I have found my experience working within the CCIS a challenging and rewarding one. It has given me the opportunity to meet and liaise with many professionals of different disciplines.

I feel that the roles and responsibilities within a non-hierarchical multidisciplinary team need to be defined. In my own experience I found it challenging to explain and defend my assessment and opinion to other professionals. Some have proposed that a doctor should take a leading role within community care (Stuart & Waters, 1985). This requires the acquisition of the necessary skills and experiences. In this respect CCIS work has given me the opportunity of gaining management skills, and of professional and personal growth.

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Expert opinion

Community ward rounds

(T. BURNS (1990) *Health Trends*, **22**, 62–63)

It is interesting to observe just how much (or little) psychiatric services adapt to changing circumstances. The progressive move to community care, with the resettlement of seriously ill patients outside hospital and the avoidance of admission for many acutely ill patients, has shifted the focus of the psychiatric team away from its traditional institutional base – or rather the focus should have shifted. Yet it is probable that many psychiatrists, while paying lip service to the needs of patients in the community, have not altered their weekly routine. Hospitals, and the security they represent, retain their magnetic attraction for many staff. But with the growing number of out-patients and chronically disabled patients being supported by team members outside hospital, how should the multidisciplinary team respond?

Nine years ago my sector team moved to a smaller ward. It soon became apparent that the ward staff expected the same amount of consultant time to manage a smaller number of patients. No extra time would be free for the growing army of patients outside the hospital walls. Our solution was to create an in-patient and an out-patient team. Each team consisted of a consultant, SHO/registrar and social worker. The out-patient team also had the services of two community psychiatric nurses (CPNs). I began to hold weekly 'out-patient rounds' (Pullen, 1987). These meetings are the equivalent of the conventional ward round. New patients are discussed in detail, problems with current patients or families are aired, and occasionally patients, couples or families are brought into the meeting for a 'case conference'. This is also the forum for setting up joint home visits, to negotiate a change of key worker or for any team member to raise problems for discussion and obtain support. Finally, this is the forum for team planning.

Tom Burns (1990) describes a similar, but rather more structured 'community ward round' in his Wimbledon service. To the list of functions above, his meetings add the allocation of new patients, the making of diagnoses on patients presented, and a review of all patients after eight sessions to prevent the development of excessive case loads. A number of rating scales are used, especially by the CPNs.

I have some reservations about the Wimbledon model, which perhaps reflect my own inability to move fully towards a team with very blurred roles. I

do not like allocation meetings as, in practice, these delay action being taken. Also I am unhappy about making a diagnosis 'by proxy'. I expect my SHO to see new cases with me nearby so that I can also see the patient briefly to confirm the main findings and agree a diagnosis. This is essential since I am invariably working with doctors in their first year of psychiatric training. On the other hand, I admire Burns' ability to 'establish obligatory procedures' within his team. My team works more like an informal co-operative within which roles are clearly defined. I can impose obligatory procedures on the junior medical staff, but not on my colleagues from other disciplines!

It is timely for each clinical team to review the balance of time devoted to its various tasks and responsibilities and the 'out-patient/community round' is worth exploring.

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As an inner-city general practitioner, I read Dr Tom Burns article 'Community Ward Rounds' with interest and disquiet. It raises several issues worthy of discussion.

The recent closure of large numbers of hospital beds for the seriously mentally ill has focused attention on community care. In common parlance, community care refers to the attempted management of discharged hospital patients. In its broader sense community care should be defined as the management of mental illness in the community at large, whether or not the patient has received specialist supervision (Shepherd, 1989). In the NHS the basic responsibility for the care of the majority of these individuals rests with the GP. The patients referred to in Dr Burns' article represent only a small fraction of the total number of mentally ill in the community.

I was therefore surprised to see in his article only one glancing mention of primary care in which the GP is described as a "co-ordinator". Co-ordinator of what? Dr Burns' article relates to the particular skills of a specialist team focusing on a particular group of patients. No mention is made of the special skills of the GP who alone accepts responsibility for continuity of care and knows that ultimately the buck stops with him or her. Further, it is the GP who has to cope with the vast majority of psychiatric patients who never reach specialist care.

The nature of the GP's job means that he/she will be responsible for:

(a) *Out of hours cover.*
Psychiatric crises have a habit of occurring out of office-hours.

(b) *Dealings with the patient's family*
In many instances a GP will already have a trusting relationship with a patient's family from whom he acquires knowledge of a patient's mental state or inability to comply with treatment.

(c) *The use of the Mental Health Act*
If and when there is a crisis, a GP's experience in the use of the Mental Health Act, combined with his relationship with the family, can lessen the trauma and distress to all concerned.

(d) *Everyday management of minor psychiatric illness, comprising 15–20% of the total workload*
This includes diagnostic assessment, counselling skills for psycho-social problems, and an understanding of the use and limitations of psychotropic drugs.

(e) *A personal relationship*
Many patients are confused by too many team members and will direct their problems at the GP despite other available resources.

On the basis of my own experience as a *practising* GP and as a teacher I would regard the GP as a "doer" as much as a "co-ordinator".

For a primary health care team to work effectively with a wide range of patient problems I feel that community psychiatric nurse and social worker attachment schemes are vital, a point that is not mentioned in Dr Burns' article. His hospital-based perspective fails to recognise the active part that the GP plays in the management of psychiatric patients frequently unknown to the psychiatrist and his or her assessment team unless they work in the surgery.

Finally there is the time-factor. Very few inner-city GPs are likely to be able to devote two hours to a weekly ward round of the type described in the article. I would be very interested to know how far Dr Burns' programme of community care will actually address the needs of the mentally ill in the community.

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