

Guideline: Using the patient assessment synthesise a multidimensional formulation

EPA 3

Description

This entrustable professional activity entails the synthesis and application of a comprehensive sociopsychobiomedical framework to evaluate and manage patients experiencing pain. Formulation represents a 'capstone' capability because it draws together the clinical assessment, reasoning, contextual interpretation, communication and management prioritisation.

The physician integrates biological, psychological, and social dimensions of a patient's condition to construct a nuanced, person-centric understanding of pain drivers, maintainers, and modulators. This process involves critical appraisal and synthesis of the medical history, physical, functional and psychological assessments, social determinants of health, and the contextual factors that may influence pain perception and treatment outcomes. Operationalising the FPM formulation framework (diagnosis – function – context) physicians generate person-centred formulations that utilise a comprehensive clinical assessment to explain the individuals' pain experiences and directly inform tailored interdisciplinary pain management strategies.

Training stage to be completed in: Core Training Stage (quarters 2,3 and 4)

Details

By the end of Q2, trainees will be able to construct a basic formulation considering socio-cultural, psychological and biomedical aspects of the presentation in conjunction with the patient's strengths and vulnerabilities and the 4Ps - predisposing, precipitating, perpetuating and protective factors for the patient's pain.

By the end of the core training stage, trainees should be entrusted to construct and communicate a coherent multidimensional formulation for patients with complex pain, independently. This includes integrating diagnosis, function, context, sociopsychobiomedical domains and 4P factors; identifying key drivers, maintainers, strengths and vulnerabilities; acknowledging uncertainty and alternate hypotheses; explaining the formulation in person-centred language and linking it to management priorities.

Direct supervision should remain available for unusually complex, high-risk, culturally or socially complex, legally sensitive or diagnostically uncertain cases.

Related Graduate Outcomes

Clinician, Communicator, Health advocacy, Professional

Related roles in practice

Role in Practice	Related Learning Outcome
Clinician role	2.1.14 – Integrate sources of information from the social, psychological and biomedical dimensions into a multi-axial formulation of diagnosis, function and context 2.1.32 – Explain to the patient the multi-axial formulation and the proposed management plan
Communicator role	2.4.2 Communicate using a patient-centred approach that encourages patient trust and autonomy, and is characterised by empathy and respect 2.4.5 Recognise and negotiate challenging communication situations including conflict and emotionally charged situations 2.4.6 – Gather, prioritise and synthesise information from a variety of sources about the patient's pain experience 2.4.15 – Demonstrate effective written and verbal communication skills tailored to audience, purpose, intent and context

Collaborator role	2.5.8 – Facilitate comprehensive referral to another service when necessary
Manager leader role	2.6.8 – Demonstrate the ability to integrate the principles of opioid and analgesic stewardship to the management of patients prescribed opioids
Health advocate role	2.7.1 – Identify social determinants that are impacting on a patient's pain experience 2.7.2 – Identify opportunities for advocacy, promotion of health and improvements in quality of life for patients with pain 2.7.4 – Identify circumstances where advanced directives or plans particularly with respect to management of pain, should be formulated by patients and their families
Scholar role	2.3.4 – Demonstrate ability to integrate knowledge in the clinical and social sciences relevant to pain medicine 2.3.7 – Critically appraise scientific literature and translate evidence into decision-making about the care of patients
Professional role	2.2.12 – Incorporate health beliefs of the individual/community into management modalities in a culturally sensitive manner
Cultural safety role	2.2.9 – Demonstrate an understanding of how personal beliefs and cultural bias may influence interactions with others 2.2.11 – Demonstrate understanding of the cultural and social context in which pain is experienced

1. Knowledge expected to be demonstrated

Trainees must demonstrate the ability to generate hypotheses based on comprehensive information collected during the patient's assessment while recognising the iterative nature of case formulation, acknowledging that it evolves as additional data about the patient's history, behaviour, and environment are unveiled. This requires clinical reasoning incorporating knowledge of pathophysiological processes, genetic, developmental and psychological domains, and social determinants of health (e.g., support systems, occupational stressors, discrimination etc), ensuring a holistic and dynamic understanding of the person's pain.

Explicitly using a sociopsychobiomedical framework trainees must identify key predisposing, precipitating, perpetuating and protective factors, and prioritise which are most relevant to the current presentation and prognosis. The formulation should link these multidimensional factors to inform diagnosis, guide therapeutic planning, and communicate a cogent narrative for interdisciplinary care. Critical to this process is synthesising information coherently while remaining receptive to modifying hypotheses as the patient's condition and context are better understood.

2. Skills expected to be demonstrated

Trainees are required to –

1. demonstrate the ability to concisely synthesise patient assessment findings into a comprehensive, coherent multidimensional formulation. This includes evaluating predisposing, precipitating, perpetuating, and protective factors influencing the pain presentation. Key considerations include biomedical contributors such as comorbidities, genetic predisposition, and associated physical illnesses; psychological and psychiatric history, including substance use disorders; familial and social dynamics; cultural influences on symptom expression; the impact of the social determinants of health; developmental history, including early attachment issues and life events such as bullying or employment challenges; and existential factors, such as the proximity of death.
2. utilise the multi-axial formulation, to prioritise interdisciplinary management strategies and assess the patient's prognosis effectively.
3. integrate cultural safety principles into formulations for Māori, Aboriginal and Torres Strait Islander patients and other non-dominant groups, including recognising the impacts of colonisation, racism, discrimination and the social determinants of health (where relevant) and identifying opportunities for advocacy or system navigation arising from these insights
4. explain the formulation to patients (and, where relevant) their families and whānau, in accessible

language, checking that it makes sense to them and inviting opportunities for their input and correction

5. explicitly acknowledge and explain diagnostic uncertainty and alternate hypotheses when appropriate
6. sensitively and empathetically acknowledge and manage challenging communication situations, conflict and distress
7. present their formulations clearly and succinctly to colleagues and multidisciplinary team members, highlighting the key elements required for shared understanding, joint management planning and delegation of follow-up.

3. Behaviours expected to be demonstrated

Trainees are expected to -

1. consistently produce concise, coherent, multi-axial formulations that clearly distinguish and integrate diagnosis, function and context without major omissions or internal contradictions
2. adopt language that is respectful, non-pejorative and acceptable to patients, their families and whānau avoiding “pathologising” or blaming terminology.
3. demonstrate flexibility to revising and refining formulations as the presentation evolves and new data emerges
4. demonstrate reflexivity about their own assumptions and biases in formulating, and adjusting interpretations when feedback or new information suggests an alternative understanding
5. identify their own limitations seeking advice from supervisors and colleagues when encountering new or unfamiliar situations

Assessment method

Assessment includes:

- Structured case-based discussions focussed specifically on the formulation
- Long case assessments
- Presentation of patients in clinical meetings
- Review of correspondence
- Case conferences including morbidity and mortality meetings
- Multisource feedback
- Patient feedback following communication of the formulation to the patient

(not all methods are required for entrustment)

Assessment requires narrative feedback to trainees on their performance across a number of the above methods according to the following requirements –

- multiple assessors
- a minimum of one directly observed formulation and explanation to the patient
- at least one written formulation review
- evidence across several case types or settings (ETAs)
- a minimum of one piece of evidence involving team or meeting presentation

It is suggested that this EPA be assessed across a case-mix including where there is diagnostic uncertainty, high psychosocial burden, substance use risk, cancer or progressive life-limiting illness and social/cultural complexity.

References / resources

1. Clinical formulation in Learn@ANZCA
2. Centralised tutorial program

3. Selzer R, Ellen S. Formulation for beginners, *Australasian Psychiatry*, 2014: 22(4), 397-401. https://www.psychdb.com/_media/teaching/selzer_r_2014_formulation_for_beginners.pdf
4. RANZCP, Observed Clinical Activity (OCA) Formulation Guidelines for Trainees, 2012 Fellowship Program, 1-7. <https://www.ranzcp.org/getmedia/7661cf69-1319-42f2-8b82-714729735d12/OCA-Formulation-Guidelines.pdf>
5. Huang, Andrew; Armstrong, Ferghal; MELLOW, PETER (2020). Improving doctors' letters – towards rivers of living water. The University of Melbourne. Preprint. <https://doi.org/10.26188/13055570.v1>
6. Engel GL. The clinical application of the biopsychosocial model. *The American Journal of Psychiatry*. 1980: 137(5); 535-544.
7. Ross DE. A method for developing a biopsychosocial formulation. *The Journal of Child and Family Studies*. 2000: 9(1); 1-6. <https://link-springer-com.ezproxy.anzca.edu.au/content/pdf/10.1023/A%3A1009435613679.pdf>