Micro-formulations exercise

1 Read the scenario

2 Making an initial micro-formulation

1 What might the referrer's story be?

Where are the gaps in the story as told in the referral letter?

What do the gaps suggest?

How might the referrer be feeling about the referral?

Can you intuit anything about the patient's relationship to the referrer and how this might have developed? What might this tell you about the patient's relationship to help more generally?

2 What is your story about this referral?

What do you feel reading the letter? (Upset, angry, sinking heart, calm?) What might this tell you?

What do you hope might be going on?

What do you hope it isn't?

What do your hopes suggest?

3 What might be the patient's story?

How might they be feeling about themselves? About the story?

How much do you think they feel in control of their story?

Can you see any assets, strengths, or values that the patient seems to have?

How might they view the problem?

3 Approach to patient

For each of the phases, think how your normal approach might need to be modified based on your initial micro-formulation.

Engagement

What challenges might you expect? How much is engagement likely to be the priority for this encounter? What might you need to pay particular attention to? What are your priorities for the first few minutes?

There are often engagement tasks in the last few minutes of a consultation as well as at the beginning. What might they be in this case?

Focussing

What are *the patient's* goals likely to be?

What focussing approaches might you use?

Thinking in terms of the three treatment trajectories (this session; this treatment episode; lifetime care needs), what are *your* goals likely to be for this session? Are there other goals that you might have for future sessions in this episode?

How might you align your goals and the patient's goals?

Are there particular areas you want to actively avoid in this session?

Evocation

How might you work with the change goals and dilemmas you have identified?

What difficulties might come up in the evocation stage? How might you address them?

Planning

What kind of plan do you want to come away with at the end of the session?

How does it fit with the patient's values? How does it use their strengths and assets?

What is the minimum safe plan you would accept?

What statutory obligations might you need to include in the plan?

5 Revision

After the initial contact with the patient, which of your initial impressions and intentions need revising?

Note for facilitators

This exercise is designed primarily for learners who are relatively new to MI. The purpose of the exercise is to cultivate learners' curiosity about the patient in a broader sense than they might have previously experienced and to encourage the responsible use of intuition. Holding curiosity while also holding on to 'not knowing' is a tricky skill: a coherent formulation can carry a highly seductive aura of truth for the clinician. Get the formulation wrong and it can be experienced by the patient as a reductive, dismissive and hurtful judgement made from a position of power. But it is difficult to navigate a consultation without some kind of hypothesis as to what is happening. The 'three stories' framework works partly to give some scaffolding to the 'not knowing' to make it more bearable. Coach the trainee to hold their initial hypotheses lightly and let them go easily. The hypothesis can't get in the way of listening.

In facilitating / debriefing the first story, it is important to take a competence approach: e.g. 'this letter is terrible, it doesn't tell you anything about the patient, the GP has just jumped to treatment' might evoke facilitator responses of:

- 'there are some gaps in the letter, that's an interesting observation, what might that tell you?' (possible response: the patient hasn't felt safe with the GP; the patient may be struggling to tell her story in a coherent way, a soft sign of trauma)
- 'working on the assumption that the GP knows what he is doing, what do you think it means that he hasn't communicated anything about the patients's subjective experience?' (possible responses: the GP is at the limits of his competence and has referred appropriately; the GP and the patient have both shied away from talking about something painful).
- 'that's an interesting point. Working on the assumption that the GP is doing his best with this patient, why do you think this letter is less than perfect? Has something about the patient pulled the GP away from their normal best practice?' (possible response: there is GP counter transference about desperately wanting to make the patient better without having to sit with the patient's pain)

In debriefing the second story, the key is to treat all reactions as useful where participants may not see the utility in their reactions: if the trainee feels frustrated by the lack of information in the letter, the response might be 'you're frustrated. What does that tell you? Might you be getting a small taste of the frustration of the GP or the patient for example?'. If the trainee feels cross that the letter is so thin on detail: 'you're angry. What might that tell you? Where might there be anger in this patient's story?' Suggesting trainees feel their way into what how their body is responding to the story (e.g. a racing heart or tightening fists) sometimes needs explicitly drawing out.

For more advanced groups, the exercise can still be helpful. It can be productive to talk explicitly about parallel processes, which can provide an extra level of challenge for a more advanced group:

- Do you see any patterns between the three stories?
- How might the patient be enacting something from her past in how she approaches the GP?
- You've got a sense of maybe how the patient has interacted with the GP. What might pull your consultation towards a similar relationship? How might you guard against this?

Variants

The exercise can be used to think about integrating other tasks within the four processes framework.

Assessment and diagnosis

As well as the three stories consider:

1 What is the most likely diagnosis?

2 What are the other *possible* diagnoses?

3 What is *unlikely* but is something you can't afford to miss?

4 What do you need to do to confirm your diagnosis and rule out your differentials (including the rare-but-can't-miss ones)? In terms of history taking and 'data collection', what is the minimum data set that you can safely leave the consultation with?

In the 'approach to the patient' part of the exercise, consider how assessment and history taking fits in to each of the four phases in an MI consistent way - e.g. in engagement with an open question or with 'typical day'; in focussing by fleshing out an agenda setting process.

Information giving

In the 'approach to the patient' part of the exercise, consider what and how you might need to tell the patient at each stage.

Metacommunication

In the 'approach to the patient' part of the exercise consider what you need to tell the patient about the process of the consultation. E.g. in the engagement phase, how will you set up boundaries (confidentiality, length of the session) that is compatible with engagement? In the focussing phase, how explicit will you be about how and why you are helping the patient prioritise? At the end of the planning phase, how will you close the consultation safely?