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Clinical problem-solving

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During the last 25 years there has been an unprecedented amount of change in all areas related to health care: successive re-organisation of the National Health Service, devolution of psychiatric services, structured post-graduate education, new investigations and treatment techniques, to mention a few. In a rapidly changing culture, it is timely to focus on those components of our professional work which are of enduring importance – establishing rapport with patients and families, history taking and skilful examination of the mental state – but the most important is the ability to make an accurate diagnosis which is the key to successful patient management.

There are other reasons for giving accurate diagnosis the highest profile. During the last two decades there has been an escalation of multidisciplinary working and more recently community mental health teams are being established. This is desirable practice but there are potential disadvantages. In these developments, together with some of the initiatives linked with community care, there are real anxieties that the importance of precise, clinical diagnosis is being eroded. With the active encouragement of government, more patients will be referred directly to community psychiatric nurses. In many instances this will occur without accurate diagnosis and therefore the opportunity for treatment will be missed. If no steps are taken to prevent this happening on a substantial scale, a situation of "custodial care" in the community could come about.

The importance of this subject was recently highlighted when the *New England Journal of Medicine* introduced a new feature: 'Clinical Problem-Solving' (Kassiner, 1992). This innovation is devoted to looking closely at the process of how a physician in busy practice faces up to complex diagnostic, therapeutic and ethical issues. It recognised that this is at the heart of the art of medicine and that medical journals failed to teach unstructured problem-solving and had failed to reflect the challenges and rewards of the practice of medicine. It was hoped that the series would be interesting and reader-friendly in contrast to most of the original articles which contained a significant amount of technical material and to the average general reader was very heavy going. At the same time the series would provide valuable insights into how a skilled clinician arrived at crucial decisions in his work.

The change in the content of psychiatric meetings and conferences mirrors what has occurred in medical journals. Case presentation at hospital level is still universal practice but is a very infrequent event at larger psychiatric meetings. Individual case presentation is not encouraged and is frequently deemed unscientific. This is to be regretted as much can be learnt from individual cases and from the way expert clinicians handle complex information and arrive at decisions. Clinical problem-solving should be seen as a vital activity within the psychiatric profession. Its rehabilitation as a challenging essential activity is timely.

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