think of relevant questions and the sequence of questioning required to arrive at a diagnosis. This may result in the future clinician learning to fill in the blanks meticulously, but unable to collect, and analyse data in their brain. This type of "fill in the blank questionnaire" requires no special history taking skill, and may also result in delay in arriving at diagnosis in an emergency situation.

I have come across some junior doctors meticulously trying to take a history with these preprinted sheets, when they should have concentrated on treating the patient. The patient is uncomfortable, and at times very ill, but the doctor starts asking questions, as printed, and fails to recognise the patient's problem, nor give importance to what the patient wants to say. This makes the patient feel that the doctor is not keen on understanding his current problem, and so loses confidence in the management. The other problem is that when the doctor is taking a history with a preprinted history sheet there is no eye contact with the patient because the doctor is keen on reading the printed questions. This breaks the patient-doctor relation and can be disadvantageous to both doctor and patient. Let us not forget that today's junior doctors are our physicians and surgeons tomorrow.

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- 3 Bates B, Hoekelman RA. Interviewing and history taking. In: *Guide to physical examination and history taking*, 5th ed. Philadelphia: JB Lippincott, 1990.

AUTHOR'S REPLY - We thoroughly agree with Srivatsa's view that taking a history is about much more than collecting information. We agree that taking a history is also a powerful way of building a relation with the patient and that this process may be jeopardised by the act of writing the history down. Srivatsa argues that the use of preprinted prompts to record the history is more likely to jeopardise the process of building a relation than traditional ways of recording the history. Srivatsa also argues that the use of preprinted prompts may lead to doctors failing to use their brains to collect and analyse data and that this can lead to delays in diagnosis.

Our study did not specifically study either of these points but we do not think they are valid. We teach our juniors to ask the patient (or parent) "What is the problem?" and then to listen. Only when the patient has had his or her say should the doctor write anything. What is then written is the "presenting complaint" and the start of the "history of the presenting complaint." We then ask the trainee to complete the rest of the history of the presenting complaint in the traditional

way. The first page of our notes is dedicated to the history of the presenting complaint and is blank except for four prompts at the bottom (about medication, food, fluids, and activity).

Although there are repeated prompts in the rest of the history and examination we emphasise to our trainees the importance of writing appropriate notes in the blank space surrounding each prompt. In our paper we reported that there were fewer words written in notes with preprinted prompts. Thus we think that far from alienating patients the use of notes with preprinted prompts improves rapport because they are quicker to complete.

We also reject Srivatsa's worry that diagnosis may sometimes be delayed because trainees will blindly tick boxes rather than use their brains to record the history. As already emphasised recording the history of the presenting complaint (the most important element of the history) is done in the traditional way. Furthermore all of our prompts concern what members of the department considered were "core clinical details" that should be recorded in all cases. Our study showed that the use of notes with preprinted prompts meant that almost invariably these details were recorded. It is hard to see how recording this information could lead to delays in diagnosis.

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SOFTWARE REVIEW

Pinpoint for windows. (£299 plus VAT; site licence £750 plus VAT (three users). Cambridge: Longman Logotron, 1993.

One aspect of improving quality in health care is using medical and clinical audit effectively to bring about change. Doctors, nurses, and other paramedical groups are increasingly required to spend time auditing their current practices and clinical processes. It is helpful to be able to design a data entry form or questionnaire from which information can be entered on to a computerised database used to sort, categorise, and summarise this information. Many database packages are now available which can be customised to perform these tasks, but they are often difficult to teach to newcomers to computing. The program used in this hospital, Pinpoint for Windows, is ideal for carrying out audit projects.

Pinpoint is a menu driven information collection and analysis package designed with market research and customer surveys in mind, which requires no prior

knowledge of programming. The program requires an IBM compatible personal computer (80286 or higher processor, at least 2MB of RAM, and at least 3 MB of free hard disk space) and runs using the Microsoft Windows (version 3.1 onwards) graphical interface with a mouse. It comes with an excellent manual.

The first task - creating a data entry form or questionnaire - is fairly easy as you first decide where to place the question of a blank form and Pinpoint then provides a dialogue box from which the question (or field) can be customised into field type. Field types include: (a) fixed length text, (b) free form text (for example, to record comments), (c) numerical, (d) date, (e) yes/no, (f) multiple choice, and (g) ordered choice.

Once the field type has been chosen Pinpoint automatically provides check boxes for answers. The question and answer areas can be moved around the form and embellished with free standing text, drawing boxes, and lines to make attractive looking data collection forms. Forms can be modified (for example, with an additional question) at any stage, and Pinpoint will automatically update all previously completed answer sheets. This is useful when additional information is requested to be collected during the course of an audit.

Photocopies of the data entry sheet can be used for data collection. The information may then be transformed on to a similar form on the computer (the answer sheet) Pinpoint can be used to analyse the data and present them as summaries or graphs. The data can then be sorted, selections made for subgroup analysis, and categorised (for example, answers from Yes/No or multiple choice questions) and calculations performed. The information can be summarised using descriptive statistics, frequency, and

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popularity analysis. A most useful tool is the ability to produce cross tabulation tables and reports. Pinpoint includes a useful range of graphs which can be a powerful tool for presenting raw data or information from subgroups, categories, or cross tabulation reports. Bar, pi, line, and scatter (including regression line) charts are available, which can be annotated with text.

We have found that this program has saved vast amounts of staff time by reducing the need for repeated searches through raw data when information on subgroups or categories is requested or the data need to be presented in another format.

Data can be imported using dBase, Paradox, and comma or tab separated value (CSV, TSV) formats. This allows data already collected on other databases or spreadsheets to be used or information collection on Pinpoint to be analysed in more detail with a statistical package. Pinpoint has a clean interface that is not cluttered with "never to be used" features and we have found this package extremely easy to use and helpful for medical and clinical audit.

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Since this review was written a major new release of Pinpoint for windows is available, details from Longman Logotron (tel 01223 425558).

BOOK REVIEWS

Shared Care for Diabetes. P M Greenhalgh (pp 35; £9.00 (£9.90 non-members)). London: Royal College of General Practitioners, 1994. (Occasional paper 67.) ISBN 0-85084-204-2.

About 2% of the population of the United Kingdom has diabetes and evidence suggests that the incidence is rising. A general practitioner (GP) with an average list size of about 2000 patients will have 25 to 35 patients with diabetes registered in his or her care, of whom about a third will be using insulin. It is essential that GPs with an interest in this condition – and 90% of practising GPs in the United Kingdom are now claiming chronic disease management fees for diabetes management – are familiar with the condition; aware of complications; and have an effective, structured method of care. Thus this review of the various methods of diabetes care is essential and extremely topical.

Although there is no actual original research, Dr Greenhalgh has methodically and brilliantly collated all the original work on shared care for diabetes, has

extensively reviewed all the differing methods of care, and looked at educational and clinical methods. Her work extends back to the mid-1960s, thus including a historical aspect, yet projects forwards with ideas for future development and research. This work has been drawn from many sources ranging from recognised diabetes journals to general medical journals and general practice journals, but the outstanding aspect must be the enormous amount of personal communication that Dr Greenhalgh has undertaken with general practitioners and recognised leading experts, in the United Kingdom and abroad, and thus this occasional paper truly represents the current state of art of diabetes care.

Towards the end a concise chapter summarises the findings and makes recommendations for effective diabetes care in general practice. Dr Greenhalgh comments that effective diabetes care is "achieved only if the system includes a register, protected time, a practice nurse with diabetes experience, a written management and educational protocol agreed with the local consultant diabetologist, and a system for auditing standard of care." She makes the most important point that unstructured care by disinterested primary healthcare teams is ineffective and wasteful of resources. The nine recommendations are intended as guidelines for workers, particularly those in primary care, and, together with the published guidelines for clinical monitoring and the requirement for chronic disease management programmes, should enable most interested practitioners to establish effective and efficient diabetes care.

This paper occupies a very important position on the bookshelves of all staff involved in diabetes care and I am sure will become the authoritative work on shared care for diabetes.

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Quality Assurance in Nursing Practice. N Kemp, E Richardson (pp 165; £11.99). London: Butterworth Heinemann, 1995. ISBN 0 75062326 8.

For those nurses who are actively involved in quality assurance this book will tell them little that is new. However, I suspect that such people are not the targeted audience. Rather this book seems to be aimed at those nurses who are at an early stage on the quality assurance learning curve. In particular it will be a useful source for nursing students on P2000 and undergraduate degree courses.

The first edition of this text, published in 1990, sold well. Many new governmental and professional initiatives about quality improvement have taken place since then and the authors do a good job updating the reader. This is one of several

such texts published this year – all of which seem to be aimed at a similar readership. However, I detect important differences which may give this book an edge over its competitors.

The authors try to unravel the differences between quality assurance and audit, competently using the scientific literature to support their stance. They are less successful in how they deal with "total quality management" and its relation to quality assurance. None the less, the text is full of useful practical examples from a wide range of health authorities and trusts around Great Britain. There is a particularly good section on the various methods that may be used for standard setting and audit and the book gives the impression that the authors have pinned their allegiance to Donabedian's structure, process, and outcome approach, particularly as adopted by the Royal College of Nursing.

Although it deals briefly with multi-professional audit this book essentially focuses on nursing and the nurse's role in quality assurance. Neophytes from other professions may learn much about the theory of standard setting and audit but I would have difficulty recommending it as a suitable text for non-nurses.

I was interested in Kemp and Richardson's subtle issues relating to quality of care (not always found in mainstream texts). These include the relation between research and quality assurance, ethical issues relating to monitoring quality, criterion maps, the effects of manpower on quality, and the practicalities of facilitating and educating practitioners to become actively involved in quality improvement initiatives.

In conclusion, the authors have succeeded in producing an easy to read British text aimed at introducing readers to quality assurance and audit. Those already familiar with these issues will probably not purchase this book but this should not deter them from recommending it to students and colleagues who are less well versed.

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Development and Implementation of Clinical Guidelines. Edited by the Royal College of General Practitioners (Report of Clinical Guidelines Working Group) (Report from General Practice Number 26) (pp 34; £11.00). London: Royal College of General Practitioners, 1995. ISBN 0 85084 207 7.

Guidelines are gift horses into whose mouths we had better look. That is the key message from the general practitioners whose deliberations are summarised in this report. It is good to see that the most thorough appraisal of development and implementation of guidelines in the