Commentary: Theory and practice of making difficult clinical decisions

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The student patient described in this report excited widespread interest in the medical community.¹ As well as heartfelt sympathy for the patient and her family over this crisis, respondents have expressed empathy for the clinical team faced with the dilemma of offering best care. Some interesting threads have emerged in the correspondence.²

Doctors of many disciplines have modelled their thinking processes, and there are some wonderful examples of clinical reasoning. From the start, a majority of readers were highlighting the probability of adult onset Still's disease, but, as at the bedside, the twists and turns of clinical progression forced careful reconsideration. There was full endorsement of the decision to get a second opinion, and the value of multiple perspectives was mirrored in the wisdom of medical microbiologists, rheumatologists, and generalists in the web responses.² The importance of optimal communication with the patient and her family amid the uncertainty was lost on none.

How we make decisions

What can we glean from the responses about how doctors approach clinical decision making in difficult cases? Many of the experts did not cite their sources, and indeed much of the knowledge that comes into play for them is stored in rapid access memory banks. For those who did cite sources, the computerised diagnostic aid was the most erroneous, coming up with a single definitive (wrong) diagnosis. We are not there yet in terms of artificial intelligence in diagnosis.

Then there was the doctor who referred to, "My little *Oxford Handbook of General Practice*." She was

clearly on the right lines, showing the place of reliable pocket books in pointing us in an appropriate direction. A generalist commented that: "I have had to read more on Still's disease," demonstrating the importance of the next stage in accessing "just in time" knowledge. Other respondents, particularly those of specialist backgrounds, went to relevant reviews and into the primary and secondary literature.

Are we doing what experts on best evidence advise? It is now over 10 years since the *Bandolier's* 1996 new year resolution to "ensure that all decision makers can find the best available evidence on tests and treatments."³ At about the same time the science of decision analysis was being promoted,⁴ and much has since been published about the application of best evidence to clinical decision making.⁵ The web discussion suggests that the processes used by the medical community for complex dilemmas are thoughtful and effective but probably not as systematic as they might be.

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- 3 New year's resolution. *Bandolier* 1996 www.jr2.ox.ac.uk/bandolier/band23/b23-1.html (accessed 15 Sep 2006).
- 4 Richardson WS, Detsky AS. *How to use a clinical decision analysis*. Center for Health Evidence www.cche.net/usersguides/decision.asp (accessed 15 Sep 2006).
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To do is not to do

While reading an edition of *Classical Rock* magazine, I was struck by a comment on the musical style of David Gilmour, Pink Floyd's guitarist. According to the writer, Gilmour had a unique style—in his use of pauses between notes, those deliberate silences. In other words, he knew when not to play. It was that remark that made me think about the way in which I practise psychiatry.

As doctors, we are trained to treat illness, to make a change, to do something. We don't readily acknowledge that there are times when it may be better not to do anything. For the most part, we are taught that, when interviewing a patient, we must give him or her freedom to talk without interrupting. How often though, do we allow that same principle to be applied to our therapeutic interventions?

Most of us are aware of the "watchful waiting" approach with prostate cancer. In psychiatry, there are less clear examples. However, in the case of debriefing of trauma victims to prevent

the development of post-traumatic stress disorder, this was later found to do more harm than good. For the management of mild depression, a short period of watchful waiting is also recommended. When it comes to psychosis we occasionally come across patients with a long history of illness who have been receiving medication for years and show some residual symptoms. For some of these patients, it might be wiser not to make any change to their treatment as they are quite satisfied with their lives. I personally have encountered more than a dozen of such patients.

We need to believe that sometimes not doing anything is a positive action to take. However, that doesn't mean we should merely let nature take its course. It is more a case of knowing when to appreciate the graceful pauses in a guitar melody.

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