On formulation

DEAR SIRS

In the *Bulletin* for August 1983 (**7**, 140–2), Julie Hollyman and Loic Hemsi present a study of what psychiatric clinicians understand by 'formulation'. It may be of interest that formulations were part of the routine at the Phipps Clinic in Baltimore at the time when I served as an intern there in 1928–30. A case history was not considered complete until the important facts had been formulated, the principle being that a formulation should cover the needs of those for whom it was written. There resulted a series of formulations, the most important being: formulation for Dr Meyer (also for the staff of the clinic); formulation for the nurses; formulation for the patient's family; and formulations for the patients.

Each formulation could cover a half to two typewritten pages, and would contain all essential facts. They thereby served the practical purpose of relatively easy access to the case history without necessarily having to study the complete history—which at the Phipps could be of considerable length. It also served the important matter of secrecy, in that it kept the principle of 'intraclinical discretion' in our mind.

For me as (I guess) for most Meyer pupils the standard of clinical work at the Phipps has been an ideal, difficult to reach, and in my own hospital a complete set of formulations has been the exception rather than the rule. But I can state with confidence that the principle of formulating a case has been one of the guiding stars of my clinical work—more or less!

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DEAR SIRS

We would like to make some brief comments on two recent contributions to the *Bulletin*. First, Julie Hollyman and Loic Hemsi's paper (August 1983, **7**, 140–3) on what constitutes a psychiatric formulation, whilst very interesting, is not the first publication of this type, and unless her survey of College examiners reveals a high level of agreement (unlikely), we will still witness the frantic last-minute consultations of utterly confused examinees in the 'sweat-box', or the calmer deliberations of those on beta-blockers. In the absence of strict guidelines from the College, we recommend that examinees ask the examiners if they require the 'short' (summary of positive points only—in the manner of a good resumé by a registrar to his consultant over the telephone) or 'long' (as for a discharge letter sent from one psychiatrist to another) formulation. In this way, the onus for definition is appropriately shifted in the direction of the immediate policy-maker. It may be of interest that one of us was not asked for either the 'history' or the 'formulation', but rather for the 'diagnosis' and a discussion of the research basis for same (psychopathic personality with secondary alcoholism).

Regarding Hugh Koch and Richard Scorer's paper on the training of psychiatric trainees in psychotherapy (August 1983, **7**, 146–7), we would like to draw the reader's attention to a recently published piece (O'Shea *et al*, 1983) on the attitudes to psychotherapy and its training among trainees in the Eastern Region (with 94 postgraduate students) of Ireland. Using a postal questionnaire, it was found that there was a strongly positive attitude to psychotherapy, but, unhappily, formal training was uncommon and inadequate. It is interesting to note that trainees, on average, reported that 11 per cent and 91 per cent of their patients were treated predominantly with psychotherapy 'alone' and psychopharmacology 'alone' respectively. We have also prepared a report on the same subject for Northern Ireland. In conclusion, we would urge that instead of increasing the ideological gulf which exists between psychotherapy and somatotherapy, and in agreement with Freud's dictum of 1905, the emphasis should be placed by the teacher on a sound match of client and therapy, rather than fitting a patient to suit any dogmatically limited treatment repertoire.

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DEAR SIRS

The correspondence about formulation drags out interminably, but I for one am not sure why such a mystery is made of the whole thing. A good formulation is simply an assessment of the patient in terms of past, present and future, and can be taken both logically and comprehensively under these three headings:

Past: How did the patient get to where he is? Follow here a temporal sequence as in the general plan. What were the remote (hereditary, childhood), intermediate (personality, marital, occupational) and more immediate (recent stresses, medical illness) factors that have brought the patient to his present position?

Present: Where is the patient now? Mental and physical state, differential diagnosis.

Future: Where does he go from here? Investigations, treatment and prognosis.

https://doi.org/10.1192/pb.7.12.225-b Published online by Cambridge University Press

I have found that these sub-titles, located in the candidate's head rather than on paper, are a valuable aid to clear thinking and make a serious omission less likely.

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(This correspondence is now closed—Ed.)

Working party on psychiatric tutors

DEAR SIRS

I write to inform readers that the Trainees' Committee of the College has recently set up a Working Party to examine problems in the present system of Psychiatric Tutors. Already the role of the Tutor is essential to the development of a good training scheme, and proposals have been put forward which would give the Tutor a greater role in the training of individuals (e.g. in sponsorship for the examination). However, there have been reports that, in addition to other problems, some tutors have had difficulties in finding sufficient time from clinical work to perform their tutorial duties adequately.

We would be grateful to receive comments from tutors or trainees about any problems which they have encountered with the scheme. These may be in the form of ideas for changes to the system generally, or in the form of specific experiences. If you wish to communicate with the working group, please write to the convener, Dr Chris Thompson, at the Maudsley Hospital, Denmark Hill, London SE5.

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Physical Treatment Units

DEAR SIRS

It was interesting to read Dr. White's letter (*Bulletin*, July 1983, **7**, 128) describing the setting up of a Physical Treatment Unit and the part that this played in the rehabilitation of long-stay patients. Working as a registrar in a general psychiatry unit, I have had responsibility for a large long-stay ward, and we have attempted to operate a similar system for the past six months.

In the hospital concerned, Middlewood, we already had a clinic that is visited by the physicians from a local general hospital. This facility is, however, primarily for the purpose of dealing with medical problems, and being an extension of out-patient facilities, it does not cater for the 'crop of physical ailments' mentioned by Dr White.

We therefore set up a 'GP surgery' on the ward. This was manned by a local GP, who had been contracted to do some clinical assistant sessions. It had been noticed that the ward residents always referred to the nursing staff whenever they had a problem or request. This surgery was part of an attempt to encourage patients to seek out the appropriate agency to help them with a problem, in this case a doctor, rather than going to the nurses and having everything arranged for them. The provision of a local GP, working as a GP, offered a simulation of life outside the hospital environment.

In the six months that the scheme was in operation, it was not entirely successful. Residents did not, on the whole, attend the clinic spontaneously, but had to be taken along by the nursing staff. The one resident who did come along spontaneously appeared to see the exercise as an opportunity to harangue someone new, rather than to get physical problems solved.

Due to changes in medical and nursing staff rotations, it has become necessary to stop the scheme. In retrospect, I feel that a slightly different approach would have increased the likelihood of success. A single ward population is perhaps too small to give the system a chance to work; a system covering a group of wards or the entire hospital would be more appropriate. If the problems of available space and staff could be overcome, a site outside the ward environment should be sought for the clinic. I also feel that six months is not sufficient time for long-stay patients to get used to such a scheme.

In conclusion, I feel that this experiment has been a worthwhile exercise, and provides useful experience for further ventures of a similar kind.

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Consent to treatment in the Mental Health Act

DEAR SIRS

Bridgit C. Dimond's article (*Bulletin*, August 1983, **7**, 145) was very interesting and thought-provoking, but I wonder whether anyone could enlighten me on a further point. Under the Mental Health Act (1959) it appeared that, strictly speaking, nobody was able to give consent to an operation for any non-lifethreatening condition occurring in a severely subnormal patient over the age of 16: by definition, the patient himself was incapable of giving valid (i.e. informed) consent, but being over the age of 16, his parents/guardians were not entitled to do so either. Has anything been done to rectify this or is the situation as bad (or worse, which is the usual result of 'improving' legislation) as ever?

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https://doi.org/10.1192/pb.7.12.225-b Published online by Cambridge University Press