# Correspondence

## *Guidelines on formulation*

DEAR SIRS

I am reluctant to criticize the excellent advice given by Dr Greenberg and others (*Bulletin*, September 1982, **6**, 160-2) on how to please one's examiner in summarizing a psychiatric patient. However, if the word is to retain any meaning it is essential to preserve the distinction between a 'formulation' and a summary. In labelling his advice 'guidelines on formulation' and then describing a summary, Dr Greenberg does us a disservice.

It is well known that the human mind, even that of a psychiatrist, can only hold on to a certain number of items while making decisions (e.g. de Dombal, 1972). The purpose of a formulation is surely to assist this decision-making process by eliminating irrelevant facts, leaving simply the items relevant to the diagnosis and management. Thus, information which 'brings the patient to life as an individual' (such as the fact that he drove a police car off Eastbourne pier complete with three policemen passengers) is precisely what should be *omitted* from a true formulation.

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REFERENCE

DE DOMBAL, F. T. *et al* (1972) Simulation of the diagnostic process: a further comparison. *British Journal of Medical Education*, **6**, 238-45.

DEAR SIRS

The excellent letter from Maurice Greenberg *et al* (*Bulletin*, September 1982, **6**, 160-2) and the appended format for a formulation, are both timely and sensible. There is no doubt that the attempt to create coherence out of disagreement, by the device of 'the formulation', has in itself led to confusion among candidates and examiners. This needs to be resolved urgently, before the next exam if possible, and I am sure many candidates are hurriedly photocopying the suggested outline referred to above.

However, there are alternative views. One would be that the formulation be part of the written exam. Given the kind of structure and details included in Dr Greenberg's format, I can imagine few candidates being able to produce a proper formulation in the five minutes traditionally allotted for 'marshalling one's thoughts'. A compulsory question, on the other hand, based on a detailed case history and mental state, would be an excellent test of formulatory acumen. More radically, a good solution would be to abolish the whole notion and return to accepted medical terminology such as *aetiology*, *diagnosis*, and *prognosis*. My reasons are based on a brief review of past attempts at defining 'formulation', the muddle created, and the obvious adequacy of the traditional headings.

In the *Shorter Oxford English Dictionary* the verb to formulate is defined as: 'To reduce to, or express in a formula; to set forth in a definite and systematic statement.' In the *Notes on Eliciting and Recording Clinical Information*, published by the Teaching Committee of the Department of Psychiatry (Institute of Psychiatry, London: OUP, 1973) formulations are discussed under two headings, 'Initial' and 'Final'. Key components of the 'Initial Formulation' include:

1. It is 'the registrar's *own* assessment of the case, rather than a re-statement of the facts'.
2. Its 'length, layout and emphasis' may 'vary considerably'.
3. It should always include a discussion of the *diagnosis*, of *aetiological factors*, of a plan of *treatment* and of *prognosis*.
4. 'Regardless of the uncertainty or complexity of the case, a provisional diagnosis should always be specified, using the nomenclature of the "International Classification".'
5. The implicit notion that it is a written document.

In its 'Guidance to Candidates' (revised April 1979), the College uses similar language: 'A formulation is the candidate's assessment of the case and not just a summary of the facts.' It calls for a 'critical discussion of diagnosis, differential diagnosis and possible aetiological factors, together with a plan of management (including investigations) and an estimate of prognosis'. Unlike the Maudsley, a written formulation is not required.

Given these guides 'to formulating their formulation', many candidates find themselves in a dilemma, which can be stated quite simply. What magical 'quintessence' should I add to my four headings (Aetiology, Diagnosis, Management and Prognosis) to make it look like it is a formulation? Any doctor, reasonably trained, expects to go through the process of 'history, examination, special investigations' in order to reach a working management plan based on diagnosis (including differential diagnosis) and treatment. There is nothing extra to add in the psychiatric business, and however well padded out, a formulation inevitably ends up as little more than a summary of a good summary. In a clinical exam there is plenty of room for questioning the candidate about the wider aspects of history and diagnosis, without resorting to a false reductionism.

Perhaps the impetus to this slightly mystifying process has been the problem of clear psychiatric diagnosis, exacerbated by the debate about 'models' of illness. The first difficulty, that of diagnosis, is a fascination of the subject, and in itself usually provides a wide area of discussion when asked about

directly. Clearly the candidate should recognize the limitations of psychiatric diagnosis as compared with, for example, surgical diagnosis, should be able to relate individual patients to the various *syndromes* commonly described, and be able to argue cogently (and with humour?) for his particular choice of label. But that it is *diagnosis* that is under discussion need not be obscured by introducing other words, such as *formulation*.

The other problem, of differing models of mental illness, again needs nothing more than a proper understanding of the word *aetiology*. (In the *OED* this is: 'The assignment of a cause'; also, 'that part of medical science which investigates the cause of disease'.) A psychiatrist should be able to assess physical, social, cultural and family factors of causation, and include those relevant to a particular patient. Likewise, the dynamic and phenomenological models of basic psychopathology should be a routine part of his/her approach, integral with the physical and mental state examination. Again, there is nothing new about this: given that an ability to use varying viewpoints is an accepted part of our specialist training, we are the true 'aetiologists' of modern medicine. In fact, the sooner we can persuade our non-psychiatric colleagues to adopt a similar approach (and using jargon words will not help in this), the better it will be for the whole profession.

The words 'management' and 'prognosis' I will not discuss at length because the same argument applies. Perhaps the appropriate use of social agencies and other health workers is more widespread in psychiatry, and such involvement needs to be emphasized when discussing treatment options.

Given, then, that the formulation adds nothing to the accepted means of assessing patients, there remains the hazy idea of 'bringing the patient to life'. This is a difficult art (not a science) and requires skills accepted of a novelist or playwright, rather than a doctor. While several doctors have been outstanding writers (e.g. Chekhov, Somerset Maugham, Conan Doyle), there is little evidence that their medical training was essential to such descriptive powers. There is no doubt that a good mental state examination should be able to give a clear picture of an individual such that the examining consultants can imagine that patient as a person as well as a case. But the emphasis there is on the need for proper training in the mental state examination, not for any superadded formulatory skill.

A final important point is the continued need for psychiatrists to communicate with other medical specialties. By using a common language this may be enhanced; for the need to see the patient as a whole can be encompassed by the traditional terminology, and words such as 'formulation', with their faint overtone of alchemy and sub-Freudian mysteries, only serve to obscure. Many younger psychiatrists no longer feel any lack of confidence in their specialist abilities, until, that is, their doubts are renewed by the call for 'your formulation, doctor'.

I would ask, therefore, that recent and prospective candidates and examiners be consulted on this issue without delay. The beautifully clear outline of Drs Greenberg, Szmukler and Tantam would go very well as a written question, and itself uses traditional words for the six major headings. As they admit, it is a 'summing up' (i.e. a summary)—so let us call it that and end the present débâcle.

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DEAR SIRS

I entirely agree with Maurice Greenberg and his colleagues (*Bulletin*, September 1982, **6**, 160-2) that there is an outstanding need to assist postgraduate trainees in the construction of a formulation which is both useful clinically and agreed by the examiners of the College. I have found that trainees have difficulty in absorbing and remembering detailed instructions concerning formulation and I have invented an *aide-mémoire* which may be of interest to readers of the *Bulletin*. Although the order of items differs somewhat from the guidelines at St Bartholomew's Hospital, all the essential details are included.

**F**acts of life. This is a brief summary or picture of the patient as a person with any outstanding facts concerning social background, personal history and prominent personality characteristics.

**O**nset of illness or illnesses. This is essentially the presenting problem and includes the history of illness and recurrences over the patient's lifetime.

**R**ecent mental illness. This is a description of the illness under consideration with its mode of onset, duration, course and any social repercussions.

**M**ental state. This is the familiar description of the mental state at the time of examination but only positive features should be described in the formulation unless there is some very good reason for stating negative findings; for example, absence of intellectual deficit need only be mentioned if the patient is very elderly.

**U**mpteen diagnoses! My *aide-mémoire* nearly came to grief because I could think of no synonym for differential diagnosis. This is a light-hearted reminder for the trainee to consider the differential diagnosis in the terms of the St Bartholomew's format.

**L**ack of information. This includes any difficulties in obtaining information from the patient and any omissions from the history and sources of further information such as physical and psychological investigations.

**A**etiology. This refers to pathogenesis and psychodynamics in the case of neurosis or personality disorder and the evaluation of life events and stress factors.

**T**reatment. This is self-explanatory.

**I**n-patient management. Nursing, occupational and rehabilitative plans are discussed with other care options such as out-patient clinic, day hospital, day