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Staff for general practice—short and long term options

THE government white paper *Promoting better health*[1] stressed the need for more and better teamwork in general practice. The stated aim was to promote good health and prevent ill health by giving advice on lifestyle and by providing screening for certain conditions. The government restated its commitment to the development of primary health care teams, and promised more resources for the partial reimbursement of the salaries of a wider range of staff such as counsellors and workers with ethnic minorities. These general statements command support.

Doubts remain, however, that future cash limits on family practitioner committee budgets may inhibit any expansion of services along the lines suggested. Many of the larger practices find practice managers essential, yet they are not mentioned in the white paper. Many family practitioner committees will only reimburse for part of their duties, and at a rate too low to attract staff with the necessary management skills.

Practice nurses play an increasing part in preventive work in general practice and restrictions are being placed on their gradings under the new pay regulations, so that they may see little of the new pay award, and may have a lower ceiling on their earnings than in the past. This will not help recruitment, or the career prospects of a very responsible job. However, the bar will be removed from practice nurses' training course fees, and more family practitioner committee funds for team development are promised.

General practitioners who wish to extend the role of their practice teams in the direction of prevention and health promotion are faced with a choice. If they do not employ the full allowance of two staff per general practitioner at present or pay them the maximum rate, should they quickly recruit staff to these limits of numbers and wages in order to forestall cash limits? It is a tempting option, but surely staff should only be recruited for specific tasks that are related to the planned objectives of the practice? They should not be employed just to fill a quota — a sort of 'staff bank', like property developers and their land banks. General practitioners would, however, be wise to consider their future plans now so that they can recruit the necessary staff without delay if a need is identified.

This is the tactical view, but what is the longer term strategy for staff in general practice? What objectives are practices aiming to achieve? The Cumberlege report[2] was wise to emphasize that teams can only function well if they have explicit and shared objectives. Perhaps the first step in strategic planning is to consult all the staff to try to make a five year plan for improvement of services and systems. Many practices do this already. The next step might be to consult the customers — like all wise businessmen do. How do patients see the shape of future health care? How much will they want to be self-reliant? Are we trying to do too much for patients? Could self-help groups provide some services better?

These are some of the fundamental questions that need to be asked. But do general

practitioners have the management skills to operate at a strategic level? If not, how can they acquire them? Training courses in management for general practitioners have been run by the King's Fund and the Royal College of General Practitioners, and by other institutions. Places are few but, while awaiting a place, doctors might benefit from a series of essays recently published by the King's Fund in memory of the late Tom Evans.[3] His own essay on the strategic response to environmental turbulence places the emphasis of planning on learning rather than producing definitive solutions to problems. Coates and Evans[4] in their essay on the 'learning organization' develop Argyris and Schon's[5] original concept of 'double-loop learning', whereby both individuals and the organizations they work in should be involved in learning and 'learning about learning'. That is to say they should be conscious of the learning process and be working to improve it all the time.

These essays might be a guide for general practitioners, staff and patients so that they can assess what learning is taking place, and develop programmes to improve learning. Each practice could develop this learning 'in-house', initially for doctors and staff, and then explore ways of involving patients, for whom achieving better health inevitably involves a learning process.

The National Health Service Training Authority, which (with its predecessor) has long supported the management training of general practitioners, held a successful joint conference with the British Medical Association in June 1988 on the topic 'Doctors and management development: the way forward'. This cooperation augurs well for the future of general practice management. But managing general practice in isolation is not enough — the management of primary and secondary care must be coordinated with each other. Management across the boundaries of health care provision tends to be neglected, though of crucial importance in ensuring the quality, equity and cost-effectiveness of health services.

General practitioners in the UK are fortunate in having the freedom to plan their future within wide limits. But do we have the capability to do so? Staff management is now a key part of general practice. Let us hope that general practitioners will make the most of the new opportunities to develop effective patient-oriented management rather than wait for someone else to do it for them.

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International travel medicine

INTERNATIONAL travel is expanding rapidly: every year there are over 20 million overseas visits by United Kingdom residents to an ever widening variety of destinations. Morbidity owing to travelling is high: about half of short-term travellers experience some illness.[1] Furthermore, the high speed of travel means that people may return while still incubating a potentially fatal infection.

Travel medicine has its own British journal — *Travel Medicine International (Journal of Emporiatrics)* — and association — International Association of Physicians for Overseas Service, and it is emerging as a specialty in its own right, albeit with only a small number of full-time doctors. Some general practitioners have a particular interest and expertise in this area and are medical advisers to commerce and industry, the armed forces, the travel industry, and voluntary bodies such as relief organizations and missionary societies, but all general practitioners are consulted about travel by their patients. The general practitioner has three roles in this field: preparing patients for travel, care during travel, and post-travel diagnosis and treatment of diseases.

In advising people before travelling general practitioners need to bear in mind that the people who have an increased risk of illness include: package holiday-makers, smokers, inexperienced travellers, those travelling to the tropics and those under 30 years old.[1]

One of the first questions to be asked is whether the patient is fit to fly;[2] patients who have recently had a myocardial infarct or laparotomy, for instance, should be advised to delay travel.[3] It is best to discuss any potential problems with the airline concerned.

The main area where the general practitioner will be involved in pre-travel preparations is immunization. This can be divided into three groups. First, boosters may be needed for immunizations given routinely to all UK citizens, including routine childhood immunizations, not forgetting bacille Calmette-Guérin (BCG), measles, mumps and rubella. Serological studies have shown, for instance, that over 20% of the population have incomplete immunity to poliomyelitis[4] and 35% are susceptible to diphtheria.[5] The traveller to developing countries will be exposed to diseases now rare in Europe. The second group includes immunizations commonly given to travellers, such as typhoid and normal immunoglobulin, and cholera and yellow fever (the only two which are compulsory for certain countries). The most problematic are immunizations which are given only in specific situations, and these include anthrax, hepatitis B, Japanese B encephalitis, meningococcus, plague, pneumococcus, rabies and tick-borne encephalitis.

Advice about malaria is rapidly changing as the plasmodium is becoming more resistant: chloroquine resistant strains have spread to most malarial parts of the tropics. The value of prophylactic drugs is constantly being reviewed and resistance renders some old drugs used a single agents, such as pyrimethamine, nearly useless. Adverse reactions severely limit the use of others, such as Fansidar (Roche), and the place of