cough linctuses are very sweetened, and brightly coloured, as well as having a syrupy consistency. In this they echo the traditional cough remedies of honey in warm milk, or in herbal tea). The official British National Formulary (Harman, 1976-78: 63), after differentiating between expectorants and cough suppressants, the two types of cough medicine, states — “Despite this distinction many preparations contain both expectorant and sedative drugs, and this perhaps reflects the lack of evidence that the ingredients have any relevant pharmacological effect”. In other words, about six million gallons of relatively useless coloured water is prescribed every year in Britain. My hypothesis is that a major reason for this is that the cough medicine, in the terms of the widespread Fevers/Colds/Chills folk model, can be seen as something that will expel or “wash out” or dilute the external entity causing the feverish cough; that is, a Germ. This cannot be proved conclusively; obviously cough linctuses do have a limited soothing or pharmacological action. Nevertheless, the flood of cough medicine in Britain, in association with conditions where increased fluid intake is considered beneficial, does seem to me to be suggestive. Cough medicines that are medically prescribed are only part of the total amount consumed; the majority of cough medicine seems to be self-prescribed (see Dunnell and Cartwright, 1972: 26–29, 107–109). I think that the widespread use of a remedy such as cough medicines, in the face of biomedical doubt as to its effectiveness, can be explained (if only in part) by the patients’ need to ‘make sense’ of treatment for their illness in terms of their indigenous medical system.

(3) Anti-Pyretics

These are probably the most widely used medicines, both prescribed and non-prescribed. Again quoting Dunnell and Cartwright’s figures, 41% of adults interviewed in a random sample had taken aspirin or other analgesic-anti-pyretic drugs in the two weeks preceding the interview (1972:100). In my study, anti-pyretic drugs were widely prescribed, or suggested, to patients by the GPs; particularly in the case of viral infections, but also in all other cases of raised body temperature within the Fevers group of disorders. These drugs have two effects; the relief of pain or discomfort, and also the reduction of body temperature if this is abnormally raised. Most medical textbooks cast doubt on the effectiveness, or even desirability, of prescribing anti-pyretic drugs to patients with a raised body temperature, unless the fever would be deleterious to the patient for some other reason; a moderate fever may well be a protective physiological mechanism, and also symptomatic improvement caused by the drug may cause the patient to be ambulatory while still infectious, and so spread the infection around. Nevertheless, large amounts of anti-pyretics are prescribed and consumed; from the biomedical viewpoint this is symptomatic
treatment for discomfort from sinus blockage, sore throats etc., as well as reducing the temperature. There is no evidence of any curative effect of anti-pyretics on, for example, the common cold or upper respiratory infections, (see Goodman and Gilman, 1965:313–314, 328–329). From the patients’ perspective, in the Fevers/Colds/Gills model, the antipyretics are curative in that they are seen to induce sweating — and thus the expulsion of the Germ through the skin — and thereby return the temperature back to normal.7

(4) Antibiotics

These are generally known by the patients “to kill Germs”, particularly Germs that cannot be expelled, starved, or otherwise eliminated. The patients do not differentiate between bacteria — where antibiotics are effective — and viral infections, where they are not. Nor, it must be said, do many GPs make this differentiation in practice; whether by a more thorough examination, or by laboratory investigations. A result of this is that, in the rushed consultations in general practice, antibiotics are often prescribed for viral infections; and an effect of this is to confirm in the patients’ minds that “Germs” are a group of homogenous entities, with no differentiation between viruses and bacteria, and therefore that all or most Fevers require antibiotic therapy. The constant demand by patients, especially the younger ones, for antibiotics is evidence of this attitude, as is the vast number of antibiotics prescribed annually.14 From the patients’ perspective, antibiotics are seen as a force introduced into the body to fight and kill the Germ in situ, with the body being the passive battlefield in this struggle. The GPs’ reluctance, or inability, to differentiate between viruses and bacteria — or between different strains of bacteria15 — has led to a vast amount of over-prescribing of antibiotics, numerous side-effects, and the development of resistant strains of bacteria; at the same time it has served to reinforce the folk model’s conception of ‘Germs’ as being all of one type, and so requiring the same type of treatment.

(5) Nasal Drops, Sprays, and Inhalations

These are widely used, both by self-medication, and prescribed by the GP. They are considered particularly useful by the patients in ‘Cold/Wet’ conditions, such as coryza, or early influenza, and the aim of treatment from the perspective of the folk model is to move the patient from the ‘Wet’ to the ‘Dry’ state. Although these are frequently used, and frequently prescribed (“I’ll give you something to dry up that Cold”), most medical authorities cast doubt on their safety in the long term, particularly on their effect on the nasal mucous membrane. In the opinion of one medical writer (Harrison, 1976), “The only nasal drops which can be prescribed with complete confidence regarding
"FEED A COLD, STARVE A FEVER"

frequency of use and efficacy are isotonic saline solution. By sniffing up such a preparation, usually made at home by dissolving one teaspoon of salt in a glass of tepid water, the patient may readily remove secretions and crusts with both efficacy and safety. A simple douche system makes this remedy even more effective" (1976:72–73). Despite this common-sense advice, a great number of nasal drops and other local preparations are prescribed by GPs, though the number is falling. The point is that Colds, which were usually treated by self-medication, are now increasingly being treated by doctors. A larger portion than before of the ‘Cold’ side of the folk model is being treated by general practitioners; and in the patients’ perspective this gives almost equal weight to both ‘Cold’ and ‘Hot’ sides of the folk model.

(6) Other Proprietary Preparations

A wide variety of proprietary preparations are available which provide symptomatic treatment for conditions in the Fevers/Colds/Chills model. Some of these (especially ‘Cold’ or ‘flu’ medicines) can be bought over the counter in pharmacies or supermarkets, while others can only be obtained with a doctor’s prescription. The significance of these preparations is that they treat a cluster of symptoms which constitute the folk model, rather than treating the cause (for example, a virus) of the biomedical disease; in other words, they treat ‘illness’ rather than ‘disease’. They are palliative rather than curative, and are widely prescribed by GPs for conditions that are likely to be self-limiting, or as an adjunct to curative therapy. From the perspective of the folk conception of illness, these symptomatic treatments are often seen as curative, preparations which reduce fever, relieve sinus or nasal congestion, induce sweating, aid expectoration, and so on, are conceived of as specific cures for the clusters of symptoms that make up the ‘illness entities’ of the Fevers/Colds/Chills model. Drugs which palliate a whole cluster of symptoms simultaneously — especially if prescribed by a doctor — tend to reinforce a folk model of ‘illness’, rather than educate the patients in the nature of biomedical ‘disease’. In the Fevers/Colds/Chills model described here, a number of proprietary preparations are available which treat simultaneously a number of symptoms within the folk model. Often Vitamin C is included as a ‘tonic’ in a modern form, especially in building up one’s energy to fight a Cold. Examples of commonly used combination drugs are:

Antipyretic-Analgesic + Decongestant (e.g., ‘Triogesic’)
Antipyretic-Analgesic + Decongestant + Cough Suppressant (e.g., ‘Triotussic’, ‘Vicks MediNite’)
Antipyretic-Analgesic + Decongestant + ‘Tonic’ (Vitamin C) (e.g., ‘Uniflu plus Gregovite ‘C’’
Antipyretic-Analgesic + Decongestant + Stimulant (Caffeine) (e.g., ‘Emprazil’)
Antipyretic-Analgesic + ‘Tonic’ (Vitamin C) (e.g., ‘Beecham’s Powders’)
Decongestant + Cough Suppressant + Expectorant (e.g., ‘Antitussin’)
Decongestant + Cough Suppressant (e.g., ‘Actifed Compound Linctus’)
Cough Suppressant + Expectorant (e.g., ‘Terpolin’)

These examples are mainly concerned with disorders of the respiratory system; combination drugs do not exist for all the symptom-clusters within the Fevers/Colds/Chills model. Nevertheless they do provide an example of how biomedical treatment, whether prescribed by a doctor or self-prescribed, can fit into the folk model without challenging its basic premises; in fact, especially in the case of medically prescribed drugs, they may actually serve to reinforce it.

In several of the examples of treatment for common Fevers or Colds that are given above, there is little or no biomedical justification for that treatment; it would seem that many prescriptions are given more to ‘fit in’ with the folk model, rather than on strictly rational or scientific biomedical grounds. The folk model still exerts a potent influence on the prescribing habits of many GPs.

**DISCUSSION AND CONCLUSIONS**

Although the conditions that fall within the Fevers/Colds/Chills model are in general trivial and non-life-threatening, they are extremely common in the population at large, and are frequently encountered in general practice. As such they provide a useful source of data for any study of the persistence of folk beliefs about illness in a Western, urban community; a community long exposed to information about biomedicine, and which is in frequent contact with the medical profession. The creation of the National Health Service in 1948, which brought free medical care to the entire population, also converted the entire population into potential patients. A wide variety of folk beliefs and folk remedies relating to illness, which, largely for economic reasons, had remained untouched by the medical profession prior to 1948, were suddenly brought into contact with the concepts and treatments of biomedicine. The Fevers/Colds/Chills model described above is just one example of such a folk system. Despite the impact of information about the true nature of microbial infections, the basic underlying classification of ‘Fevers’, ‘Colds’, and ‘Chills’ seems to have remained largely unchanged. It is suggested that a reason for this is that GPs in the area studied (and presumably in other parts of the country) give their patients diagnoses and treatment which clearly ‘make sense’ in the terms of reference of the folk model. Biomedical concepts are tailored to fit in more closely with the patients’ model in the consultation; partly to avoid ‘cognitive dissonance’ in the interpretation of the illness; partly because most
conditions in the Fevers/Colds/Chills model are self-limiting and not life-threatening—so that in treating them symptomatically the GPs are less concerned to be biomedically 'scientific', than they would be in more dangerous conditions. The rushed consultation times of only a few minutes per patient also make it difficult to be more scientifically exact in diagnosis and treatment, and afford the doctor less opportunity to dispute or tamper with folk models of illness. ("My job," as one GP put it, "isn't to educate — it's to cure"). The effect of these factors is to reinforce, in the patients' minds, many aspects of their traditional folk models of illness, and the traditional remedies used for them.

It would seem, therefore, that in some respects the 'operational model' used on a day to day basis by the GPs is closer to that of the lay model than to the official biomedical model of disease—as found in hospital medicine, the medical textbooks, and the medical schools. However, this effect on the prescribing habits of GPs is by no means always benign; many of the drugs prescribed have undesirable side-effects, both in the short- and the long-term. Antibiotics, antipyretics, and even anti-histamines may all cause dangerous side-effects. In addition, the cost of N.H.S.-prescribed drugs is spiralling in Britain.\textsuperscript{19} If six million gallons of cough medicine are annually prescribed by doctors, in the face of biomedical doubt as to its pharamacological effectiveness, a case might be made for the much wider use of harmless 'placebo' drugs— at least in those conditions known to be trivial and self-limiting. The increased use of traditional remedies by patients should be encouraged, provided that they are free of harmful side-effects, and that the doctor is confident that biomedical treatment cannot improve on the traditional remedies—in safety, or in effectiveness. If life is being 'medicalised', as Illich has suggested—that is, brought under the aegis of the biomedical model of misfortune—then at least one can ensure that the treatments prescribed are not dangerous to the patients in any way. As the common conditions within the Fevers/Colds/Chills model are now firmly within the biomedical sphere of influence, at least in Britain, it is important that doctors should be more aware of the traditional medical systems of their patients, and of the effect of these systems on their own prescribing habits.

Contrary to its original intention, the National Health Service in Britain may have reinforced the 'folk healer' aspect of its General Practitioners; a much wider range of life experience and misfortune is now being dealt with by GPs—not only a wider range of illness and disease than formerly, but also psychological crises, life crises (such as bereavement, divorce, etc.), and all the normal biological landmarks, such as birth, childhood, puberty, menopause, and death. In an age of preventive medicine, the GP deals increasingly with healthy people (as biomedically defined), for immunisations, ante-natal clinics, cervical smear clinics, baby clinics, and so on. The more intimate and long-term relationship between GP and patient that this brings about does not seem to have drastically changed folk models of illness. The Fevers/Colds/Chills model is one example of
this, but undoubtedly there are many others that remain to be studied, with the eventual aim of improving health care, with less side-effects to the patient.

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NOTES

1 I have used the term 'biomedicine' throughout the paper; in Fabrega's definition it is "The whole medical complex in Western nations, which includes knowledge, practices, organisations, and social roles" (1975:969). It is therefore "our own culturally specific perspective about what disease is, and how medical treatment should be pursued" (1975:969). It is the world-view of a professional subculture, the medical profession. The term 'biomedicine' is rarely used in British anthropological or medical writings.

2 The history and sociology of the British National Health Service are well described in Stacey (1976), and Levitt (1976). In Stacey's book, see Gill's article (1976:10-12) for a history of the N.H.S. and of the medical systems which preceded it.

3 See Levitt (1976:96. Table 4). She quotes a study of the 'Annual Morbidity Experience in Average British General Practice of 2,500 Persons (i.e., numbers of patients suffering from the diseases that the doctor may expect to see each year). Of the patients seen, 1365 had 'Minor Illness', 288 had 'Major Illness', while 558 had 'Chronic Illness'. Of the 'Minor' conditions, 674 had Upper Respiratory Infections, 84 had Acute Otitis Media, 51 had Acute Urinary Infections, and 53 had 'Common Digestive Disorders' (which presumably includes Gastro-enteritis). Of the 'Major' conditions, 184 patients had Pneumonia and Acute Bronchitis.

4 Many medical anthropologists have noted that definitions of 'normality' in health differ between cultural groups and social classes. In Britain there are significant differences in the definition of 'illness', and in the threshold at which it is brought to a doctor, between the different socio-economic classes. For a study of this, see Cartwright and O'Brien (1976:77-94).

5 For example, see Camp's article (1976:70-76) on the medical use of hydros and spas in France ("la thermalisme"). In France there are over a hundred of these spas and hydros to which half a million patients are referred by their family physicians every year. This practice is now almost unknown in Britain, though 'hydrotherapy' flourished here from the 17th century. French spas are supervised by 'thermal specialists', many of whom are doctors who have taken a 'diploma in hydrology'.

6 See Levitt (1976:98. Table 4).

7 One popular book of folk remedies (Mellor, 1975) puts this concept in a similar way; for example, the treatment she recommends for the common Cold is: "Hot lemonade with a pinch of cinnamon and a little honey in it, and hot elderflower-and-mint tea, with a pinch of composition powder in it, will induce sweating and excretion of waste-products through the skin. The body should be rubbed down with a rough towel; this will remove the sweat, and will induce further sweating and further elimination of unwanted debris through the pores of the skin" (1975:89).

8 Cf. Mellor (1975:66) on the treatment of "Bronchitis and Broncho-Pneumonia" - "The best way to cure both of these ailments is to fast, on juices only, for a day or two. A cup of hot elderflower-and-mint tea should be taken every half hour until sweating begins, then only every hour. The sweat should be removed with a dry towel."

9 See Lewis, I. M. (1971:66-99) for a description of the "malign pathogenic spirits' who cause illness by possession of the victim's body, in parts of Africa and elsewhere. In these societies 'spirits' are hypotheses for the causation of illness. These spirits are capricious and amoral in their attacks, and their victims are considered blameless. Among the Luo of Kenya, for example, "amoral, malevolent spirits of external origin"
existing alongside the ancestor cult, cause a wide variety of afflictions, especially among women (1971:81). In other similar societies, these spirits "strike without rhyme or reason; or at least without any substantial cause which can be referred to social conduct. They are not concerned with man's behaviour to man. They have no interest in defending the moral code of society, and those who succumb to their unwelcome attentions are morally blameless" (1971:71).

10 An inadequate diet, especially, is now increasingly blamed for Colds. Cf. Mellor (1975:89) – a Cold is "Nature's way of forcing you to rest, so that your body can throw out unwanted debris that has accumulated in the blood. An unclean bloodstream, loaded with unwanted debris, provides a favourable breeding ground for the common-cold virus, which cannot live and multiply in a clean bloodstream because it requires waste-matter on which to feed. It gains entry into the body via the nose or mouth, but, if waste-matter is not present in the blood, it will have nothing to feed on and will soon die and be excreted, together with other unwanted debris, through the eliminative organs of the body. A clean bloodstream is, therefore, the best insurance against all forms of germs, including the cold-virus and the 'flu-virus."

11 One patient whom I diagnosed as having a "viral infection", replied "That means you don't know what's wrong with me, doctor."

12 Similar advice for the common cold can be found in many medical textbooks; in Maclean and Scott (1968:178) for example, treatment of the common cold includes bed rest in a warm room, together with hot drinks and a hot bath.

13 See Goodman and Gilman (1968:328); and Chatton, Margen, and Brainerd (1970:5–6).

14 See Trethowan (1975:749) – In 1972, in England, 36 million prescriptions for 'Anti-Infective Drugs' were issued by GPs in the N.H.S., at a total cost to the state of £23.7 million. This amount excludes anti-infective drugs prescribed under the N.H.S. in Wales, Scotland, and Northern Ireland, and those prescribed by hospital doctors.

15 Medical textbooks stress the fact that viruses are not susceptible to antibiotic therapy; see Garrod and O'Grady (1968:427), and British National Formulary (Harman, 1976:115).

16 Details of all prescribable proprietary drugs available in the United Kingdom, together with their pharmacological constituents, can be found in the monthly publication 'MIMS' ('Monthly Index of Medical Specialities'), published by Haymarket Publishing Company, London. It is sent free each month to most doctors in the UK. Some patent remedies are not included in it, especially those that can be bought in pharmacies and supermarkets.

17 Emprazil's slogan, written on each box, is: "Clears the nose, eases aches and pains – Helps you carry on through the cold."

18 Byrne and Long's study (1976) of consultations between GPs and patients in several areas in Britain, includes transcripts of a few conversations which seem to exemplify these points; for example, in one conversation between D(Doctor) and P(Patient): D. "Hello, come in, how are you?" P. "Got a cold . . ." D. “It's the fashion this week, everybody's got it. Well, now, how's the breathing going, any different?” P. “Not so bad, doctor, can't grumble. I feel a bit better than I did before.” D. “That's a good sign. Are you coughing at all?” P. “A bit. Just got a bad chest, just my arms you know.” D. “It's the cold and damp – that sort of thing . . ." (1976: 93–94).

19 See Trethowan (1975:749) – In England only, in 1972, 255.9 million prescriptions were issued by General Practitioners in the N.H.S., with a total cost to the state of £155.1 million.

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“FEED A COLD, STARVE A FEVER” 137


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