by the bill would have been able to recoup money paid out to victims of accidents attributable to third parties—for example, the drug companies.

It is impossible to put an exact figure on the cost of a no fault scheme because one cannot cost the present system, but savings in legal fees and legal aid payments would be substantial.

I can scarcely believe the assertion by Mr Capstick and colleagues that a no fault scheme would not ensure proper accountability for the medical profession. I would not have let a bill that did not deal adequately with this issue go forward in my name. The bill allowed the Medical Injury Compensation Board to investigate claims fully, give explanations, and where appropriate seek apologies and refer matters to other authorities, including disciplinary bodies. Lessons would have been learnt and accountability ensured. Mr Capstick and colleagues are also somewhat critical of my decision not to prevent claimants from choosing the current legal process if they desire. Under my bill, those dissatisfied with the board's offer could have refused it and pursued a claim in the courts. The board's offer would then have fallen. My view is that most claimants would rather pursue a claim with the board than entrust themselves to the vagaries of the legal process. One of the major deterrents to pursuing a tort action in the courts is the time it takes to complete the process. I am sure that most people would rather receive "less" now than take the risk of "more" later.

As the government has implicitly accepted the concept of no fault compensation in their award to those haemophiliacs who contracted HIV from infected factor VIII there is no good reason not to extend the principle to all those suffering as a result of medical accidents. If £4bn can be found to save the government's face over the fiasco of the poll tax then the estimated £100m needed to establish a no fault compensation scheme can, I am sure, be found immediately—financed perhaps by an increase in VAT?

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1 Capstick B, Edwards P, Mason D. For debate: compensation for medical accidents. *BMJ* 1991;**302**:230-2. (26 January.)

Re: VAMP revamp

SIR,—Ms Linda Beecham's article on the crisis in VAMP[1] reminds me that the history of computing is littered with company failures and subsequently unsupported systems. The problem is that the failed company usually retains the software source code and documentation, thus rendering the system almost unsupportable even by a computer expert.

A resource is available, however, that would overcome many of the traumas of software companies going out of business: an escrow agreement. None of the general practitioner computing companies seem to offer their customers the facility of placing their software in escrow; neither have any of the guides to buying a general practitioner computer system that I have seen mentioned this facility.

Briefly, in an escrow agreement the supplier deposits its program's source code with a third party, such as a solicitor or the National Computing Centre. The supplier contracts to supply the third party with all software updates and documentation.

If a supplier stops trading the escrow agreement is enforceable and the users who have subscribed to it have access to the source code and documentation to support and maintain their systems. Suppliers retain the copyright of their software while they are trading. Both users and suppliers normally contribute towards the costs of escrow.

In the case of general practitioner computer systems, the user group would seem ideally placed to negotiate an escrow agreement with the supplier. Should the supplier cease to trade, the user group could hire computer experts to support and maintain general practitioners' systems.

I have only once had to enforce an escrow agreement when a system supplier ceased trading; the transition was not painless, but it enabled us to maintain the software until a suitable successor system was available.

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1 Beecham L. Re: VAMP revamp. *BMJ* 1991;**302**:489-90. (2 March.)

SIR,—That practices "receive the basic computer system and £500 a month on average in return for supplying anonymised morbidity and prescription information"[1] is a common misconception, probably because the scheme was originally called a "no cost option." In reality, practices either buy the computer system or lease it from a leasing company independent of VAMP, paying the standard purchase and maintenance costs. In a separate agreement they then sell anonymised data for VAMP in return for a regular monthly payment. This payment is not for the computer, it is in respect of the increased work incurred in collecting data of a quality that is useful for morbidity analysis and research.

It is important to get this matter straight for three reasons. Firstly, it is not the hardware and software development side of VAMP that was in financial trouble but the data payments side of the company—largely because the level of data payments had been extremely generous in the early stages.

Secondly, it should be clear that, because the payment is for the work involved in producing data and not for the computers, practices on the research panel should not be excluded from direct reimbursement for computer purchase and maintenance costs.

Thirdly, the scheme shows the value that the company has put on high quality data. For these routinely collected data to be useful they have to have a high level of completeness and accuracy, and this requires record keeping by the participating practices far above that normally required for the provision of general medical services. The profession is fortunate that independent companies have taken the initiative to build up such a research database, which is currently being validated; it might otherwise never have been realised. Although general practitioners will always prefer large fees with no risk, it may well be that the new profit sharing scheme will provide even greater incentives to good record keeping than the original one.

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1 Beecham L. Re: VAMP revamp. *BMJ* 1991;**302**:489-90. (2 March.)

Large computer databases

SIR,—The recent editorial entitled "Large computer databases in general practice" is highly misleading as it relates to the VAMP database.[1] The VAMP validation study we reported in the *BMJ* was begun in mid-1989, at a time when only a small fraction of practices enrolled in the VAMP research program had completed the 12 months of training for proper recording of clinical data.[2] As noted in our paper, most practices entered the plan between July 1989 and June 1990 and had not completed their training when the study was initiated. Thus the reported results related only to the practices enrolled earliest in the program.

Currently over 500 VAMP practices encompassing some three million patients are considered to be up to standard, and our most recent studies indicate that the quality of the information available from practices which have come up to standard since the time of our validation study have continued to show a high standard of data quality.

It is most important to understand that practices which come up to standard differ in principle from practices which do not only in regard to how thoroughly they record relevant data, not in terms of the effects of the drugs they prescribe. In studies of drug safety based on computer data it is critical that relevant data items be recorded routinely. The a priori standardised exclusion of data of inferior quality in no way influences the results of studies that are based on data of high quality. The suggestion that drug safety studies should be based on inadequately collected data as well as properly collected data simply to achieve the purpose of including a representative sample of doctors is a nonsense. It is simply not correct to state that drug safety studies should include a representative sample of doctors because such studies evaluate how drugs behave, not how doctors behave.[3]

We have no experience with the AAH Meditel data resource, but there is no a priori reason to assume that it is of the same quality as the VAMP data resource simply because they are both derived from general practice.

The editorial concludes, based in part on our report, that "Early hopes for large databases have not been fulfilled" and that the VAMP data are of "poor quality"; but we conclude, based on our considerable firsthand experience with the VAMP data resource, that reasonable hopes for its utility have been surpassed by the high quality and size of the data available for research.

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1 Pringle M, Hobbs R. Large computer databases in general practice. *BMJ* 1991;**302**:741-2. (30 March.)
2 Jick H, Jick SS, Derby LE. Validation of information recorded on general practitioner based computerised data resource in United Kingdom. *BMJ* 1991;**302**:766-8. (30 March.)
3 Jick H, Vessey MP. Case-control studies in the evaluation of drug-induced illness. *Am J Epidemiol* 1978;**107**:1-7.

Improving outpatient services

SIR,—As reported, the National Audit Office recently published a review of NHS outpatient services, which was then the subject of discussion by the parliamentary Public Accounts Committee on 27 February.[1] In our review we examined the management of outpatient services in a sample of 10 hospitals. These hospitals also undertook surveys of a number of clinics for us, recording among other criteria the staffing levels, patients' waiting time in clinic, and the incidence of missing patient records.

We found that many patients had to wait a long time after their arrival at the clinic before they were seen by the doctor—in 53% of clinics patients' average waiting time was less than 30 minutes, but in 40% it was between 30 minutes and an hour, and in 7% it exceeded an hour. We were therefore interested to read Dr M Jennings's account of his introduction of a new appointments system and its beneficial impact on patients' waiting times in clinics.[2] Realistic appointment arrangements are clearly a great step towards achieving improvements. Studies like ours cannot prescribe ideal

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