Many general practitioners were suspicious that the chief aim of the medical adviser was to reduce expenditure on drugs and to interfere with clinical freedom.³ But rational prescribing means directing resources to where they can be used most effectively,⁴ and improving prescribing is not simply a matter of eliminating waste. Thus in some practices, where conditions such as asthma and hypertension may be undertreated, advisers will prompt doctors to increase their prescribing costs.⁵

Advising about prescribing is only part of the work of most medical advisers, and in some family health services authorities the job of providing guidance on prescribing has been delegated to pharmacist advisers. The medical advisers themselves may be overseeing health promotion, facilitating medical audit, and, in some cases, taking a management role within the authority.⁶ A further task, recently acquired, is monitoring the use of controlled drugs, which was formerly undertaken by the disbanded regional medical services.

Most full time medical advisers have come from general practice or from the regional medical service, while most part timers are still practising general practitioners. Some have wanted a change from general practice and a new challenge, whereas others have a powerful vision of where general practice should be going in the 1990s. All advisers will bring to the job their own experience of general practice, but they need to add new skills, including a knowledge of clinical pharmacology,⁷ management, and health economics. Other new skills need to be developed, such as ways of interpreting and presenting prescribing data,^{8,9} and a support centre has been introduced to meet these needs.²

At its broadest the role of medical adviser is the equivalent in general practice to that of the clinical director in hospital, with responsibilities for planning, resource allocation, service development, and standards. Those with this sort of role see themselves as bridge builders between individual general practitioners and family health services authority managers; they may also become bridge builders between hospital specialists and general practitioners in discussions over protocols for shared care.¹⁰ As family health services authorities and district health authorities (and fundholders) clarify their roles in commissioning¹¹ the medical adviser may act as a district specialist in primary care and form a natural link

between the commissioning authority, provider units, and the regional authority. An example of this wider role is the monitoring of fundholding practices, already part of the duties of some advisers, and one that may grow with the number of fundholders.

Medical advisers have many problems to overcome, not least maintaining their accountability both to a wary profession and to family health services authority managers. They need to establish relationships with public health specialists, and full time advisers will have to preserve their clinical credibility among their general practitioner colleagues. A newly established committee of the BMA is considering terms and conditions of service, and the advisers themselves are addressing the ethical, legal, and educational issues that are part of their daily work. A crucial task for the first advisers is to develop a flexible career that provides professional fulfilment for them and their successors.¹²

Arguably, medical advisers fill a gap between primary care and the wider health service that has existed since the beginning of the NHS. If they fulfil their promise of becoming key figures in "maintaining and improving the health of local people"¹³ and in developing general practice they will be an unexpected benefit of the "Improving Prescribing" initiative.

TOM WALLEY
Clinical Pharmacologist
JOHN BLIGH
General Practice Adviser

National Medical Advisers Support Centre,
Hamilton House,
Pall Mall,
Liverpool L3 6AL

- 1 Department of Health. *Indicative prescribing budgets for general medical practitioners*. Working paper 4. London: HMSO, 1989.
- 2 Department of Health. *Improving prescribing*. London: HMSO, 1989.
- 3 O'Dowd TC, Wilson AD. Set menus and clinical freedom. *BMJ* 1991;303:450-2.
- 4 British Medical Association. *Leading for health: a BMA agenda for health*. London: BMA, 1991.
- 5 O'Brien B. Indicative drug budgets for general practitioners. *BMJ* 1989;298:944-6.
- 6 Rous E. The role of the medical adviser at the FHSA. *Br J Gen Pract* 1990;49:519-20.
- 7 McGavock H. Promoting rational therapeutics: the Swedish guidelines and a UK response. *Br J Gen Pract* 1990;40:1-3.
- 8 Harris CM, Heywood PL, Clayden AD. *The analysis of prescribing in general practice*. London: HMSO, 1990.
- 9 Forster DP, Frost CEB. The use of regression analysis to explain the variations in prescribing rates¹ and costs between family practitioner committees. *Br J Gen Pract* 1991;41:67-71.
- 10 Shapiro J. We may never understand each other. *BMJ* 1991;303:1138.
- 11 Foster A. *FHSAs: today's and tomorrow's priorities*. London: NHS Management Executive, 1991.
- 12 Richards C. General practice as a career. *BMJ* 1991;303:827-8.
- 13 Department of Health. *The health of the nation*. London: HMSO, 1991.

Prison medicine: beginning again

Time to hand over everything to the NHS

Britain's new private prison is thinking about how to organise health care for its prisoners. Starting work on a blank canvas must be much more rewarding than reworking an old picture, especially one as badly botched as the prison medical service. It's most unlikely that anybody would advise the new prison to copy the existing medical service. So why shouldn't the whole system have a chance to start all over again?

The stars seem favourable for just such a dramatic development. In December the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment declared that some of the treatment received by British prisoners was inhuman and degrading.¹ As a result the prison system is in deeper opprobrium than ever, and last week the chief inspector of prisons published yet another damning report on a prison, this time Canterbury; it was so dirty, cramped, and dispiriting, he said, that it was no longer

fit to serve as the local prison for Kent.² Overcrowding is now desperately bad all around the country after a 9% increase in the prison population last year.³ The Woolf report urged root and branch reform of the whole service,^{4,5} and a management report commissioned by the Home Office recommended that the prison service should become a stand alone organisation.⁶ An efficiency scrutiny has already recommended fundamental reform of the medical service,⁷ and its recommendations are inching towards implementation. Sir Donald Acheson has just been appointed the first chairman of the health advisory committee for the prison service. And—perhaps most importantly—the changes in the NHS should make it easier for it to take over responsibility for providing health care to prisoners.

Many of those who have looked at prison health care—particularly the social services committee of the House of Commons⁸—have stopped short of recommending scrapping

the prison medical service. Critics have recognised that many of its problems arise from the appalling state of the prisons themselves, and reform of the health services alone may thus achieve little. Problems have also arisen in prisons from the rundown of the NHS mental hospitals and the unwillingness of some psychiatric teams to accept mentally disordered offenders into their facilities. Although many have criticised the prison doctors, they have also acknowledged that some do an excellent job that other doctors are unwilling to do and that special skills are needed for practising medicine in prisons. Then, there have been doubts about the ability of the NHS to provide for the needs of prisoners.⁹ Would a cash limited district health authority give much priority to the needs of prisoners? It seems unlikely.

For all these reasons—combined with inertia—the policy has been to soldier on with attempts at piecemeal internal reform. In particular, a committee of the Royal College of Physicians recommended improving the training of prison doctors rather along the lines that have been successful in raising the quality of emergency medicine.^{10 11}

But internal reform is clearly not enough. There is little or no evidence of improvement and much of continuing problems. The European committee found many defects with the medical services and recommended that “all prison medical officers should belong to the wider health community.”¹¹ This message is supported by the chief inspector of prisons, who in his annual report produced yet again a catalogue of criticisms of the medical services full of phrases like “We can only reiterate that . . .” and “We continue to note the apparent lack of . . .”¹² Little or nothing improves, and his final conclusion was: “The standard of medical care afforded to prisoners falls far short of that provided in the community.” The nearest that we have to an “outcome” measure for the prison medical service is the suicide rate, and this, sadly, has continued to rise.^{13 14}

It was presumably considerations like these—combined with the present government’s enthusiasm for the market—that led the efficiency scrutiny to propose radical reform of the prison medical service. It suggested that the service should stop providing health care directly and instead purchase it from the NHS. The prison medical service would thus become a purchasing authority. The efficiency scrutiny was published in the autumn of 1990, and the Home Office is making heavy weather of implementation. It seems to be trying to turn an apple into an orange by stealth, a policy doomed to failure.

Why not go further? Why should the purchasing not also be done by the NHS? Firstly, combinations of district health

authorities and family health service authorities are busy developing purchasing skills in a way that the prison medical service would be hard put to match. Secondly, the purchasers have access to the public health skills that have been lacking in prisons. Thirdly, the purchasing authorities should be able to purchase for prisoners at the same time as purchasing for the rest of the community and so get a broader range of services at better prices. What can be achieved by NHS staff working in the prisons is illustrated in the paper on p 152: diabetologists from Liverpool, who in an earlier paper identified serious problems in delivering diabetic care in prison, were able to abolish serious diabetic instabilities and improve glycaemic control in diabetic prisoners by running a fortnightly clinic in the prison.

The funds for prison health care should probably continue to come through the Home Office rather than the Department of Health so that prisoners do not have to compete directly with other groups in the community for restricted resources. But purchasing might produce savings because the evidence is that prison medical services have been inefficient.¹² It would be necessary to develop special purchasing skills for prisons, and purchasing authorities would need to study prison health care needs and ensure that some staff devote time especially to prisons. Similarly, the purchasing authorities would need to write requirements for special training into provider contracts. But in the end prisoners have advantages over the general public in that the chief inspector, whose staff include people with medical skills, and Sir Donald’s committee will continue to watch the quality of the health services available to prisoners. Such wholesale reform would be unlikely to reduce quality and might improve it dramatically.

RICHARD SMITH

Editor, *BMJ*

- 1 European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment. *Report to the United Kingdom government on the visit to the United Kingdom*. Strasbourg: Council of Europe, 1991.
- 2 Her Majesty’s Chief Inspector of Prisons. *HM Prison Canterbury*. London: Home Office, 1992.
- 3 Carvel J. Howard League blames Baker for 9pc rise in jail population. *Guardian* 1991 December 31:5.
- 4 Woolf H, Tumim S. *Prison disturbances April 1990*. London: Home Office, 1991. (Woolf report.)
- 5 Smith R. Root and branch reform of prisons. *BMJ* 1991;302:550-1.
- 6 Lygo R. *Prison service management review*. London: Home Office, 1991.
- 7 Smith R. Arise the new prison health service. *BMJ* 1990;301:892-3.
- 8 House of Commons Social Services Committee. *Prison medical service*. London: HMSO, 1986.
- 9 Smith R. *Prison health care*. London: BMA, 1984.
- 10 Working Party of the Royal College of Physicians. *Report to the chief medical officer, March 1989. The prison medical service in England and Wales: recruitment and training of doctors*. London: Home Office and Department of Health, 1990.
- 11 Bluglass R. Recruitment and training of prison doctors. *BMJ* 1990;301:249-50.
- 12 Her Majesty’s Chief Inspector of Prisons. *Report January 1990-March 1991*. London: HMSO, 1991.
- 13 Her Majesty’s Chief Inspector of Prisons. *Suicide and self harm in prison service establishments in England and Wales*. London: HMSO, 1990.
- 14 Smith R. “Taken from this place and hanged by the neck. . . .” *BMJ* 1991;302:64-5. (12 January.)

Drug treatment for acute upper gastrointestinal bleeding

Works in selected subgroups of patients

Acute gastrointestinal bleeding from the oesophagus, stomach, or proximal duodenum results in about 25 000 admissions to British hospitals each year, with one in five patients requiring emergency surgery and one in 10 dying from the effects of severe blood loss.¹ Morbidity and mortality are particularly high in elderly patients, those who require large transfusions, and those with continuing or recurrent bleeding. Despite advances in diagnostic endoscopy and treatment of peptic ulcer disease, mortality from acute upper gastrointestinal bleeding has remained stubbornly high.

Admission to highly specialised units, close collaboration between gastrointestinal physicians and surgeons, and early surgical intervention for high risk patients can appreciably reduce mortality to 2-4%. The quest for therapeutic agents that reduce transfusion requirements, operation rates, and overall mortality has continued unabated over the past two decades.

An acidic environment impairs platelet function and haemostasis, and therefore reducing the secretion of gastric acid should reduce bleeding as well as encouraging healing.