Reflections

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Over the years in practice I attended various symposia at which *decision-making* was a subject. I discovered that there were, of course, theories about decision-making, that models had been developed and that there were suggestions about the inevitable worth of these sometimes very different models.

I don't recollect that anyone actually referred to medical diagnosis. It was always implied that this was just another kind of decision making – nothing unique about it. I often wondered how the dictum I sometimes enunciated to my registrars – that if in general practice they hadn't got a very good idea (a short list) of the diagnostic possibilities within the first sixty seconds of the consultation, and moreover, if they hadn't got a ranking order of the possibilities, then they would be unlikely to have a bona fide diagnosis by the end of the interview – would appeal to those in charge of the seminars.

Of course, compressed and provocative though it may seem, the idea did have more than a little merit. I became, as I went to more of the sessions, cynical about decision making groups – principally because I'm not a group person – and found the cross-play in groups and the clash of differing agendas nothing but a hindrance. And I fancy the dictum attributed to an English Lord – a dictum that I encountered very early in a secondary school English class and which has embedded itself in my mind – that the best committee is of three people: myself as Chairman, myself as Secretary, myself as Treasurer. A very sensible idea, even if there do seem some rather obvious difficulties with the concept. As an avowed non-groupie, it's just what you'd expect.

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And there are occasions when it does seem better not to make a decision but to remain poised and indeterminate. One way of accomplishing this business of not making a decision is beloved of those in the psycho-social sciences: you toss the problem back to the customer, thus 'empowering' the customer. (A ghastly word 'empowering' – should be abandoned, discarded, abolished, forbidden, spat upon). The customer is then supposed to make what is called the 'right' decision. Well I guess there is something to be said for all this, but despite all that the theorists and the protagonists of this and that method say, those of us who make face-to-face contact with thirty to forty patients a day will know that the possibility of the patient becoming an 'informed' decision maker is indeed a forlorn one; a bit like hoping for Elle to drop into your bed. And besides, a large segment of the population isn't interested in acquiring 'knowledge' about their condition, whatever the condition is. They want a simple decision about what to do; some clear description of what's going to happen, but they expect you to make the decisions. Pragmatism? Surely. Convenience? Surely. Unempowering? Certainly.

One of the prettiest examples I encountered of decision-making was during a visit I made as an assessor to a general practice in a small country town. The surgery started at 9am and by 11am the practitioner, with me sitting unobtrusively in the corner, had seen 28 people. Twenty-eight; I kid you not. They came in, got their skin disorders treated, their pills for this and that prescribed, and had various simple physical checks done without any gossip or deviation or flannel. One, two, three...twenty-eight. At the end of this remarkable performance (and examining the situation medically I could see nothing wrong with the standards of physical treatment) I said to this man, "How come I don't see people like those I have in my surgery with psychological problems, problems of living and so on?"

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"Oh," he said, "I haven't time for all that. If they want those matters looked at they see my wife."

I must have looked somewhat baffled as he pursued, "She's in the surgery every afternoon and if they've got that kind of a bother she deals with them."

Later I met his wife, a charming and obviously very competent lady. She was not a doctor, nor a psychologist, and had no training in counselling, but she seemed to have that wonderful attribute called 'common sense'. And later on I talked to a number of patients who, while recognising that their doctor did perhaps have a slightly unorthodox way of doing things in general practice, were enthusiastic about him and more particularly about the combination – the husband/wife combination.

Well I left to go home – another four hour drive (I'd left at 5am to get to the morning surgery by 9am) and I thought and thought about all of this. How did he make his decisions?

How did he eliminate the negative – in this instance the psychological problems? And those self-referrals to his wife which were apparently so successful – just how did these work? Exactly what sorting out process of diagnosis did he use? Was he really doing the best for his patients? Was this a good or a poor method of practice? Did it matter? And how did all this square with the precepts of the College I was representing?

Pondering on all this and consulting a number of colleagues as the time went by, after two months I was ready to make a decision. Such a time scale seems unusual for me, but you will appreciate the dilemmas I was facing. Anyway, I then got a phone call. The good doctor had decided to leave medicine and enter the church. He had no need for the assessment. Well, you can wonder about how he would get on with the parish work he'd be about to undertake, and I guess I'll never know. And for the record, I had decided, contrary to the advice of a number of colleagues whom I had consulted, to recommend his admittance to the College at the designated level. Collusion? Well, think about it.

Anyway, take what you will from this little tale. I was impressed by the doctor's physical diagnosis. But I was more impressed with his wife, her assuming the pastoral functions of a doctor and her display of what I thought was 'common sense'. Don't ask me to define common sense. Try John Ralston Saul if you must – and you will probably be as confused as I am about it.

I suspect the good lady gave advice, listened, probably did a little more counselling, although she most likely did what most of us do, combined counselling and advice. Perhaps she might even have 'empowered' some people. But it was her common sense that struck me as being such a feature of her afternoon activities. It's not a common quality amongst general practitioners, and never once in my years of listening to people talking about decision making do I recall anyone discussing the merits of common sense, or discussing the qualities that presumably go towards making common sense.

You'll have gathered that I am a 'believer' in common sense, even if I don't know how to define it, even if I can't enunciate its components, and even if I do think I can recognise it. But it probably doesn't matter much about the understanding of all this. When you think about it, it seems impossible to know whether, for instance, a training scheme in general practice is of any real use. Proof of efficiency? Proof of common sense? Get real. That is, don't get complicated. Keep it simple. It's only common sense to do that.