Correspondence

Guidelines on formulation

DEAR SIR

There is considerable scope for disagreement in psychiatry: about diagnosis, aetiology and even the very nature of psychiatric disorders. In fact we find this is one of psychiatry's great attractions. It is presumably out of this large area of debate that the process of formulation evolved; a device whereby the features of an individual case can be discussed and evaluated in order to describe a series of probabilities which will guide the management. This seems to be an admirably flexible way to deal with the complexities and uncertainties of psychiatric problems and it is, therefore, both sensible and necessary to focus attention on this skill in the qualifying examination.

We are concerned about the reports we have received from candidates about the various ways in which this skill is currently being assessed by some examiners. Comments such as 'This is a summary, not a formulation ...', 'The formulation does not include management ...' or 'Give us your formulation in two sentences, please ...' are not only unsettling, but appear to us to reflect an unnecessarily rigid point of view, particularly since the main function of the formulation is to avoid a dogmatic and inflexible approach to psychiatry. One of us has made videotapes of 15 'mock' clinical examinations and has been impressed by the lack of consistency in what the examiners regard as a 'formulation'.

In order to avoid a sterile debate taking place during the examination concerning the nature of a formulation, we would like flexible guidelines provided for both examiners and candidates in order to facilitate discussion about the patient and his/her problem which is, after all, the purpose of a clinical examination.

We have appended a format we use when teaching our students and suggest that this could be used as the starting point for debate.

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Guidelines on formulating a case for the MRCPsych Examination

The formulation represents your summing up of a case and its structure helps you in organizing your thoughts around the case's important aspects. It is the next step in understanding and evaluation after the basic history has been obtained.

Some general principles should be borne in mind. The formulation is about an *individual* case and general psychiatric knowledge should be introduced only in so far as it is relevant to the particular case. It should not sound like a textbook account of a psychiatric disorder as manifest in an individual. Although there is a fairly well accepted structure to the formulation, you need to be *flexible* in its use and to adapt it to the particular problems presented by the patient. For example, if the patient is unable to give you a good account of the history and is unable to elaborate on the content of his thinking, then more attention will need to be paid to the mental state examination and much of the discussion on management will be devoted to means of obtaining further information. The formulation should *bring the patient to life* as an individual rather than present the patient as an example of a particular psychiatric disorder.

You should be able to present your formulation in about 10 minutes but you should also be able to contract or expand it, to 5 minutes or 15 minutes for example, if the occasion demands.

The structure of the formulation

1. *Introductory comments*

It is customary to introduce some of the salient socio-demographic features of the patient in the first sentence, e.g. Mrs J. is a 40-year-old lady, divorced for 4 years, with 2 children, who works as a legal secretary and lives with her mother.

If you have experienced any difficulties in taking a history from the patient you could mention this next. The examiners will then know that they must take this into account for the remainder of the presentation—e.g. there were major difficulties in taking a history from Mrs J. as her attention was very limited and she was very unforthcoming in response to simple questions; Mr K. refused to answer questions on a number of subjects raised during the interview, e.g. his marriage, forensic history.

2. *The presenting problem*

This must be brief, usually a paragraph or so. State the main problems without any irrelevant detail. It is essential to make the *chronology* clear. Mention briefly how the patient's life has been affected by the problems. Obvious events closely related in time to the onset or exacerbation of symptoms could be mentioned here, as could a brief reference to treatments in the past.

An account of the important findings in the patient's *mental state* should then be given. The amount of detail you should provide will vary with the case. You might at this point only label the psychopathological features found (e.g. third party hallucinations, delusions of passivity) and reserve a more detailed discussion of the content for the differential diagnosis later. If you give details at both stages in the formulation you might find that you are wasting time with needless repetition.

3. *Differential diagnosis*

If there is little doubt about the diagnosis, say so—also say why. You will usually mention a few possible differential diagnoses and be able to dismiss them easily.

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