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

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