WORKSHOP REPORT

Workshop on decision making in general practice

From 1–4 December 1983 about fifty delegates from all over the world gathered in Nottingham to hear papers and discuss decision making in general practice. Dr Nigel Stott gives a personal view.

YOU, the reader, will soon be able to judge for yourself what was achieved as the papers and discussants' summaries will be published by mid 1984, remarkably quickly thanks to modern word processors, dedicated organizers and a willing publisher. What follows is a personal view which makes no attempt to be either comprehensive or platitudinous because the real value of such occasions is always the small group discussions over meals and elsewhere which are kindled by the formal sessions.

One of the most interesting features of this meeting was the mix of clinicians, psychologists, educationalists, social scientists, computer experts, statisticians and academics of various kinds; this led to some diversity of values and perspectives and enlivened some of the discussions, but frustrated others.

Model mania

The first session, late Thursday afternoon, led to an extraordinary debate over use of the word 'model'. Anne Cartwright was dismayed by models and feared that the academic orientation of general practitioners may be weakening their relationship with patients. Others argued about semantics: should we speak of models or frameworks or constructs or conceptual diagrams or *aides memoire*? What is quite clear is that the term 'model' has very clear meaning to the mathematicians, chemists and students of physics: it implies measurable and predictable relationships between variables which can be combined to predict exact outcomes. Biologists and social scientists can seldom use the word in this sense. Paradoxically the cue to this debate was Professor Howie's use of the doctor-patient-disease triad (after Balint) yet in his paper he has not used the word 'model' at all. Dr F. M. Hull attempted to steer discussion towards consideration of the barriers which inhibit early diagnosis, treatment and prevention, but this was hardly heeded and the Chairman paled as the debate reeled back again and again to a 'model' as tool, toy, construct and destruct.

Decision making models

An elegant (33 page) review by Professor McWhinney on this theme is a scholarly and well referenced text which describes tension between two fundamentally different clinical methods in medicine, a tension which some delegates welcomed and others regretted. We were back to 'self-centredness' or 'patient centredness' in the consultation and the tidy historical summary of the historical and philosophical roots of these concepts, starting with General Smuts and 'holism' in 1926, was most refreshing.

Dr Jo Levenstein, well tee'd up by the previous speaker, launched into a practical account of his 'model for the general practice consultation'; unashamedly patient centred and sensitively constructed this package is compatible with the principles of emphatic interviewing. Expectations, feelings, fears, 'everything is significant', roared avuncular Jo. Studies to validate the model are underway now too.

David Pendleton (RCGP Stuart Fellow) pointed out that the rhetoric of general practice is patient centred, but the behaviour is doctor centred and that there is a need to elevate the patient beyond expectations, feelings and fears so that what the patient 'thinks' becomes valued 'let patients have theories and ideas' said the liberated psychologist from the Kings Fund Centre. The ever thoughtful Donald Crombie was less impressed and suggested that we must be flexible and willing to switch our *modus operandi* according to need. I heaved a sigh of relief, 'the principle of balance' was at last being described, but there remains a terrible risk of pseudo-profundity in all this. We need more outcome studies and fewer process descriptions.

One of the moving forces behind the conference, John Brooke, took the podium next. 'If you think you are a good decision maker, perhaps you are not', and he waggled his finger as he reminded us that 'hypotheses can be incorrect, cognitive bias is rampant, premature hypotheses may be dangerous and generalized models are of little value unless they encourage awareness of diversity'. 'Humans are not, after all, optimal decision makers' . . . John Fox then rose to the occasion with a paper still hot from the Imperial Cancer Research Laboratories press, to tell us how new computer based technology could assist us (the general practitioners) with the ever increasing complexity of medicine. His belief in the new systems which will think, absorb concepts, search for judgements (and behave almost like us) struck fear or excitement into the hearts of those who heard him. He implored general practitioners to become more involved and fashion technology to their needs.

The discussant (M. Fitter) asked us to begin to look on the computer as another aid . . . 'use it like any investigation or test to enhance diagnostic precision'. Freeling quoted Balint and said 'organizing disease is inherently dangerous', but someone muttered that disease is also dangerous in its disorganized state. Back to 'balance'; no tool or device will be wholly good, even the artificial intelligence systems can have side effects.

Diagnosis

A duet by Philip Marsden and Janet Gale presenting their work on the cerebral processes concerned with diagnosis threw light on the mechanisms of pattern recognition, thought processes and content. Concepts like 'forceful features' which act like catalysts to transform stored or perceived fragments of data were brought into our view. These intra-psychic events seem to be amenable to research. This had Robin Hull jumping up and down with excitement because the data matched some of his own perceptions and fascinations. Others with unusual minds also found that the concept sparked off possibilities in the field of artificial intelligence systems and man-machine interfaces.

Methodology

By Saturday morning the nocturnal group activities had relaxed the meeting and Professor Benston showed how our discipline can only hope to progress beyond its infancy if components of the diagnostic process can be described and identified with international accuracy. He reviewed the WONCA glossary for primary care, the encounter classification, process classification and pursuit of health status indicators.

Donald Crombie assured us that the new College classification is a refinement of the ICHPPC system with easy

code conversions downwards. Our European colleagues remain to be fully convinced that this is not just a last kick from the empire, but the issue is no longer as complicated as it was and it should be clarified very soon. Perhaps the most exciting developments will be in the realm of health status indicators and measures of function.

Two general practitioners from the UK led the next session. Nigel Stott encouraged the meeting to appreciate that the consultation in primary care can be approached in depth by researching some specific dimension or in breadth by looking from the consultation outwards. He illustrated the first with analyses of videorecorded consultations and the latter by application of the familiar *aide memoire* to help clinicians widen the potential benefits which can accrue from a disciplined consultation. Ben Essex excited the computer enthusiasts and his clinical colleagues by showing how he, with nothing more than a pack of cards, was analysing his decision making in his practice. Mike Pringle felt that this work could become a leader towards the development of artificial intelligence and decision support systems, particularly as computer systems can now match concepts and ideas.

Experience and current research

The Glasgow computer assisted diagnostic system for dyspepsia (Knill-Jones and Dunwoodie) excited a lot of interest as it has potential for teaching, audit research and service use. The next phase in general practice will be watched with interest. Measurement of areas of uncertainty by the Nottingham team provided confirmation of a phenomenon which is difficult but important to measure. Dr Aulbers (Rotterdam) reviewed the multi-factorial nature of referral decisions, helped by Donald Crombie who had also brought his data which confirmed the wide variance and complex reasons for referral. This is another field where studies of the outcome of referral are more likely to modify practices than further analyses of the process, for example the demonstration of the poor value to patients from most tonsillectomies has led to radically changed referral behaviour.

Implications for education, decision support systems and general practice

The Sunday morning reviews by Drs Alan Rector, George Brown and Ian Priban ranged over these concluding issues to orientate the audience after three days of very diverse papers. Brown's points about the qualities of an ideal course are an appropriate note to finish on: 'it should be active, relevant, safe, have objectives and meet needs (ARSON)'. The ensuing debate about whether you can feel 'safe' while changing your methods or thoughts or attitudes should emphasize how difficult it is going to be for many of us to cope with expert computer systems, extraordinary communication power and even artificial intelligence as these tools begin to move towards the front-lines of medicine.

All credit to the Nottingham team for such a well organized and hard-working conference.

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