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. But rational prescribing means directing resources to where they can be used most effectively, 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.

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. 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, management, and health economics. Other new skills need to be developed, such as ways of interpreting and presenting prescribing data, and a support centre has been introduced to meet these needs.

At its broadest the role of the 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. As family health services authorities and district health authorities (and fundholders) clarify their roles in commissioning 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.

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” 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, London SW1Y 5AL

10 Sharpe J. We may never understand each other. BMJ 1991;303:1138.

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. 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 spiriting, he said, that it was no longer fit to serve as the local prison for Kent. Overcrowding is now desperately bad all around the country after a 9% increase in the prison population last year, and the Woolf report urged root and branch reform of the whole service, and a management report commissioned by the Home Office recommended that the prison service should become a stand alone organisation. An efficiency scrutiny has already recommended fundamental reform of the medical service, 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 Commons—have stopped short of recommending scrapping
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 gastroenterologists 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.