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CORRESPONDENCE

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- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Greeks bearing gifts

SIR,—The "no cost" schemes being offered by AAH Meditel and VAMP Health provide an opportunity for improving general practice information systems comparable with what the charter did for working conditions or compulsory vocational training for education. Sadly, Dr Mike Pringle's leading article on the subject (26 September, p 738) is almost entirely discouraging.

And on so little evidence. Dr Pringle first produces the confidentiality objection, but the systems satisfy every one of his criteria. He then discusses the difficulty of adequate data collection, which nobody would deny, and few achieve this without good clerical support. He supports his argument, however, only with his own research (which measured time taken for increased preventive care not increased recording) and that of another group, which has since changed to one of the systems on offer. Having complained that the extent of recording is unreasonable, he then condemns VAMP for recording "only [sic] consultation diagnoses that result in a prescription or admission." He then moves on to suggest that the systems might reduce reporting to the Committee on Safety of Medicines or through prescription event monitoring, whereas in fact the data should be of a quality to make both activities more effective. Finally, Dr Pringle rehearses the repeated accusation that "general practitioners will have no control over the analysis and presentation," whereas both companies have made it clear that the data will be available for research free or at cost of extraction.

In the face of such an unreasonable review as Dr Pringle's, what is a more realistic appraisal? We currently have problems in practice with no direct funding for computerisation, financial disincentives to producing quality,[1] little incentive to keep records, poor data for planning, and inadequate reporting of adverse drug reactions. All these problems may be overcome by the "no cost" schemes. Of course there are problems. High quality recording will be impossibly time consuming unless organised on a doctor/staff joint system. The contract must not "lock doctors in." Data must be—and are being—made available for research.

If the schemes are successful they will provide the best data base we have ever had. At practice level that means information for managing patients' acute, chronic, and preventive care. At an aggregated level the data would provide a base for clinical or health services research, for audit and feedback to benefit the practice, for correlating practice peformance and characteristics to facilitate planning, or for detection of adverse reactions to new drugs so quickly that current methods of prescription event monitoring would become irrelevant.

Let those who spend so long looking this alleged Trojan horse in the mouth not forget that the Greeks also showed that exposing threatening infants on the mountainside does not ensure a peaceful life. It is all too easy to suggest that the way to behave tomorrow is how we behaved yesterday, but our recording of data yesterday was pretty awful. If we want something better we must think positively.

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1 Bosanquet N, Leese B. Family doctors and their choice of practice strategy. *Br Med J* 1986;293:667-70.

SIR,—Mike Pringle (26 September, p 738) warns that though free computers on offer from commercial firms such as VAMP Health and AAH Meditel will yield detailed statistics on workload and efficiency and offer insights into the care received by patients with chronic diseases, general practitioners will have no control over analysis and presentation of data and will be vulnerable to selective misrepresentation. The only alternative, he says, is for the profession to collect, pay for, and control the information, which he correctly dismisses as unrealistic.

Commercial firms want this information because it is valuable for planning the work of the pharmaceutical companies, which are therefore willing to pay for it. There was a time, before 1979, when most people assumed that the Department of Health and Social Security would also have found this information necessary in planning its work and would have been the natural source of funding. Are we now so decivilised that we are no longer surprised to find salesmen more interested in a public service than the ministry responsible for it?

If the Department of Health and Social Security will not pay for an intelligence service and VAMP Health and AAH Meditel will general practitioners sufficiently interested in their work and willing to put in the considerable unpaid time entailed in recording data will use them. They can, in fact, present their own data themselves and will be able to compare them with data from other practices, otherwise none of us would have signed our contracts. There are risks, but we have no alternative but to take them. The principal danger lies not in the gullibility of general practitioners but in a situation where a ministry with responsibility for a vital public service continues to grope blindly into the future, without any apparent sense of direction other than that imparted to it indirectly by commercial forces, which VAMP and Meditel data will now increase but personally presented data may hopefully modify. I do not believe that the Chief Medical Officer at the Department of