CHARTER ON TRAINING OF MEDICAL SPECIALISTS IN THE EU

TRAINING REQUIREMENTS FOR THE SPECIALITY OF PSYCHIATRY

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SECTION OF PSYCHIATRY

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A - Preamble

The UEMS (Union Européenne des Médecins Spécialistes, or European Union of Medical Specialists) is a non-governmental organisation representing national associations of medical specialists at the European level. With its current membership of 40 national associations and operating through 43 Specialist Sections and their European Boards, 17 Multidisciplinary Joint Committees and 4 Thematic Federations the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the professional consensus on the framework for the highest possible level of their training which will pave the way to the improvement of quality of care for the benefit of all European citizens and beyond.

UEMS and its Postgraduate Medical Specialists Training programmes. In 1994, the UEMS adopted its Charter on Postgraduate Training aiming at providing the recommendations at the European level for high quality training. This Charter set the basis for the European approach in the field of harmonisation of Postgraduate Specialist Medical Training, most importantly with the ongoing dissemination of its periodically updated Chapter 6's, specific to each specialty. After the most recent version of the EU Directive on the recognition of Professional Qualifications was introduced in 2011, the UEMS Specialist Sections and other UEMS Bodies have continued working on developing the documents on European Training Requirement(s) (ETRs). They reflect modern medical practice and current scientific findings in each of the specialty fields and particular competencies covered and being represented within the UEMS. In 2012 the UEMS Council adopted the document Template Structure for ETR.

The linkage between the quality of medical care and quality of training of medical professionals. It is the UEMS' conviction that the quality of medical care and expertise are directly linked to the quality of training, achieved competencies and their continuous update and development provided to the medical professionals. *No matter where doctors are trained, they should have the same core competencies.* The UEMS ETRs reflect many years (or even decades) of experience on the ground of the UEMS Sections/ Multidisciplinary Joint Committees (MJCs) and Boards developing in close collaboration with the relevant European Scientific Societies training requirements coupled with European Medical Assessments. It is one among the clear aims of the UEMS ETRs to raise standards of training to make sure that European patients find high quality standards of safe specialist care. While professional activity is regulated by national laws in EU Member States, it is the UEMS understanding that it has basically to comply with international treaties and UN declarations on Human Rights as well as the WMA International Code of Medical Ethics.

UEMS and European legislation facilitating the mobility of medical professionals. The UEMS Council and its Specialist Sections, first created in 1962, have regularly provided advice and expert opinion to the European Commission. This helped create the framework that informed the drawing up of the Doctors Directives in 1975, which provided for the mutual recognition of medical diplomas and the free movement of doctors throughout the EU. The revised EU Directive on the recognition of Professional Qualifications (2013/55/EU) allows member states to decide on a common set of minimum knowledge, skills and competencies that are needed to pursue a given profession through a Common Training Framework (CTF) which represents the third mechanism that could be used to ensure mobility within the EU. This directive states that "p*rofessional qualifications obtained under common training frameworks should automatically be recognised by Member States. Professional organisations which are representative at Union level and, under certain circumstances, national professional organisations or competent authorities should be able to submit suggestions for common training principles to the Commission, in order to allow for an assessment with the national coordinators of the possible consequences of such principles for the national education and training systems, as well as for the national rules governing access to regulated professions".* The UEMS supported CTFs since they encompass the key elements developed in modern educational and training models, i.e. knowledge, skills, professionalism. In addition, the Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare introduced a strong incentive for harmonisation of medical training and achieved competencies among EU/EEA Countries through the requirements to assure good and comparable quality of care to increasingly mobile European citizens.

The UEMS ETR documents aim to provide for each specialty the basic training requirements as well as optional elements, and should be regularly updated by UEMS Specialist Sections and European Boards to reflect scientific and medical progress. The three-part structure of these documents reflects the UEMS approach to have a coherent pragmatic document for each individual specialty, not only for medical specialists but also for decision-makers at the national and European level interested in knowing more about medical specialist training. To foster harmonisation of the ETR by adopting more specific guidelines, the CanMEDS competency framework is recommended which defines the entire set of roles of the professionals which are common across both medicine and surgery. UEMS has an agreement to use an abbreviated version of the competencies within those roles.

Importance of making a distinction between Knowledge and Competency in ETR documents. Competency-based education is not oriented towards the period of clinical rotations, but towards trainee, and trainee's progress in the acquisition of competencies. Having a clear distinction within an ETR's contents between competencies and knowledge helps define both how that training should be delivered and how it should be assessed. The UEMS considers that the appropriate use of different methods of assessment of knowledge and acquired skills, emphasising the workplace-based assessment, is an essential component of quality postgraduate training, focused on high standards of specialist medical practice. To improve the methods of assessment it is also recommended to use the so-called Entrustable Professional Activities (EPAs) in all specialties ETRs. In order to recognise common and harmonised standards on the quality assurance in specialist training and specialist practice at a European level some UEMS Specialist Sections and Boards also have, for a long time, organised European examinations (supported and appraised by the UEMS CESMA - Council of European Specialist Medical Assessments).

Overlapping of learning outcomes and competencies. Each of the UEMS ETRs defines a syllabus or knowledge base and describes learning outcomes defined for given competencies. Some of these curricula encompass a whole specialty, others focus on areas within or across specialties and define content of the training requirements for specific areas of expertise. By recognising the potential overlapping it creates the opportunity for those writing ETRs to draft overlapping or common goals for learning outcomes. Similar measurement does not necessarily equate to the same targets. Rather, across different specialties the final goal may differ, i.e. there may be clearly defined individual goals for trainees with different expectations.

UEMS ETRs and national curricula. The UEMS strongly encourages the National Medical Competent Authorities (NMCAs) to adopt such requirements and believes that this is the most efficient way of implementation of good standards in postgraduate training. We clearly respect and support the vital role of the NMCAs in setting high standards of training and care in their respective Countries and checking through robust quality control mechanisms the qualifications of medical specialists moving across Europe. *The UEMS ETRs are developed by professionals for professionals and this adds unique value to them.* UEMS aim is to indicate the knowledge and competencies that should be achieved by trainees in EU/EEA countries and also competencies and organisation of the training centres. The training environment and results described in UEMS ETRs may be achieved in adapted ways, depending on local traditions, organisation of healthcare system and of medical specialist training. Adaptation of UEMS ETRs to local conditions assures the highest quality of specialist training and each state may include additional requirements, depending on local needs.

Importance of collaboration with other representative European medical bodies. The UEMS always wishes to work with all Colleagues, NMAs, professional and scientific organisations across Europe. In the process of ETRs development, the UEMS recognises the importance of meaningful collaboration with the other European medical representative bodies, the European Junior Doctors (EJD representing doctors in training), the European Union of General Practitioners (UEMO – Union Européenne des Médecins Omnipraticiens), the Standing Committee of European Doctors (CPME - Comité Permanent des Médecins Européens), the Federation of European Salaried Doctors (FEMS) and the European Association of Senior Hospital Doctors (AEMH - Association Européenne des Médecins des Hôpitaux). In addition, UEMS continues to develop closer links with the many European Specialist Societies. UEMS, in collaboration with its fellow European representative bodies, has constantly been highlighting the importance of coordinated postgraduate specialist medical training programmes always accepting the differing needs of different specialties. In this way quality medical care is delivered by highly qualified medical specialists - essential to ensuring consumer confidence and protection all over Europe.

Conclusions. UEMS is very proud for all the hard work that has been done until now in developing the UEMS ETRs as well as that they are increasingly implemented as national curricula. However, we also recognise the need for constant improvement, and we are always open to further suggestions. The UEMS insists that the medical profession remains the driver in defining its own specialist training and continuous professional development needs. On this basis, we sincerely look forward to working with the key European Union responsible bodies, as well as the national stakeholders in implementing the basic common strategies and requirements outlined with this initiative. We are confident that the priorities detailed in UEMS ETR documents developed for individual specialties (and/or competencies) will become evident in national strategies and programmes, as well as action plans for postgraduate medical education and training.

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B - Introduction

The UEMS Section of Psychiatry in consultation with National Associations of psychiatrists and other stakeholder organizations, including the European Federation of Psychiatry Trainees, developed the Training Requirements for the Specialty of Psychiatry. The content of the Training Standards was based on earlier documents produced by the UEMS Section and Board of Psychiatry, including The Profile of a Psychiatrist (2005, revised 2018), The European Framework for Competencies in Psychiatry (2009, revised 2022), Training in Psychotherapy as part of Training in Psychiatry (1995), Psychotherapy (2004), Supervision in Psychiatry (2002) and Psychiatry services focused on a community: challenges for the training of future psychiatrists (2004).

The Training Requirements for the Specialty of Psychiatry relate to the practice of psychiatry as it relates to adult patients. That is, mostly with people who have reached the age of majority. The Training Requirements for the Specialty of Child Psychiatry are being developed by the UEMS Section of Child and Adolescent Psychiatry.

I. Training Requirements for Trainees

1. Content of Training

a. Knowledge

b. Skills

c. Professionalism

1.1.1 The training process must include practical clinical work and relevant theory, covering biological treatment modalities, psychological and social treatment modalities.

1.1.2 The training process should ensure development of all aspects of the knowledge, skills, attitudes and personal attributes (professionalism) in the roles as Psychiatric Expert/Clinical Decision-Maker, Communicator, Collaborator, Leader, Health Advocate, Scholar and Professional as described in the European Framework for Competencies in Psychiatry (see Appendix 1)

1.1.3 Training should at least include practical experience of different areas of psychiatric practice including: exposure to psychiatric conditions throughout the life span, community psychiatry, consultation-liaison and psychotherapy.

1.1.4 Psychiatry is an integral part of medicine. Trainees should acquire and maintain adequate knowledge and skills to recognize relevant medical conditions and refer to other medical specialists when appropriate.

1.1.5 Trainees should have formal teaching about critical appraisal of literature, scientific data and evidence-based medicine, and have opportunity to participate in research related activities.

1.1.6 Trainees should have an active role in teaching, including the teacher of medical students, other members of the healthcare team, other healthcare professionals and the general public.

1.1.7 Training should foster general aspects of medical professionalism to enable the doctor to act in the best interests of patient and the public

1.1.8 The training process should ensure an increasing degree of independent responsibility as skills, knowledge and experience grow and this should be defined explicitly for each stage of training.

1.1.9 Trainees are expected to behave as adult learners and to take responsibility to fully engaged in the learning process. Each trainee must have a training log-book, training portfolio or similar document that is maintained throughout their specialty training in which, they record their learning experiences

1.1.10 Trainees should be involved in the formulation of mission and

outcomes statements of the training programmes

II. Organisation of Training

a. Assessment and evaluation

2.1.1 The training must include a process of assessment and the competent authorities must define and state the method used for assessment of trainees, including the criteria for passing examinations or other types of summative assessment. The summative end of training Psychiatry Board Examination that is being developed under the authority of a Joint Board of the UEMS Section of Psychiatry and the European Psychiatric Association will adhere to this requirement.

2.1.2 Assessment systems must include formative in-training methods.

2.1.3 The assessment system must have regard to Appendix 1 of this ETR and must demonstrate how all the competencies and supporting competencies in the Framework are to be assessed in a way that is fair and transparent, referring to the psychometric properties of the assessment tools that are used.

2.1.4 Competent authorities must demonstrate how the concept of Entrustable Professional Activities as described in Appendix 1 are incorporated in the assessment system.

2.1.5 The training should be directed and the trainee guided by processes of supervision and regular appraisal and constructive feedback from trainers, supervisors and teachers. This should include a minimum of one hour a week personal supervision for each trainee delivered by their trainer and a formal evaluation of the trainee's progress by the trainer and trainee twice a year.

2.1.6 The Chief of Training should ensure that each trainee's progress is formally reviewed against the relevant curriculum requirements at least once a year.

2.1.7 Trainees who are experiencing difficulties must be identified as quickly as possible and the difficulties described through reference to objective assessments. Wherever possible, remediation procedures should be developed in collaboration with the trainee concerned. There should be a procedure that is consistent with the legal requirements of the nation concerned to remove an unsuitable trainee from training. Participation of trainee organisations in developing this procedure is desirable. There should be an effective and independent appeal procedure for the trainee.

b. Schedule of training, (including access to specialty training)

2.2.1 Candidates for specialty training in psychiatry should have completed the study of medicine at one of the universities of the EU or associated countries or an EU recognised equivalent

2.2.2 The competent authorities and the medical professional organisations must agree on a policy on the criteria and process for selection of trainees and must publish and implement it

2.2.3 The trainee should have sufficient linguistic and communication skills to communicate with patients, their families, and other health professionals and the understanding of scientific literature

2.2.4 The overall composition, structure and duration of training and professional development must be described and must demonstrate how the training programme will meet its stated outcomes which should be sufficient to enable independent practice in psychiatry.

2.2.5. The minimum duration of training will be five years.

2.2.6. The training can take place in different institutions, either inside or outside the EU, as long as the training is recognized by a competent authority. Experience of a different training and mental health system as an observer (e.g. exchange programmes) should be promoted as a means to gain further skills.

2.2.7 Part-time (ie less than full-time) training should be possible in every EU member state and should be facilitated by general regulations.

III. Training Requirements for Trainers

1. Process for recognition as trainer

a. Required (requested) qualifications and experience

3.1.1 Responsibilities for the professional leadership for the psychiatry training programme must be clearly stated

3.1.2 The Chief of Training should have been practicing as a psychiatrist for at least five years after specialist accreditation as a psychiatrist and must also have five years experience of holding an educational role.

3.1.3 Trainers, supervisors and teachers must be officially recognised in their training institution. Therefore there should be transparent procedures for the appointment of trainers, supervisors and teachers. These must specify the expertise required and the responsibilities and duties of each post.

b. Core competencies

3.1.4 Trainers must understand the structure and purpose of and their role in the relevant training programme and they must be able to give constructive feedback on performance.

3.1.5 Trainers, supervisors and other personnel who are involved in the assessment of trainees both in the workplace and in formal examinations must be trained in the use of the assessment method and be clear as to what is acceptable performance.

3.1.6 Trainers must have training in adult learning theories, and demonstrate competencies in setting learning objectives, monitoring trainees' progress and in understanding the process to be followed in dealing with a trainee whose progress gives cause for concern.

3.1.7 Trainers must be trained in how to use logbooks, training portfolios or equivalent documents to support the learning of trainees. Where a specific e-portfolio is used, trainers must be trained in its use.

3.1.8 Psychotherapy supervisors are required to have a recognised training in psychotherapy and must be trained in supervision methodologies. The director of the psychotherapy training programme for psychiatrists must be a psychiatrist.

2. Quality Management for Trainers

3.2.1 Trainers, supervisors and teachers should receive regular feedback on their performance of these roles and must demonstrate reflection on this feedback. This feedback should include commentary from trainees

IV. Training Requirements for Training Institution

1. Process for recognition as a training centre

4.1.1 The training locations must be selected and recognised by the competent authorities which maintain a set of published standards for the approval of training institutions and a transparent process for taking approval away from institutions that fail to meet the standard

2. Requirement on clinical activities

4.1.2 Training locations must have sufficient clinical/practical facilities to support the delivery of training and sufficient number of patients and an appropriate case mix to meet training objectives. The training must expose the trainee to a broad range of experience in psychiatry and, when relevant, include both inpatient and outpatient care and on-duty activity.

4.2.2 The apprenticeship nature of professional development must be respected to ensure that the integration between training activities and service provision (in-service training) is assured. Clinical training should be complementary to and not subordinated to service demands.

4.2.3 The training must take place in a range of settings, in particular in community settings that are relevant to mental health services in that country. Trainees should receive training in a full range of specialist psychiatric services, including outpatient clinics, community mental health centres and day care, and emergency services including acute in-patient units and on-duty activity. The residents should also receive training in more differentiated mental health services focusing on specific problems such as eating disorders, addiction problems, early intervention services, assertive community treatments, a variety of vocational training programmes, as well as alternatives to both acute hospital beds (crisis and home treatment teams) and to those needing long term care (hostels and residential homes). Training personnel in primary care will continue to be an important task for psychiatrists, and trainees should receive training in this as well as in consultation-liaison services.

4.2.4 Psychiatrists in training need to have opportunities to develop skills at multidisciplinary practice and in multidisciplinary team-work and in working with other agencies.

4.2.5 Programmes must include theoretical and practical exposure to psychotherapy, including supervised practice. The quantity of such training should be defined and should consist of at least 120 hours of theoretical teaching and 100 hours of supervision of which at least 50 hours should be individual. The definition should include the number of cases to be included. At the minimum, the training must be sufficient to ensure that trainees can demonstrate acquisition of the relevant competencies in the European Framework for Competencies in Psychiatry. The experience should be gained with a broad range of diagnoses, including psychosis and with individuals, groups and families. It should include assessment and evaluation of outcome as well as research methodology as applied to psychological therapy. As part of this, a personal psychotherapeutic experience is highly recommended, but not mandatory. Where this experience is not available, there must be some provision of a learning experience in which the trainee has the opportunity to explore the impact of his/her thinking and feeling as part of the interpersonal contact with patients and to use this therapeutically. Training in psychotherapy should be in working time and should be funded as part of the training programme.

4.2.6 Acceptable standards of performance should be explicitly specified and conveyed to both trainees and supervisors

4.2.7 Trainees must have access to competent clinical supervision at an appropriate level to the trainee, from a named person at all times when the trainee is providing clinical services. This includes supervision in psychotherapy

3. **Requirement on equipment, accommodation, facilities, etc.**

4.3.1 There should be sufficient additional teaching personnel (trainers, supervisors and teachers) to enable the safe and effective delivery of all aspects of training

4.3.2 The time required for providing training, supervision and teaching must be included as responsibilities in the work schedules of trainers and their relationship to work schedules of trainees must be described

4.3.3 The trainee must have space and opportunities for practical and theoretical study and have access to adequate national and international professional psychiatric literature as well as equipment for training of practical techniques

4.3.4 There should support and resources for trainees in helping to ensuring that their logbook, learning portfolio or equivalent is kept up to date. This should include access to appropriate IT resources if an e-portfolio is used.

4.3.5 Trainees should work in a safe environment, there should be systems in place to ensure their safety and they should have training in personal safety

4.3.6 When trainees are expected to stay in hospital accommodation, it should be safe, comfortable and socially appropriate

4.3.7 Training institutions must have administrative staff of sufficient numbers and expertise to support the implementation of the programme

4.3.8 Every trainee should have access to educational advice that should include appropriate guidance on professional, training and career development matters

4.3.9 Appropriate services should be made available to ensure doctors in training seek help if they become unwell. They should be supported and not feel stigmatized or punished in doing so.

4. Quality Management within Training Institutions

4.3.10 There must be evidence that training is adequately resourced, including evidence that trainers, supervisors and teachers have access to resources to ensure that they up to date in educational matters.

4.3.11 There should be a clear line of responsibility and authority for the budgeting of training resources.

4.3.12 The number of trainees in a Training Institution must be proportionate to the clinical/practical training opportunities, supervisory capacity and other resources available

4.3.13 There should be regular internal review of the quality of training provided. The internal review should be informed by a wide range of quality data, including systematic feedback from trainees, survey results, results of summative assessments of trainees, feedback from employers and evidence of impact of training on patient care. The data should provide assurance that each trainee receives one hour of timetabled educational supervision per week and should also measure the quantity of psychotherapy teaching and supervision delivered. The results of the review will be reported to all stakeholders, both internal and external. There should be evidence that the findings from the quality review are acted upon.

4.3.14 There should be an effective and independent procedure for the trainee who wishes to express complaints or appeal decisions about training matters.

4.3.15 Trainees should participate in local quality management processes

4.3.16 When visits to training institutions are conducted, they must follow explicit guidelines, such as those produced by the UEMS Section of Psychiatry

C – Glossary of Terms

Chief of Training
Sometimes known as Training Programme Director. This is the senior member of the faculty who is responsible for organising the training programme. Among other things, this person will be responsible for arranging the allocation of training posts. They will take a strategic and long term view of the training needs of the trainees for whom they are responsible.

Director of Psychotherapy Training
This person allocates and coordinates the psychotherapy training for psychiatrists engaged in a training programme. In some programmes this may be a senior psychotherapy supervisor; the role may be fulfilled by the Chief of Training.

Supervisor
A clinician, which may or may not be a medical doctor, who takes responsibility for supervising an element of a trainee’s work. This may be psychotherapy or another element of clinical work, or the trainee’s research, teaching or leadership activities.

Teacher
This is usually a clinician, which may or may not be a medical doctor, who delivers theoretical teaching to psychiatrists in training.

Trainer
A clinician, usually a medical doctor, who oversees a trainee’s development within a placement. This person is responsible for the trainee’s one hour per week of individual supervision. In some places, this role is referred to as educational supervisor

Training Programme
A training programme is a formal alignment or rotation of posts, which together comprise a coherent programme leading to completion of specialist training

Appendix 1

EUROPEAN FRAMEWORK FOR COMPETENCIES IN PSYCHIATRY

A – INTRODUCTION

In April 2007 the European Board of Psychiatry (part of the UEMS Section of Psychiatry), in collaboration with the European Federation of Psychiatric Trainees (EFPT) established a working group to draw up a competency framework for psychiatry based on the Profile of a Psychiatrist (UEMS Section for Psychiatry, 2005) and the UEMS Charter on Training of Medical Specialists in the EU (UEMS Section for Psychiatry/European Board of Psychiatry, 2003). The Working Group included medical educationalists, senior psychiatrists with expertise in training and psychiatrists in training.

The Working Group met on several occasions between 2007 and 2009. In its work, the Group was guided by the CanMEDS 2005 physician competency framework (Frank, 2005) and consulted the American Board of Psychiatry and Neurology's Core Competencies for Psychiatric Practice (Scheiber et al, 2003), the Royal College of Physicians and Surgeons of Canada's Objectives of training in psychiatry (RCPS, 2007) and the UK Royal College of Psychiatrists' Curriculum for Psychiatry Specialty Training, (Royal College of Psychiatrists, 2006). The group developed this framework for competencies through an iterative process that involved consulting national psychiatric associations, trainee organisations, patient and carer organisations, European Psychiatric Association and World Psychiatric Association.

The Section gave the final approval to the first version of the European Framework for Competencies in Psychiatry (EFCP) at their autumn meeting in Ljubljana, Slovenia on 17 October 2009.

Because medical education and the practice of psychiatry are continually evolving, it is intended that the EFCP will be seen as a living document that will be periodically reviewed and amended.

In 2016, the Section approved an Annex to the EFPC covering learning outcomes of knowledge, skills and professionalism required for the care of refugees and asylum seekers. These learning outcomes have now been incorporated fully into the EFPC.

Under the leadership of the Standing Committee on Training of the Section (SCT), the Section undertook a major update and revision of the EFPC in 2020-2021. The contribution of the following members of the Section to this work is gratefully acknowledged:

- Andrew Brittlebank Royal College of Psychiatrists

- Asilay Seker European Federation of Psychiatric Trainees
- Georgios Pagkalos Hellenic Association of Professional Psychiatrists
- Harold van Megen Dutch Psychiatric Association
- Ingo Butzke Swiss Society of Psychiatry
- Krzysztof Krysta Polish Psychiatric Association
- Marc Hermans UEMS Vice President
- Maria Fe Bravo Ortiz Spanish Association of Neuropsychiatry (AEN)
- Morten Selle Norwegian Psychiatric Association

The update of the EFPC continues to be based on The CanMEDS physician competency framework as amended in 2015 (Franke et al, 2015) and it drew on the revised version of The Profile of a Psychiatrist, which was approved by The Section of Psychiatry in April 2018.

In addition, the update has incorporated learning outcomes that emanated from the UEMS Section of Psychiatry Position Paper on the Use of Coercive Practices in Mental Health Services (UEMS, Section of Psychiatry, 2022), Training objectives for UEMS specialists pertaining to the care of adolescents and young adults (UEMS Council, 2022, attached as Appendix 2), and Incorporation of 'Genetics and Genomics' in all UEMS ETRs (UEMS Council, 2022).

PURPOSE OF THE EUROPEAN FRAMEWORK FOR COMPETENCIES IN PSYCHIATRY (EFCP)

The main aim of the European Framework for Competencies in Psychiatry (EFCP) is to provide a list of learning outcomes that national associations and other regulators of psychiatry training in Europe may refer to when constructing curricula for postgraduate training as well as systems for continuing professional development.

A curriculum is more than a statement of learning outcomes: it should also include descriptions of the training structure that is to be followed and the methods of learning and assessment that are to be used (Grant, 2006). Because these elements are determined by national conditions, the working group deliberately refrained from addressing them and in particular decided not to place the competencies into a professional development structure.

The EFCP should be read in conjunction with the Training Requirements for the Specialty of Psychiatry (TRSP) which was approved by the Council of UEMS in 2023. The TRSP sets out the standards that should be met in the postgraduate training of psychiatry in Europe. It is addressed to national regulators, national psychiatric associations and local educational providers. In simple terms, the EFCP sets out the 'what' of psychiatry training and the TRSP sets out the 'how'.

B - STRUCTURE OF THE EUROPEAN FRAMEWORK FOR COMPETENCIES IN PSYCHIATRY (EFCP)

The learning outcomes in the European Framework for Competencies in Psychiatry are arranged under the seven physician roles or metacompetencies, derived from the CanMEDS 2005 physician competency framework (Frank et al,2005 & 2015) as adapted for the UEMS Profile of a Psychiatrist (UEMS, 2005 & 2018). The seven physician roles consist of Psychiatric Expert/Clinical Decision-Maker, Communicator, Collaborator, Leader, Health Advocate, Scholar and Professional.

Each physician role is divided into key competencies, which are underpinned by supporting competencies. The working group has attempted to formulate the supporting competencies in an operational way that will facilitate the delivery of learning and assessment. In doing so, the group was aware of the need to strike a balance between the need to provide meaningful guidance and the risk of being over prescriptive.

The Framework includes a grid of suggested methods that may be used to assess the acquisition of each supporting competency. The rationale for the selection of assessment methods is described in more detail in the glossary of terms at the end of the Framework. The Framework also includes a description of how Entrustable Professional Activities (EPA) may be included as part of an assessment system and there is a description of a number of suggested EPA's.

1 Psychiatric Expert/Clinical Decision-Maker

	Knowledge	Competence	Performance
	Knowledge tests WE OE[1]	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
1.1.1 understand the history of psychiatry and how this has impacted upon contemporary psychiatry	WE OE		
1.1.2 conceptualise both mental health and mental disorder using different models such as biological, developmental, psychological, behavioural, sociological and systemic	WE OE		DOP DBD
1.1.3 understand the factors contributing to predisposition, precipitation and perpetuation of mental disorder as well as protective factors This will include but not be limited to genetics, the influence of family life, the effects of loss, trauma, abuse, forced migration, human rights violations such as torture, war, incarceration and politically, ethnically and racially based persecution. Protective factors will include personal resilience and social inclusion	WE		DOP DBD
1.1.4 understand the full range of psychopathology and international diagnostic systems	WE		DOP DBD
1.1.5 obtain a comprehensive psychiatric history appropriate to the patient's developmental level, including information from other sources		CE	DOP DBD
1.1.6 perform and document a psychiatric assessment with attention to cultural diversity including the ways that cultural and ethnic factors influence a person's response to and expression of distress and psychiatric symptoms and the influence of cultural factors and migration on common psychiatric disorders.		CE	DOP DBD
1.1.7 carry out and document a mental state examination		ASCE	DOP DBD
1.1.8 assess patient's capacity for decision making		ASCE	DOP DBD
1.1.9 assess patient's functional status		ASCE	DOP DBD
1.1.10 recognise medical conditions that are incidental, consequential or contributory to mental disorder and its treatment	WE	ASCE	DBD
1.1.11 perform and document a relevant physical examination		ASCE	DOP DBD
1.1.12 understand and interpret the results of the main psychometric assessments and psychological tests relevant to mental disorders	WE	ASCE	DBD
1.1.13 understand and interpret the results of the main neurophysiological and neuroimaging examinations relevant to mental disorders	WE	ASCE	

1.1.14 elicit and recognise signs and symptoms, and apply them to a multiaxial differential diagnosis		CE	DOP DBD
1.1.15 identify and appraise the factors affecting the course and prognosis of mental disorders	WE	CE	DBD
1.1.16 take into account the interaction between the disorder and personal life		CE	DBD MSAP
1.1.17 identify and appraise the factors affecting the course and prognosis of mental disorders	WE	CE	DOP DBD
1.1.18 draw up a diagnostic formulation including risk assessment		CE	DOP DBD
1.1.19 review and revise a diagnosis over time			DBD MSAP

Definition

Psychiatrists deal with the prevention, diagnosis and treatment of patients with mental disorders. To manage this, psychiatrists possess a defined body of medical and psychopathological knowledge and a defined set of procedural skills that are used to collect and interpret data, make appropriate clinical decisions and carry out diagnostic and therapeutic procedures using a combination of biological, psychological, and sociological methods, providing high quality, safe and patient centred care.

Description

Medical experts perform diagnostic and therapeutic activities involving the management of situations where medical prioritization and decisions are required. The distinctive features of healthcare services are that they are often complex and unpredictable. In some cases, priority setting and decision-making take place based on inadequate information and uncertainty about evidence and best practice. Medical experts' work requires the mastery of creative solutions based on health-scientific knowledge, skills, and abilities and ability to handle uncertainty. The role of the medical expert is central to the function of specialist psychiatrists and draws on the competencies included in the roles of communicator, collaborator, health advocate, manager, scholar and professional.

Competencies

The psychiatrist is able to:

1.1 Demonstrate diagnostic skills within defined scope of practice to investigate, describe and define psychopathological and other clinical findings.

1.2 Demonstrate therapeutic skills for effective and ethical management of the spectrum of diagnosed patient care problems. The therapeutic skills include especially: Biological treatment, Psychotherapy, Community psychiatric intervention. Ability to integrate treatment modalities to optimize treatment, (establishing) promoting recovery focused goals of

care and optimal patient centred management plan based upon a comprehensive biopsychosocial formulation of relevant aetiological factors

1.2.0 General Competencies

The therapeutic skills include especially:

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
1.2.0.1 establish, maintain & repair a therapeutic alliance			MSAP DOP
1.2.0.2 determine which available biological, psychotherapeutic and social psychiatric interventions are appropriate to the patient's treatment expectations, circumstances and culture	WE OE	CE	DBD
1.2.0.3 draw up, document and implement an integrated and individualised biological, psychotherapeutic and social treatment plan, including risk management in consultation with patient, carers and allied professionals		CE	DBD MSAP
1.2.0.4 use voluntary and involuntary admission and treatment measures appropriately in compliance with legal standards and ethical principles	WE	CE	MSAP DBD
1.2.0.5 recognise, prevent, and address adverse effects associated with therapeutic interventions	WE OE		DBD
1.2.0.6 perform and monitor basic medical interventions for the physical health problems encountered in the treatment of mental disorder			DBD DOP
1.2.0.7 perform basic resuscitation		ASCE	
1.2.0.8 optimise concordance with the treatment plan, with the expectation that treatment will be provided with the patient's consent, except on rare occasions			DBD MSAP
1.2.0.9 review, revise and document changes to a treatment plan over time			DBD MSAP
1.2.0.10 systematically evaluate outcomes, know when to terminate a course of treatment and facilitate appropriate follow-up	WE	ASCE	DBD MSAP
1.2.0.11 recognise and manage potential risk to self and others in a clinical encounter		ASCE	DBD MSAP

1.2.1 Biological Treatments

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
1.2.1.1 understand the theories that underpin biological treatments of mental disorders	WE OE		
1.2.1.2 use safely and effectively biological treatment methods in psychiatry on the basis of values and the best evidence available in consultation with patients (where possible)	WE		DBD
1.2.1.3 take into account the psychological aspects of using biological treatments, such as medicalisation, labelling, placebo effects and the meaning that prescribed medication carries for the patient			MSAP

1.2.2 Psychotherapies

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
1.2.2.1 understand the theories that underpin standard accepted models of individual, group and family psychotherapies available for treatment of mental disorders	OE WE		
1.2.2.2 practise psychotherapy safely and effectively on the basis of values and the best evidence available			DBD DOP

1.2.3 Community psychiatric intervention

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
1.2.3.1 understand the theories that underpin the models of social psychiatric interventions available for treatment of mental disorders	OE WE		
1.2.3.2 use safely and effectively social psychiatric interventions on the basis of the best evidence available			DBD
1.2.3.3 engage with local social and cultural networks, voluntary organizations and self help groups			MSAP

1.2.4 Demonstrate skills in utilizing the social context as a tool for psychiatric rehabilitation and recovery

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
1.2.4.1 understand the theories that underpin different models of psychiatric rehabilitation, including recovery, in facilitating return to a life that is meaningful to the individual	WE OE		
1.2.4.2 use psychiatric rehabilitation methods safely and effectively on the basis of values and the best evidence available			DBD MSAP

1.2.5 Apply psychiatric expertise in situations other than in direct patient care

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
1.2.5.1 apply the medico-legal knowledge and skills required to give appropriate psychiatric advice to courts of law and other settings		ASCE	DBD
1.2.5.2 apply the knowledge and skills to contribute to the development of health services	OE		MSAP

1.2.6 Recognise personal limits of expertise

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
1.2.6.1 reflect on own limitations of expertise by, for example, using self assessment			DBD
1.2.6.2 consult and liaise with other professionals, and promptly refer when needed, for optimal patient care			MSAP DBD

1.2.7 Consult effectively

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
1.2.7.1 offer consultation and liaison services to medical and non-medical professionals			DOP MSAP
1.2.7.2 offer professional advice on a specific clinical situation		ASCE	DOP
1.2.7.3 offer appropriate verbal or written advice to a professional on a patient examined for second or specialist opinion		ASCE	DOP DBD

2 Communicator

Definition

As communicator, psychiatrists form therapeutic relationships with patients and their families. It is vital to ensure and facilitate effective gathering and sharing of essential information regarding a patient's mental condition and general health condition. In addition, the psychiatrist must develop communication skills in relation to colleagues.

Description

Psychiatrists enable patient centred therapeutic communication by exploring the patient's symptoms, and by active listening to the patient's experience of illness and all the circumstances that have led to mental health difficulties. One of the basic skills of psychiatrists as a communicator is the de-escalation of agitated and aggressive patients. Communication in clinical settings means exploring the patient's perspective, including fears, ideas about the illness, feelings about the impact of the illness, and expectations of health care professionals. The psychiatrist as a communicator integrates knowledge and shares decision-making by finding common ground with the patient in developing a plan and health goals in a manner that reflects the patient's needs, values, and preferences. This plan should, when possible, be made according to evidence and guidelines. In the revised CanMed version, the communicator role includes both oral and written communication as well as visual media to optimize clinical decision-making, patient information, confidentiality and privacy. As communicators, psychiatrists convey medical problems and solutions through respectful rapport with involving patients, their relatives, colleagues and other collaboration partners. The psychiatrist must also be able to communicate constructively with patient/consumer organizations, policy makers and media as well as legal and social authorities.

Competencies

The psychiatrist is able to:

2.1 establish therapeutic relationships with patients and their families, foster an environment characterized by understanding, trust, empathy and confidentiality

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
2.1.1 be aware of factors influencing the patients' reactions to the physician and others, including the effect of previous trauma, and one's own reactions when dealing with patients.			DBD MSAP
2.1.2 communicate effectively, professionally and empathically, both verbally and non-verbally appropriate to the patient's developmental level where necessary across linguistic and cultural boundaries, using appropriate translation services and technological support, ie telepsychiatry.		ASCE	DOP MSAP
2.1.3 establish, maintain and conclude appropriate therapeutic relationships with patients and where appropriate, with family and carers. This will include with people from different cultural backgrounds from your own that properly respect appropriate boundaries at all times, especially with vulnerable and marginalised people			DBD MSAP
2.1.4 facilitate a structured clinical encounter		ASCE	DOP

2.2 elicit and synthesise relevant information from the patient, their families, and their communities about patients' problems

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
2.2.1 obtain comprehensive and relevant information systematically and understand the meaning of this information in the context of the patient's culture, diversity and expectations		ASCE CE	DBD DOP
2.2.2 Perform a detailed developmental history with particular reference to the impact of adverse life events		ASCE CE	DBD DOP

2.3 Listen effectively

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
2.3.1 Demonstrate the ability to understand all aspects of communication, including verbal and non-verbal, and lead the interview effectively in an open and non-judgemental way		ASCE CE	DBD DOP
2.3.2 Demonstrate the ability to use de-escalation techniques to help prevent violent and aggressive behaviours in the workplace		ASCE CE	DBD DOP

2.4 discuss appropriate information with the patient, their families and other healthcare providers to facilitate optimal healthcare for patients.

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
2.4.1 recognise and respect the patient's right to be optimally informed about their illness and treatment options		ASCE	DOP MSAP
2.4.2 communicate with the patient, family and carers using a wide range of information resources including written material and online sources		ASCE	DOP MSAP
2.4.3 foster a shared understanding of issues, problems and plans with patients, families, primary health care and other professionals through discussion, questions and interaction in the encounter		ASCE	DOP MSAP
2.4.4 effectively handle challenging communication issues such as obtaining informed consent, delivering bad news, addressing emotional reactions and other factors that may lead to misunderstanding or conflict		ASCE	DOP

2.5 Use available means to handle the challenges to effective communication posed by differences in language, culture and other factors

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
2.5.1 use available means to handle language, cultural and other communication barriers when appropriate and demonstrate empathy while doing so			DOP DBD

2.6 Document and share, including providing written reports and electronic information when appropriate to do so, about the medical encounter to optimize clinical decision- making, patient safety, confidentiality, and privacy

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
2.6.1 document and present reports of clinical encounters and care plans appropriately in a clear and understandable manner			DOP DBD

2.7 Demonstrate effective communication skills in non-clinical settings

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
2.7.1 when opportunities arise, effectively present appropriate information on mental health issues to the public or media		ASCE	MSAP DOP

3 Collaborator

Definition

Psychiatrists do not work in isolation: as all medical specialist, a psychiatrist works as a partner within a system involved to provide optimal, safe, and high-quality care for patients. For most psychiatrists this will also involve working within a multi-disciplinary team and therefore it is essential that a psychiatrist is able to effectively work in such settings.

Description

The psychiatrist as a collaborator works in partnership with others who are involved in the care of their patient, including other physicians, health care professionals and patients' family. Collaboration involves the effective negotiation, and solution of interpersonal conflicts.

Successful collaboration requires relationships based on trust, respect, and shared decision-making among a variety of professionals involved in the health-care system. Professional culture and practice style play an important role in developing effective collaborative care for patients. The collaboration process requires an understanding of the roles of others, pursuing common goals and outcomes and managing differences. Psychiatrists need to collaborate with patients, their families and healthcare team members to develop a personalized plan of care to promote health and wellbeing that incorporates integrative approaches.

Competencies

The psychiatrist is able to:

3.1 Establish and maintain positive relationships with patients, colleagues, other medical and non-medical specialists in order to support a collaborative culture

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
3.1.1 clearly define own role and responsibilities to other professionals		ASCE	DOP MSAP
3.1.2 recognise and respect the diversity of roles, responsibilities and competences of other professionals			MSAP DOP
3.1.3 maintain professional relationships with health care providers for the provision of quality care			MSAP DBD DOP
3.1.4 effectively work with other health professionals to prevent, negotiate and resolve conflict			MSAP DBD DOP
3.1.5 Be able to work with local social and cultural networks, voluntary organisations and self-help groups			DBD DOP

3.2 Negotiate overlapping and shared responsibilities with other medical specialists and other colleagues in episodic and ongoing care, including the transfer of patient care to another health care professional or setting and the provision of safe handover during a patient transition

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
3.2.1 serve as an effective consultant to other medical specialists, mental health professionals and community agencies			DOP MSAP
3.2.4 obtain, interpret and evaluate consultations from other professionals		ASCE	DBD MSAP
3.2.2 Effectively participate in handovers of patient care between professionals		ASCE	DOP MSAP
3.2.3 Effectively participate in the transitioning of patient care between services, including when patients transition between age related services			DBD DOP MSAP

3.3 Engage in respectful shared decision-making process with patients, their carers and health care professionals

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
3.3.1 work jointly with patients and carers in the formulation and revision of care plans and be receptive to their preferences and views			MSAP DOP DBD
3.3.2 demonstrate effective shared decision making with other health care professionals			DBD DOP MSAP

4 Leader
Definition

A psychiatrist as a leader is someone who engages in shared decision-making and takes responsibility for the operation and ongoing evolution of the health care system. The psychiatrist is also able to handle different aspects of their practice and make every day systematic decisions involving resources, co-workers, tasks, policies and their personal life in the settings of individual patient care, practice organizations and in the broader context of the healthcare system.

Description:

It is expected from psychiatrists to function as individual health care providers, as members of teams, and as participant and leader in the relevant health care system.

Leadership is based on several values, among which are: providing understandable, personalized care for the patient in continuity and confidentiality; adapting care to meet the needs of the population, maintaining one's own physical and mental health, submitting one's daily practice to peer review, engaging in continuous improvement of one's practices in response to new requirements, and recognizing that research and instruction are part of psychiatrists' professional obligations.

As healthcare is increasingly focused on multidisciplinary teams and working in partnership with consumers and other physicians, leaders should be able to lead effectively within the diversity that characterises an effective system.

Competencies

The psychiatrist is able to:

4.1 Demonstrate personal qualities based on values and self-awareness in order to deliver high standards of care and professionalism

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
4.1.1 Recognise and articulate their own values and principles, understanding how these may differ from those of other individuals and groups			MSAP DBD
4.1.2 Identify their own emotions and prejudices and understand how these can affect their judgment and behaviour			MSAP DBD
4.1.3 Obtain, analyse and act on feedback from a variety of sources			MSAP DOP
4.1.4 Recognise the biases of others and as far as possible ensure that these do not adversely affect the delivery of healthcare			

4.2 Encourage improvement and innovation of health care services and medical education

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
4.2.1 plan relevant elements of health care and educational delivery and implement change where appropriate	WE		MSAP DOP
4.2.2 Design and implement quality improvement projects or interventions that improve clinical effectiveness, patient safety and patient experience using up to date improvement methodologies	WE		MSAP DOP
4.2.3 participate in clinical audit to continually improve the quality of services			MSAP DOP
4.2.4 Take necessary actions to increase the resources including workforce, finance and workspace to improve care and educational provision			

4.3 Utilize time and resources effectively to balance patient care, learning needs, outside activities and personal life

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
4.3.1 manage one's own time to balance patient care, earning needs, other activities and personal life			MSAP DOP
4.3.2 balance personal and professional priorities to ensure personal health and sustainable practice			DOP MSAP
4.3.3 manage and allocate the available resources to ensure optimal professional circumstances for self, patients and the wider team			MSAP DOP

4.4 Allocate finite healthcare and health education resources effectively

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
4.4.1 understand essential principles of resource and finance management	OE WE		
4.4.2 understand organisational features of national, regional and local (mental) health care structure	OE WE		
4.4.3 recognise the importance of equitable allocation of healthcare resources, balancing effectiveness, efficiency and access with optimal patient care.	OE WE		DOP
4.4.4 base resource allocation and clinical guidelines on best evidence and practice	OE WE	ASCE	DBD
4.4.5 prioritise patient case loads on the basis of severity, impairment and urgency			DOP MSAP DBD
4.4.6 appropriately delegate tasks and responsibility			DOP MSAP

4.5 Demonstrate effective administrative and managerial skills

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
4.5.1 understand computer based information and the fundamentals of medical informatics	WE		DOP MSAP
4.5.2 use patient related databases at a basic level			DBD MSAP
4.5.3 use information technology to promote patient safety and welfare			DOP

4.5.4 ensure implementation of evidence based guidelines in clinical practice			MSAP DOP DBD DOP
4.5.5 understand the principles of risk management and clinical governance	WE		DOP
4.5.6 work with systems for handling complaints from patients, carers and staff in a way that supports effective governance of clinical services		ASCE	DBD DOP
4.5.7 understand current mental health and other relevant legislation including international conventions as well as national legislation on refugees, asylum seekers and awareness of related human rights issues	WE OE		DBD
4.5.8 encourage and facilitate the professional development of peers and other related professionals			MSAP
4.5.9 question and challenge the performance of other team members when standards appear to be compromised and be responsive to comments by other team members about one's own performance			DOP MSAP
4.5.10 Acquire and maintain leadership skills to effectively lead the mental health team in the setting in which you work and adapt your leadership style to changing healthcare contexts			MSAP DBD

5 Health Advocate

Definition

A psychiatrist as a health advocate represents the needs of psychiatric patient in terms of preventive measures of psychiatric illness as well as improving the general health and well being of people who have mental illness. A psychiatrist should advocate with integrity, showing the challenges to mental health represented by social, environmental, and biological factors. Psychiatrists should contribute to efforts to improve the health and well-being of their patients, the prevention of psychiatric disorders and promote the anti- stigmatization of psychiatry in society.

Description

Psychiatrists should see advocacy as an essential and fundamental component of mental health promotion that occurs at the level of the individual patient, the practice population, and the broader community. In the definition advocacy involves promoting public discussion, making the community aware of important issues and guiding the decision makers toward a solution.

One of the main goals for a psychiatrist in order to be a good health advocate is to help change society's perceptions of people who suffer from psychiatric disorders. A key skill of a psychiatrist like all doctors is the ability and the need to be empathic and engage patients in both the short and long term. For patients who are receiving treatment from primary care physicians and/or other mental

health professional, the psychiatrist must act as an advocate and set the standards for high quality care.

Psychiatrists advocate the right of their patients to be treated equally, receiving health care and social integration processes.

Advocacy often requires engaging other health care professionals, community agencies, administrators and policy-makers. A psychiatrist may need to influence policy changes through presenting the challenges faced by people who use mental health services.

Competencies

The psychiatrist is able to:

5.1 Identify the determinants of mental health that affect the patient and the community

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
5.1.1 recognise the determinants of mental health of populations and how public policy including legislation impacts on mental health	WE OE		
5.1.2 recognise the impact of mental disorder on families and carers, and take remedial measures	WE		DBD DOP
5.1.3 collaborate with other community sectors to promote mental health and prevent mental disorder at all levels focusing particularly on family, school and workplace			MSAP
5.1.4 identify and address barriers and inequity in access to care, particularly for vulnerable or marginalised populations			MSAP
5.1.5 Provide relevant psycho-education whenever required especially to vulnerable and marginalised people for example, recently arrived refugees and asylum seekers			DOP

5.2 Be aware of the factors that affect the physical health and well-being of people who have mental illnesses and be able to intervene appropriately

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
5.2.1 promote good physical health and well-being in patients particularly in those with severe mental disorder based on best evidence			DBD

5.3 Recognize and respond to those issues, settings, circumstances or situations in which advocacy in collaboration with and on behalf of patients, professions, or society are appropriate to ensure the best interests of patients

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
5.3.1 respect and promote the human rights of people with mental disorders and collaborate with user and carer associations and advocacy groups			MSAP
5.3.2 empower people with mental disorders and their carers			MSAP
5.3.3 recognise and address prejudice, stigma and discrimination associated with mental disorder and its treatment			MSAP DOP
5.3.4 use strategies to enhance patient's harm reduction, self-management and autonomy		ASCE	DBD
5.3.5 actively oppose the use of psychiatry for social and/or political repression	WE		
5.3.6 recognise the possibility of conflict inherent in their role as a health advocate for a patient or community with that of manager or gatekeeper	OE		DBD MSAP

6 Scholar

Definition

The psychiatrist as a Scholar is a person who commits to lifelong learning, continuously improving their own skills and using knowledge to achieve excellence in practice as well as teaching patients, colleagues, doctors in training, medical students, and others.

Description

The Scholar is a learned or erudite person, especially one who has profound knowledge of a subject and who studies in great details. A psychiatrist as a Scholar should engage in a lifelong pursuit of mastery of their professional expertise. A psychiatrist should recognize psychiatry as a science which develops, changes and gets more and more enriched by evidence-based information. A psychiatrist should recognize the need to continually learn and inspire the education of colleagues, as well as patients, doctors in training, medical students, and others, including, when appropriate, the general public.

The active role of scholar ensures that a psychiatrist arrives at clinical decisions that are informed by evidence while taking patient values and preferences into account. Using the abilities of a Scholar, a psychiatrist shows excellence in their professional work and provides high quality mental health care. The Scholar also invests time, energy, and personal knowledge in assisting the growth and development of colleagues, doctors in training and medical students which may involve the use of supervision and mentoring

Competencies

The psychiatrist as a scholar is able to:

6.1 Develop, implement, and document a personal and continuing education strategy.

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
6.1.1 recognise the principles for maintaining competence	WE OE		
6.1.2 recognise and reflect on learning issues in practice through methods such as self audit and CPD			DBD DOP
6.1.3 access and interpret the relevant evidence and integrate this new learning into practice			DBD
6.1.4 evaluate the impact of any change in practice			DBD
6.1.5 document the learning process (e.g. logbook)			DBD

6.2 Use the best source and relevant evidence based medicine for clinical decision making in daily work.

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
6.2.1 understand the principles of critical appraisal and their application in clinical contexts	WE		DOP
6.2.2 integrate critical appraisal conclusions into clinical care			DBD

6.3 Be familiar with general scientific principles and methods, contribute to research and to the development of new knowledge

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
6.3.1 recognise the principles, methodology and ethics of research and scholarly inquiry	WE OE		
6.3.2 formulate a research question and conduct a systematic search for evidence	WE OE		DOP
6.3.3 select and apply appropriate methods to address the question	WE OE		DBD DOP
6.3.4 analyse, interpret and report the results	WE OE		DBD DOP
6.3.5 appropriately disseminate and utilise the findings of a study			DBD DOP MSAP

6.4 Contribute where appropriate as an effective teacher, to the learning and development of others including medical students, doctors in training and other health professionals.

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
6.4.1 understand the principles of learning and the ethics underpinning medical education including mentoring	WE OE		
6.4.2 work with others to identify respective learning needs			MSAP
6.4.3 select teaching strategies and interventions based on best evidence			MSAP DOP

6.4.4 recognise that one's own clinical behaviour can be a model for the learning of others			MSAP DOP
6.4.5 teach, present and reflect on feedback			MSAP DOP
6.4.6 recognise and apply the principles of assessment. Demonstrate the difference between formative and summative assessment	WE		DOP
6.4.7 recognise and apply the principles of appraisal	WE		DOP MSAP
6.4.8 give feedback in a timely and constructive manner showing respect and confidentiality			DOP MSAP

7 Professional

Definition

A psychiatrist is expected to work together with patients and with all relevant stakeholders in order to achieve best outcomes for the patient. This is done by reference to ethical frameworks, maintaining high standards, showing integrity and respect to all, by demonstrating a commitment to continuous professional development and by being aware of one's limitations.

Description

The psychiatrist as a Professional is dedicated to the health and care of others. The role of the Professional incorporates contemporary society's expectations of physicians, which include clinical competence, a commitment to ongoing professional development, promotion of the public good, adherence to ethical standards and values.

The fundamental principles of professionalism are primacy of patient welfare, patient autonomy, social justice with commitment on the part of physicians to professional competence, honesty with patients, confidentiality, improving quality of and access to care, just distribution of finite resources, scientific knowledge and professional responsibilities including values such as integrity, altruism, humility, respect for diversity, and transparency with respect to potential conflicts of interest.

Professionalism is the basis of the implicit contract between society and the medical profession, granting the privilege of physician-led regulation with the understanding that physicians are accountable to those served, to society, to their profession, and to themselves.

Competencies
The psychiatrist is able to:

7.1 Deliver the highest quality of care with honesty, integrity and compassion

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
7.1.1 maintain highest standards of clinical competence and professional behaviour based on values and evidence			MSAP DOP DBD
7.1.2 care for patients with integrity in a sensitive, empathic and compassionate manner		ASCE	MSAP DOP
7.1.3 conduct oneself in a way that commands respect and confidence of patients and carers and show respect for patients and their carers			MSAP DOP
7.1.4 observe professional boundaries with patients and carers			MSAP DOP
7.1.5 understand all aspects of professional relationships including the power differential between psychiatrists and patients and do not misuse this power differential			MSAP DOP
7.1.6 understand and address the issues involved when the doctor-patient relationship ends		ASCE	DOP
7.1.7 recognise and address problems with end-of-life care for patients with mental disorders	WE		DOP

7.2 Exhibit appropriate personal and interpersonal professional behaviours

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
7.2.1 observe professional boundaries with colleagues and others involved in patient care			MSAP DOP
7.2.2 recognising professional needs of other colleagues and respond appropriately			MSAP DOP
7.2.3 respond to communication with health professionals in a sensitive and timely manner			MSAP DOP

7.3 Practise medicine in an ethically responsible manner that respects medical, legal and professional obligations of belonging to a self-regulating body

	Knowledge	Competence	Performance
	Knowledge tests WE OE	**Clinical examinations ASCE CE**	**In-training assessment DBD DOP MSAP**
7.3.1 observe professional, regulatory and legal obligations at all levels	WE	ASCE	MSAP DBD
7.3.2 maintain high quality records of clinical encounters and plans			DBD
7.3.3 observe ethical codes of practice and manage conflicts of interest		ASCE	DOP MSAP
7.3.4 maintain transparent relationships with commercial organisations (including pharmaceutical industry) based on ethical principles			MSAP
7.3.5 recognise the principles and limits of patient confidentiality as defined by professional practice standards and the law	WE OE	ASCE	DBD
7.3.6 identify and address appropriately unprofessional conduct of other health care professionals			MSAP
7.3.7 review own professional conduct and acknowledge and remediate medical errors, should they occur and demonstrate an awareness of the impact of your own world view on professional conduct			DBD MSAP
7.3.8 understand the components of informed consent, including capacity	WE	ASCE	DBD DOP
7.3.9 recognise the extent of one's own limitations and seek advice and support			MSAP DBD

C - GLOSSARY OF TERMS

Introduction

This glossary accompanies the assessment grid of the European Framework for Competencies in Psychiatry (EFCP). The assessment grid shows suggested methods of assessing the competencies. The purpose of this glossary is to explain what the different methods are and to give examples of how different tools based upon these methods may be used in practice.

It is now widely recognized that assessment drives learning therefore an assessment system must be considered as being an integral part of any curriculum that is to be developed from the competency framework. This applies as much to professional training as to continuing professional development.

There are three principles that should guide the construction of assessment systems:

- Assessment systems should be transparent, so that learners and teachers know what is being assessed and how it will be assessed.
- Each competency should be assessed, not just those that are easy to assess
- Competency assessment must be triangulated, that is each competency must be assessed in more than one way on more than one occasion.

A further consideration is the utility of the assessment system. Van der Vleuten (1996) pointed out that in mathematical terms the utility of an assessment system might be considered as the product of its reliability, validity, feasibility and educational impact (that is the effect that assessment has upon learning). It follows that if the value any of these qualities approaches zero, no matter how positive the remaining values are, the utility of the assessment system will also approach zero.

Miller (1990) described a conceptual model of the different domains of medical skill and how they may be assessed. Miller's model emphasizes the importance of the assessment of performance (that is, what the doctor actually does in their day-to-day practice), rather than surrogates, which are actually assessments of knowledge or competence.

In this assessment grid, we have sought to identify at least two methods of assessment for each competency. For ease of viewing, we have arranged the assessment methods into one of the three domains in Miller's model, knowledge ('what the doctor knows'), competency ('what the doctor can do') and performance ('what the doctor does'). In the following sections of the glossary, we will describe each method of assessment and what is known about the reliability, utility, feasibility and educational impact of tools that are based on the methods, so that national associations and other regulators of psychiatric training may make informed choices regarding assessment methods. We will give more attention to the tests of the 'does' level, as they are likely to be less familiar to readers.

KNOWLEDGE ASSESSMENTS (TESTS)

Written examinations (WE)

There are two main types of written assessment: multiple-choice papers, in which the candidate selects the correct response from a number of alternatives and essay papers or short answer papers, in which the candidate has to construct text.

Multiple-choice questions: Papers based on multiple-choice questions (MCQ) offer a high degree of reliability per hour of testing time (Schurwirth and van der Vleuten, 2003) and if constructed well, they can test more than factual recall. There are now several question types available in addition to the traditional 'true/false' format. They clearly offer a reliable, valid form of assessment as long as due care is given to the construction and evaluation of questions. The facility to mark MCQ's electronically contributes to their high feasibility.

Essays and Short Answer Papers: Essay papers have been used to examine the ability of candidates to express themselves in writing and to use other intellectual skills (Schurwirth and van der Vleuten, 2003). Indeed, there is a great degree of face validity to this form of assessment in a highly language dependant discipline such as psychiatry. The use of this form of assessment is limited by the time taken to answer essays and hence essays have only limited feasibility. Short answer papers appear to assess similar domains of knowledge as MCQ papers, and since they depend on human markers, they can be less reliable and are also less feasible.

Oral examinations (OE)

Oral examinations may be defined as "examiner/examinee encounters where topics unrelated to specific patients are discussed" (Wass et al, 2003). This form of assessment is intended to assess clinical reasoning and decision-making skills and professional values. Swanson et al (1995) estimated that approximately eight hours of examiner time (either as paired examiners or individual examiner) is needed to produce an acceptable degree of reliability. A similar study of UK general practice candidates indicated that a well structured oral examination covering between 20 and 25 topics over three to three and a half hours of testing could produce acceptable reliability (Wass et al, 2003). The validity of this form of assessment must be carefully monitored, however, as Roberts et al (2000) found evidence the oral examination has a particular potential for bias against candidates from minority ethnic groups.

COMPETENCY ASSESSMENTS

Clinical examinations (CE)

The long case examination is one of the most venerable forms of assessment in medical education (Jolly and Grant et al, 1997). In the long case, candidates are given up to an hour to assess a non-standardized patient. They are assessed on the subsequent presentation they deliver to the examiner(s) and sometimes also on a brief observed interview with the patient. The examination may take up to an hour and a half.

There are serious concerns about the reliability of the long case examination (Jolly and Grant, 1997) and these concerns arise because the assessment is based upon an encounter with one patient and unstructured questioning by examiners (Fitch et al, 2008). Norcini (2002) has reported reliability estimates for a single long case of 0.24. Having more assessments performed by more assessors and observing the whole encounter between candidate and patient increase the reliability of the long case. Six such long case assessments are needed to bring a reliability coefficient of 0.8. Unfortunately, however, the large amount of assessment time needed and the lack of willing and suitable patients severely limits the feasibility of the long case examination. Calls to restore the long case in psychiatry periodically emerge but have been rebuted (Burn and Brittlebank, 2013).

Assessment of simulated clinical encounter (ASCE)

The ASCE examination seeks to assess clinical competency by rotating each candidate around a number of standardized situations. Typically, each 'station' (encounter) in the examination will consist of a clinical scenario enacted by a role player and the candidate is given a task. The examiner observes the candidate performing the task and marks the performance against a given set of criteria, which is why this form of assessment is widely referred to as the Observed Structured Clinical Examination (OSCE). Newble and Swanson (1998) found that acceptable levels of reliability are attained after about 16 OSCE stations with one examiner at each station. This equates to about three hours of test time per candidate. The OSCE examination in UK postgraduate psychiatry has been shown to produce similar reliability estimates (Lunn, personal communication). Recruiting and training examiners and role players, as well as finding suitable examination venues, are the factors that most restrict the feasibility of this assessment tool.

PERFORMANCE ASSESSMENTS

This form of assessment is often referred to as workplace-based assessment (WPBA) to emphasize that it is based upon a doctor's real-time day-to-day work and to distinguish it from standardized tests that may be conducted at a national level or will involve visiting an examination centre away from the place of work.

Fitch et al (2008) identified three methodologies to WPBA:

- The observation and assessment of a doctor's performance conducting their work - direct observation of practice
- The collation of standardized data from several assessors – multi source feedback
- Retrospective assessment of performance through conversations based upon written material, such as log books or clinical records – document-based discussion

The results of a small pilot study (Brittlebank et al, 2011) and of a larger field study (Brittlebank et al, 2013) of WPBA in UK psychiatry demonstrated that the assessments are feasible to deliver and that with a relatively modest deployment of resources, they may offer acceptable levels of reliability and validity.

Directly observed practice (DOP)

The DOP method entails an assessor watching a doctor conducting a task, which may involve interacting with a patient, performing a practical procedure or performing a non-clinical task, such as teaching or giving expert testimony. A large number of different DOP tools have been evaluated.

The mini-Clinical Evaluation Exercise (mini-CEX) involves an assessor observing a doctor performing a task, such as history-taking or gaining informed consent, which involves communicating with a patient. It takes around 20 minutes, followed by 5-10 minutes for feedback. The mini-CEX has a large evidence base, with a generalisability coefficient (reliability score) of 0.77 for 8 assessments (Kogan et al, 2003) and reasonable construct validity (Holmboe et al, 2003).

The Clinical Evaluation Exercise (CEX) involves an assessor observing the doctor conducting an entire clinical encounter with a patient, in this way it is a WPBA equivalent of the long case assessment and it has strong face validity in psychiatry (Brittlebank, 2007). A CEX takes over an hour to perform. Its reliability is quite low; Norcini (2002) reported that two CEX assessments conducted in internal medicine produced a combined reliability coefficient of 0.39.

The Direct Observation of Procedural Skills (DOPS) was developed as a tool to assess a trainee's performance of practical procedures, such as venepuncture or intubation (Wilkinson et al, 2003). Early psychometric data on the DOPS suggests that the reliability and validity of this instrument compares favourably with the data for the mini-CEX (Wilkinson et al, 2008).

The feasibility of DOP-based assessments in psychiatry is determined by the length of time involved in the process, the acceptability to patients of having an observer present in the consultation and (especially in the case of mini-CEX and DOPS) how easily psychiatric practice may be broken down into smaller portions. It is also influenced by the training needed to complete assessments; Holmboe et al (2004) has demonstrated that assessors need to be trained in order for them to be able to conduct fair assessments.

A number of other DOP type instruments have also been evaluated in psychiatry and been shown to be useful these include tools to assess performance in teaching (Assessment of Teaching), presentation skills (Journal Club Presentation and Case Presentation) and performance of non-clinical skills (Direct Observation of non-Clinical Skills).

Multi-source assessment of performance (MSAP)

MSAP entails the assessment of a doctor's performance from several viewpoints, using a standardized measure that is then collated and fed back to the doctor. The feedback may be from colleagues, both peers and coworkers from different professions and/or levels in the organisational hierarchy, and from patients. MSF may also involve an element of self-assessment.

MSAP has been widely used in professions outside healthcare for many years, where it is more commonly referred to as multi-source feedback or 360^0 appraisal

(Fletcher, 2004). According to Malik et al (2008) the use of MSAP in medicine has three main attractions:

- Assessments from multiple sources may be perceived as being fairer than assessment from a single source
- MSAP may facilitate assessment of areas of performance (such as the humanistic and interpersonal aspects of medicine) that are not easily assessed using other methods
- To address wider social issues about the accountability of the medical profession.

The feasibility of MSAP is influenced by the availability of competent raters and their access to components of the doctor's practice; raters can only assess that which they can observe and are competent to assess. There will be aspects of practice that peers have not observed and areas that coworkers and patients may not be qualified to comment upon. Feasibility also depends upon the time taken to complete MSAP tools and the ability of the person who collates the data to give helpful feedback to the doctor. Wilkinson et al (2008) have demonstrated that it takes an average of six minutes to complete a typical MSAP form used in medical practice.

The published data on the peer and coworker MSAP tools that have been used in medical training suggest that responses from as few as four (Archer et al, 2006) to 12 assessors (Wilkinson et al, 2008) can produce reliable data. Furthermore, one form, the Sheffield Peer Review Assessment Tool (SPRAT) has been shown to have good feasibility and construct validity data (Archer et al, 2005). A high level of reliability was also demonstrated for nine responses on an MSAP tool (the Team Assessment of Behaviour) that was developed to be mainly a screening tool to identify trainees in difficulties (Whitehouse et al, 2007).

Although a number of tools have been developed to enable patients to give feedback on the performance of their doctor, none has been developed to be used on doctors in training and only two, the Physician Achievement Review (PAR) and SHEFFPAT, have been subjected to reasonably rigorous reliability and feasibility studies (Chisholm and Askham, 2006). These studies indicated that around 25 patient responses were needed to provide reliable data on doctors' performance (Crossley et al, 2005, Violato et al, 2003).

Document-based discussion (DBD)

In this method, a doctor's documented performance in clinical work is assessed through a discussion led by an assessor. There are two main methods in this, discussions based on logbooks or based on patient case records. Although logbooks have been in use in medical training for some time, there is little information in the literature concerning their use as part of a structured assessment. There are several descriptions and evaluations of the use of case records as the focus of assessed discussions – 'Chart Stimulated Recall' (CSR) in the United States. A review of these studies (Fitch et al, 2008) showed that CSR displayed good reliability and validity in assessing medical undergraduates and physicians.

In the CSR, a doctor presents a number of case records to an assessor, who chooses one record to be the focus of the discussion. The assessor questions the doctor on their performance and handling of the case, based on information the doctor has recorded. The discussion allows the doctor to explain their decision-making and can allow exploration of the doctor's clinical reasoning, including the medical, ethical and legal aspects.

The process takes between 20 and 30 minutes to complete and assessors need little training in this method, other than guidance regarding the format of the assessment. It is therefore potentially a highly feasible form of assessment.

Entrustable professional activities – a holistic approach to real world performance assessment

In response to the limitations of workplace based assessment, a number of national assessment systems in psychiatry, including those of the Royal Australian and New Zealand College of Psychiatrists (Boyce 2011) and the Royal College of Psychiatrists in the UK, have looked at incorporating ten Cate's (ten Cate 2014) notion of entrustable professional activities (EPA's) into workplace based assessment.

Ten Cate (2014) defined EPA's as 'units of work' that a supervisor may delegate to a doctor in training. An EPA is an observable activity that will involve the engagement of multiple curricula competencies. The activity is a complete task that a trainee would be expected to conduct as a part of their routine work. One of the advantages of EPA's is that decisions made about trainees' performance of the activity can be framed within a scale of increasing autonomy and therefore reduced degree of supervision. This being a real-world judgement that supervisors are used to making. The wording of the judgement for the supervisor is, whether I would trust this trainee to perform this task only with direct clinical supervision, ie with a senior present observing at all times and able to intervene or can the trainee be left to perform all or part of the task with indirect clinical supervision, ie with the trainee reporting some or all of the task to a senior or is the trainee now able to perform the whole task autonomously.

Assessments may be combined as described in the following suggestion, to form EPA's.

SUGESTED EPA's

Here are some suggestions which have been written to illustrate how assessments conducted in the doctor's workplace may be used to provide evidence about a doctor's performance and may be combined to support judgements about Entrustable Professional Activities. It is not an exhaustive list. It is recommended that no more than six EPA's are mandated in each year of training and it is a matter for local decision as to which tasks are prioritised for EPA assessment for each trainee. Workplace assessments that are not linked to a specified EPA should also be carried out, to give the doctor in training many opportunities to gather and to respond to formative feedback.

Workplace assessment can be very efficient in that the doctor being assessed may use a single episode of assessment to provide evidence against several supporting competencies. It should be noted that this form of assessment is different from other ways of assessing doctors in many important respects. Most obviously, in workplace assessment, the doctor being assessed takes the initiative for each episode of assessment in that he or she is responsible for asking an assessor to perform the assessment. However, the number of assessments and the subject areas to be assessed are determined by the curriculum and included in the doctor's individual learning plan. Workplace assessment should always be performed in the course of normal clinical work, clinical encounters should never be arranged for the sole purpose of assessing a doctor. Although the assessments are conducted in work that may involve patients it is essential that the record of the assessment does not contain any information that would breach patient confidentiality. Wherever possible, patients should be informed that an assessment of the doctor's performance is taking place.

After the assessment is finished, the doctor retains the completed assessment form and submits it in a portfolio of evidence, which the trainee may use to demonstrate their capability to respond to feedback and to be a reflective practitioner.

If the assessment forms an element of an EPA assessment, the trainee's programme will prescribe a format for the recording and storage of the summative element of the assessment.

EPA one

A doctor in her early years of psychiatry training wishes to demonstrate her competence in assessing the suicide risk (supporting competency 1.1.16) of patients who present to hospital after an episode of self-harm.

To achieve this, she has asked a senior psychiatrist to observe her performing an assessment of such a patient using the mini-CEX (a form of Direct Observation of Performance, DOP). In this episode of assessment, the assessor watches the doctor taking the patient's history and performing a mental state examination. This episode of assessment may therefore also be used as evidence for competencies 1.1.5, 1.1.6, 1.1.7 and 1.1.12.

Later, the doctor has asked a supervisor to conduct a Chart-stimulated Recall (a form of Document-based Discussion, DBD) on her assessments of similar patients. In this assessment, the assessor asks the doctor to describe the interviews she performed and to explain the reasoning she used to arrive at her clinical decisions in the cases, based on what she has written in the clinical records. The episode of assessment may be used as evidence for competencies 2.1.1, 2.3.6 and 7.3.2

If the two episodes of assessment are based on the same task, the supervisor may combine them to arrive at an EPA based judgement of the level of supervision the trainee requires in this task and thus come to a summative assessment of the level of autonomy the trainee has achieved for this task.

EPA two

A doctor in the early stages of psychiatric training has taken the initiative to be assessed in drawing up a treatment plan, communicating with patients and carers

and fostering shared understandings (supporting competencies 1.2.0.3, 2.3.2 and 2.3.3).

To do so he asks the supervisor to observe their performance (DOP) during a meeting with a person recently diagnosed with schizophrenia, his mother, the clinical psychologist and the nurse who had previously seen the patient. The supervisor will observe the doctor handling the meeting and negotiating the therapeutic plan with the patient. The following competencies could also be assessed during the meeting: 2.1.1, 2.1.3, 2.2.1, 2.3.1,.3.3.1.

The persons involved in the meeting will receive a questionnaire regarding the skill of the doctor in eliciting all the relevant information during the meeting (MSAP).

After the meeting the doctor will write up the therapeutic plan and fix a date with the supervisor to have a discussion based on the file (DBD). The trainee will be assessed regarding their ability to integrate biological, psychological and social factors into a plan and put it in writing. During this session competency 2.3.6 could also be assessed.

The supervisor’s judgement of the degree of supervision the trainee needs for this task informs the EPA of treatment planning with patients who share the same type of clinical problem.

EPA three

A doctor at the advanced stage of psychiatric training wishes to be assessed in the following Manager role competencies: ensuring the implementation of evidence based guidelines in clinical practice (supporting competency 4.3.3) and participation in clinical audit to continually improve the quality of services (supporting competency 4.3.4); and Communicator competencies: communicate effectively, both verbally and non-verbally (supporting competency 2.1.1).

This could involve requiring the doctor to draw up, implement and present a clinical audit cycle on the department’s compliance with published guidelines on patient selection and safety monitoring in atypical antipsychotic drug prescribing.

The doctor would draw up the clinical audit cycle methodology and discuss this at the management team meeting where an assessor may observe their performance and rate it by using the Direct Observation of non-Clinical Skills tool (a form of DOP).
Subsequently the trainee will perform, write up and finally present the audit results at a peer group meeting, where a further DOP may be performed and members of the audience be asked to complete a MSAP.

Competency 4.3.3 is thus assessed using direct observation of practice (DOP) in the planning and implementation phases. Communicator competency skill 2.1.2 is assessed using direct observation of practice (DOP) during the peer group presentation and multisource assessment of performance (MSAP) through audience feedback.

The individual assessments of this task may then be combined to contribute to an EPA constructed around the trainee’s level of autonomy in the team based implementation of evidence-based practice.

EPA four
A doctor in their last year of specialist psychiatric training wishes to be assessed on their ability to manage complex clinical situations.

In the past week, the trainee has been treating a 30-year-old single mother who presented with an acute psychotic episode 2 weeks after the birth of her baby. She is a foreign national who has recently been granted refugee status. She requires the use of an interpreter. She has 3 other children under the age 10. She has little or no social support. She required involuntary admission due to her lack of insight.

The doctor arranges for their supervisor to assess them by directly observing an interview with this patient through an interpreter (Directly Observed Practice, DOP). In this way, the trainee wishes to demonstrate attainment of the following supporting competencies: 1.1.6, 1.2.0.1, 2.3.4, 3.2.1, 5.1.3.

During the next educational supervision, the trainee undergoes an assessment of their management of this case as documented in the patient's case note (Document Based Discussion, DBD). In this way, the trainee wishes to demonstrate his attainment of the following competencies: 1.2.0.4, 1.1.6, 1.1.14, 1.2.0.5, 2.3.5, 5.1.3.

The patient is making very slow progress. The trainee wishes to seek the opinions of other specialists in the department and arranges to present the patient at a departmental case conference. The supervisor assesses the trainee's performance by completing an Assessment of Case Presentation (a form of DOP): 2.1.1, 2.3.6, 2.3.7, 6.3.4.

The trainee arranges for their peers and allied colleagues to assess their performance in this case, as well as their overall clinical practice. They arrange a Multi-Source Assessment of Performance (MSAP). This would enable the trainee to demonstrate the following competencies: 1.1.14, 1.2.0.1, 1.2.0.3, 1.2.0.5, 1.2.0.11, 1.2.3.3, 1.4.2, 3.2.1, 4.1.6.

The supervisor may draw the evidence from these assessments together to give evidence that supports a summative assessment on the EPA of managing a complex clinical situation.

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Appendix 2

Training objectives for UEMS specialists pertaining to the care of adolescents and young adults

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A - Context

Worldwide, the specific health needs of adolescents and young adults (AYAs) defined as individuals aged 10 to 24 are increasingly recognized. This phase of exploration and of shaping of one's identity drives both opportunities and risks, such as improved self-confidence, health enhancing behaviours, or poor therapeutic adherence, lack of long-term vision, which potentially interfere with treatment. Both specialists and primary care practitioners (e.g. in-practice paediatricians, family physicians, school doctors) can play a pivotal role in tailoring their approach to the specific needs of AYAs. This training package has been developed by members of the UEMS Multidisciplinary Joint Committee in Adolescent Medicine and Health (Chair, Prof. P.-A. Michaud, Lausanne, Switzerland), an initiative launched by the European Academy of Paediatrics. The content has been carefully discussed and reviewed by the MJC members, as well as an international group of experts working in the field and belonging to the Euteach training program (www.euteach.com). The present document lists a set of practical, clinically oriented, holistic objectives that should allow all European specialists and primary care providers (paediatricians and family doctors) to respond better to the special health care needs of AYAs. They are competency-based and integrate knowledge, attitude and skills. In this respect, they are inspired by the CanMEDS model, as well as the "EPA" (Entrustable Professional Activities) approach. They can be freely adapted to the specific health care approaches and topics of various UEMS specialties (including paediatricians) and family doctors. Additionally, they should be applied taking into account the variety of cultural and legal frames of European countries. In the near future, it is foreseen to develop an accompanying tutorial (content, slides and videos) to assist trainers in implementing and developing teaching sessions.

The health care provider initiates and conducts the consultation with an AYA patient in a developmentally appropriate way (considering the patient's puberty stage, age as well as cognitive & affective level)

- ✓ Offers a setting that respects privacy and guarantees a trustful, empathetic and respectful relationship with the patient,
- ✓ Explains confidentiality and makes sure to get time alone with the patient for an appropriate part of the consultation. Agrees with the AYA what to disclose or not to disclose to the parent/guardians by the end of the consultation
- ✓ Uses developmentally appropriate communication skills: adapts language and wording to the age/cognition, verifies that the patient understands the information
- ✓ Clarifies the reason for the consultation and its goal and process. Gives the parents/guardians time to voice their worries
- ✓ Is attentive to cues for undisclosed problems ("hidden agenda").
- ✓ Assesses the adolescent's capacity in autonomous decision making (competence)
- ✓ Involves the parents/guardians in the evaluation, treatment and further measures, balancing the importance of the patient's privacy and increasing autonomy on one hand, and the communication within the family on the other hand
- ✓ Pays attention to the needs of AYAs minority groups, low socio-economic groups, homeless, refugees, LHBTI. Collaborates with trained interpreter when meeting AYA & family of foreign origin/cultural context.

The health care provider assesses and responds to the patient's lifestyle/behaviour in a non-judgmental way, paying extra attention to areas prone to be problematic in the age group and the AYA's resources *(The HEADSSS acronym provides useful guidance in this regards)*

- ✓ Assesses the patient's cognitive and affective development and daily functioning
- ✓ Identifies AYA's personal and environmental resources/protective factors, including the presence of trusted adult(s)
- ✓ Discusses daily leisure, diet, sports and social activities
- ✓ Assesses school/academic performance, screens for learning difficulties and other conditions (developmental/neurocognitive) leading to poor academic outcomes

- ✓ Screens for overt and covert symptoms of depression and/or anxiety in exploring mood, behaviour and expectations. Identifies self-harm, suicidal ideation and former or planned suicide attempts, as well as any victimization or violence
- ✓ Explores the value of substance use from the patient's viewpoint, the patient's use/misuse of drugs, the associated risk factors, the perceived range of consequences and the preparedness for change
- ✓ Discusses screen/internet/social media misuse and its health consequences
- ✓ Respectfully explores sexuality and reproductive life, including questions of gender identity and sexual orientation. Responds appropriately to common situations
- ✓ Assesses safe/unsafe sexual behaviour and risk for sexually transmitted infection and treats or refers for treatment; identifies need for contraception and responds empathetically to a suspected or verified pregnancy (pregnancy test, referral)
- ✓ Opens up for disclosure of subjection to violence and involvement in criminal activity.

The health care provider performs a physical examination taking into account the patient's growth and development

- ✓ Explains the process of any physical examination and the reasons for it
- ✓ Adapts the examination to the AYA's complaints/symptoms, physical/sports activity, social and professional background
- ✓ Follows a sequence that respects patient comfort and intimacy
- ✓ Evaluates and comments the patient's pubertal stage (e.g., Tanner stage)
- ✓ Assesses systems that change particularly during puberty (skeletal, sight, skin etc.)
- ✓ Investigates body shape's representations and self-image within the cultural and social context

The health care provider provides appropriate care to an AYA living with a chronic condition and facilitates transition and adaptation to adult health care settings

- ✓ Assesses the impact of chronic condition on patient's daily functioning
- ✓ Fosters an inter-professional approach and collaborates with the appropriate resources and people to assist the patient in coping with the chronic condition and life

- ✓ Promotes optimal adolescent development: minimizes the impact of the chronic condition on education and social life together with interdisciplinary team members
- ✓ Promotes self-confidence and capacity in managing health and illness
- ✓ Beyond the care of the chronic condition itself, addresses the basic health care needs of the patient; (HEADSSS, immunization, complaints regarding general health)
- ✓ Participates in the transition process from paediatric to adult health care settings: preferred age for transfer, adolescent's expectations, available support during transition (e.g. clinical nurse, social worker and psychologist) and joint consultation with both paediatric and adult health care provider. Actively involves the AYA in all decisions regarding transition.

B - Training tool

Teachers and mentors who want to set-up training sessions (bedside, small groups. Lectures) can access to a series of concrete training tools which have been specifically developed by EuTEACH faculties (www.euteach.com) to cover the UEMS training objectives. They can be particularly useful to professionals who are not familiar with the field of adolescent medicine and health. They are *freely accessible* at: https://moodle.unil.ch/course/view.php?id=24722. Once on the website, click on "invite" and use the password: euteach2022

In addition, the Euteach website offers a set of educational illustrations as how to organize and deliver effective and interactive training: https://www.unil.ch/euteach/home/menuinst/how-to-teach/interactive-teaching-methods.html