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 blank mechanically, 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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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 junior 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 confirm that 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


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