UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES
EUROPEAN BOARD OF PSYCHIATRY
APPROVED
Ljubljana, Slovenia, 17 October 2009
Due for revision: October 2013

EUROPEAN FRAMEWORK FOR COMPETENCIES IN PSYCHIATRY

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 present 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 European Framework for Competencies in Psychiatry (EFCP) will be seen as a living document that will be periodically reviewed and amended.

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.

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

The learning outcomes in the European Framework for Competencies in Psychiatry (EFCP) are arranged under the seven physician roles or metacompetencies, derived from the CanMEDS 2005 physician competency framework (Frank, 2005) as adapted for the UEMS Profile of a Psychiatrist (UEMS, 2005). The seven physician roles consist of Psychiatric Expert/Clinical Decision-Maker, Communicator, Collaborator, Manager, 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 overprescriptive.

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.

WORKING GROUP MEMBERS

Andrew Brittlebank, Royal College of Psychiatrists, UK

Joanna Carroll, Royal College of Psychiatrists, UK

Roelof ten Doesschate, Dutch Psychiatric Association, the Netherlands

Manuel Gómez-Beneyto (Chair), Spanish Association of Neuropsychiatry, Spain

Izu Nwachukwu, EFPT, Ireland

Joseph Saliba (Vice-Chair), Medical Association of Malta / Maltese Association of Specialists in Psychiatry, Malta

Ian Soosay, EFPT, UK

The working group consulted the following UEMS colleagues:

Jacek Bomba, Polish Psychiatric Association, Poland

Homayon Chaudhry, PWG, Switzerland

Elisabete Fradique, Portuguese Medical Association, Portugal

Dan Georgescu, Swiss Society for Psychiatry and Psychotherapy, Switzerland

Slaðana Iveziæ, Croatian Medical Association / Society for Clinical Psychiatry, Croatia

Luboš Janu, Czech Psychiatric Association, Czech Republic

Nils Lindefors, Swedish Psychiatric Association, Sweden

Anne Lindhardt, Danish Psychiatric Association, Denmark

Amit Malik, EFPT, UK

Kajsa Noström, EFPT, Sweden

Eva Pálová, Slovak Psychiatric Association, Slovakia

László Tringer, Hungarian Psychiatric Association, Hungary

Andreas Zachariadis, Hellenic Psychiatric Association, Greece

Slavko Ziherl, Psychiatric Association of Slovenia, Slovenia

EUROPEAN FRAMEWORK FOR COMPETENCIES IN PSYCHIATRY (EFCP)

DEFINITION OF PSYCHIATRY

Psychiatry is the branch of medicine concerned with the study and application of biopsychosocial principles to the aetiology, assessment, diagnosis, treatment, rehabilitation and prevention of mental, emotional and behavioural disorders alone or as they coexist with other medical disorders across the life span (adapted from the Royal College of Physicians and Surgeons of Canada, 2007).

KEY COMPETENCIES IN PSYCHIATRY

The psychiatrist in the role of:

1. Psychiatric Expert/Clinical Decision Maker is able to
   - 1.1 conceptualise, understand and apply the diagnostic skills to investigate, elicit, describe and define psychopathological and other clinical findings.
   - 1.2 apply therapeutic skills to effectively and ethically manage the spectrum of patient care problems diagnosed.
   - 1.3 apply psychiatric expertise in situations other than in direct patient care
   - 1.4 recognise personal limits of expertise
   - 1.5 consult effectively
2. Communicator is able to
   - 2.1 establish a therapeutic relationship with patients
   - 2.2 elicit and synthesise relevant information from the patient, their carers and other relevant sources
   - 2.3 discuss appropriate information with the patient, their carers and health professionals that facilitate optimal care. This implies the ability to inform and counsel a patient in a sensitive and respectful manner while fostering understanding the patient's active participation in decisions about their care.
3. Collaborator is able to
   - 3.1 effectively consult with other physicians and healthcare professionals
   - 3.2 contribute effectively to other interdisciplinary team activities
   - 3.3 participate actively in shared decision making with patients and carers
   - 3.4 collaborate effectively with patient and carer organisations
4. Manager is able to
   - 4.1 allocate limited healthcare resources
   - 4.2 manage personal resources
   - 4.3 work in a healthcare organisation
   - 4.4 use information technology to optimise patient care, continued self-learning and other activities
5. Health Advocate is able to
   - 5.1 identify the determinants of mental disorder as well as the factors that may contribute to positive mental health so as to be able to prevent disorder and promote mental health
   - 5.2 identify and address issues and circumstances when advocacy on behalf of patients, professions, or society is necessary

6. Scholar is able to
   - 6.1 develop, implement and document a personal continuing education strategy
   - 6.2 apply the principles of critical appraisal to sources of medical information
   - 6.3 facilitate learning in patients, students, trainees and health professionals
   - 6.4 facilitate the learning of colleagues, trainees and students through the appropriate use of assessment, appraisal and feedback
   - 6.5 contribute to research and to the development of new knowledge
7. Professional is able to
   - 7.1 deliver the highest quality of professional care
   - 7.2 relate to co-workers in a professional manner
   - 7.3 practise medicine in an ethically responsible manner that respects medical, legal and professional obligations

1 Psychiatric Expert/Clinical Decision-Maker

Definition

Psychiatrists deal with the prevention, diagnosis, treatment and rehabilitation of patients with mental disorders. To manage this, psychiatrists possess a defined body of medical, and in particular 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 an appropriate combination of biological, psychological and sociological methods. Their care is characterised by up-to-date, ethical and cost-effective clinical practice and effective communication with patients, other health care providers and the community. The role of psychiatric expert/clinical decision-maker 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 conceptualise, understand and apply the diagnostic skills to investigate, elicit, describe and define psychopathological and other clinical findings.

	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	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 including information from other sources		CE	DOP DBD

[1] For explanation of acronyms see the glossary of terms (page 16)

1.1.6 perform and document a psychiatric assessment with attention to cultural diversity		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 recognise medical conditions that are incidental, consequential or contributory to mental disorder and its treatment	WE	ASCE	DBD
1.1.10 perform and document a relevant physical examination		ASCE	DOP DBD
1.1.11 understand and interpret the results of the main psychometric assessments and psychological tests relevant to mental disorders	WE	ASCE	DBD
1.1.12 understand and interpret the results of the main neurophysiological and neuroimaging examinations relevant to mental disorders	WE	ASCE	
1.1.13 elicit and recognise signs and symptoms, and apply them to a multiaxial differential diagnosis		CE	DOP DBD
1.1.14 identify and appraise the factors affecting the course and prognosis of mental disorders	WE	CE	DBD
1.1.15 take into account the interaction between the disorder and personal life		CE	DBD MSAP
1.1.16 determine and apply the necessary range of investigations to complete the diagnostic process	WE	CE	DOP DBD
1.1.17 draw up a diagnostic formulation including risk assessment		CE	DOP DBD
1.1.18 review and revise a diagnosis over time			DBD MSAP

1.2 apply therapeutic and communication skills to effectively and empathicaly manage the spectrum of patient care problems as well as those of their carers

1.2.0 General Competencies

	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 and circumstances	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 including wherever possible, shared understanding and informed consent from patient or their carer			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

The therapeutic skills include especially:

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 Social 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 Rehabilitation

	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 rehabilitation, including recovery, in facilitating return to a life that is meaningful to the individual	WE OE		
1.2.4.2 use rehabilitation methods safely and effectively on the basis of values and the best evidence available			DBD MSAP

1.3 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
1.3.1 apply the medico-legal knowledge and skills required to give appropriate psychiatric advice to courts of law and other settings		ASCE	DBD
1.3.2 apply the knowledge and skills to contribute to the development of health services	OE		MSAP

1.4 recognise personal limits of expertise

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

1.5 consult effectively

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

2 Communicator

Definition

To provide humane, high-quality care, psychiatrists establish effective and empathic relationships with patients and their carers, other physicians, and other health professionals. Communication skills are essential for the functioning of a psychiatrist and are necessary for obtaining information from, and conveying information, to patients and their families. Furthermore, these abilities are critical in eliciting patients' beliefs, concerns and expectations about their illnesses and for assessing key factors impacting on patients' health.

Competencies

The psychiatrist is able to:

2.1 establish a therapeutic relationship with patients

	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, and one's own reactions when dealing with patients.			DBD MSAP
2.1.2 communicate effectively and empathically, both verbally and non-verbally		ASCE	DOP MSAP
2.1.3 establish, maintain and conclude appropriate therapeutic relationships with patients and carers			DBD MSAP
2.1.4 facilitate a structured clinical encounter		ASCE	DOP

2.2 elicit and synthesise relevant information from the patient, their carers and other relevant sources

	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

2.3 discuss appropriate information with the patient, their carers and health professionals that facilitate optimal care. This implies the ability to inform and counsel a patient in a sensitive and respectful manner while fostering understanding the patient's active participation in decisions about their care.

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
2.3.1 recognise and respect the patient's right to be optimally informed about their illness and treatment options		ASCE	DOP MSAP
2.3.2 communicate with the patient, family and carers using a wide range of information resources including written material and online sources		ASCE	DOP MSAP
2.3.3 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

2.3.4 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
2.3.5 use available means to handle language, cultural and other communication barriers when appropriate			DOP DBD
2.3.6 document and present reports of clinical encounters and care plans			DBD MSAP
2.3.7 when opportunities arise, effectively present information on mental health issues to the public or media		ASCE	MSAP DOP

3 Collaborator

Definition

Psychiatrists work in partnership with others who are involved in the care of individuals or specific groups of patients. It is therefore essential for psychiatrists to be able to collaborate effectively with patients, their carers and a multidisciplinary team of expert health professionals for the provision of optimal patient care, education and research.

Competencies

The psychiatrist is able to:

3.1 Effectively consult with other physicians and healthcare professionals

	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
3.1.4 effectively work with other health professionals to prevent, negotiate and resolve conflict			MSAP DBD
3.1.5 obtain, interpret and evaluate consultations from other professionals		ASCE	DBD DOP
3.1.6 serve as an effective consultant to other medical specialists, mental health professionals and community agencies			DOP MSAP

3.2 Contribute effectively to other interdisciplinary team activities

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
3.2.1 participate effectively in a multidisciplinary team and, where appropriate, demonstrate leadership			DOP MSAP
3.2.2 work effectively to prevent, negotiate and resolve conflict within the multidisciplinary team			DOP MSAP
3.2.3 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

3.3 participate actively in shared decision making with patients and carers

	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

3.4 collaborate effectively with patient and carer organisations

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
3.4.1 proactively involve patient and carer organisations in the planning, provision and evaluation of mental health services			MSAP DOP
3.4.2. maintain professional relationships with patient and carer organisations	WE		MSAP

4 Manager

Definition

Psychiatrists function as managers when they make everyday practice decisions involving resources, co-workers, tasks, policies and their personal lives. They do this in the settings of individual patient care, practice organisations and in the broader context of the healthcare system. Thus, psychiatrists require the abilities to prioritise and effectively execute tasks through team work with colleagues and make systematic decisions when allocating finite healthcare resources. As managers, psychiatrists take on positions of leadership within the context of professional organisations and the healthcare system.

Competencies

The psychiatrist is able to:

4.1 allocate limited healthcare resources

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

4.2 manage personal resources

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
4.2.1 manage one's own time to balance patient care, earning needs, other activities and personal life			MSAP DOP
4.2.2 balance personal and professional priorities to ensure personal health and sustainable practice			DOP MSAP

4.3 work in a healthcare organisation

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
4.3.1 plan relevant elements of health care delivery and implement change where appropriate	WE		MSAP DOP
4.3.2 negotiate between competing interests for mental health care resource allocation			MSAP DOP
4.3.3 ensure implementation of evidence based guidelines in clinical practice			MSAP DOP
4.3.4 participate in clinical audit to continually improve the quality of services			DBD DOP
4.3.5 understand the principles of risk management and clinical governance	WE		DOP
4.3.6 deal with patient, carer and staff complaints		ASCE	DBD DOP
4.3.7 understand current mental health and other relevant legislation	WE OE		DBD
4.3.8 encourage and facilitate the professional development of peers and other related professionals			MSAP

4.4 use information technology to optimise patient care, continued self-learning and other activities

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

5 Health Advocate

Definition

Psychiatrists recognise the importance of advocacy and health promotion in responding to the challenges represented by those social, environmental and biological factors that determine the mental health and well-being of patients and society. They recognise 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. Health advocacy is appropriately expressed both by the individual and collective responses of psychiatrists in influencing public health and policy.

Competencies

The psychiatrist is able to:

5.1 identify the determinants of mental disorder as well as the factors that may contribute to positive mental health so as to be able to prevent disorder and promote mental health

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
5.1.1 recognise the determinats of mental health of populations and how public policy including legislation impacts on mental health	WE OE		
5.1.2 promote positive mental and physical health in patients particularly in those with severe mental disorder based on best evidence			DBD
5.1.3 recognise the impact of mental disorder on families and carers, and take remedial measures	WE		DBD DOP
5.1.4 collaborate with other community sectors to promote mental health and prevent mental disorder at all levels focusing particularly on family, school and workplace			MSAP
5.1.5 identify and address barriers and inequity in access to care, particularly for vulnerable or marginalised populations			MSAP

5.2 Identify and address issues and circumstances when advocacy on behalf of patients, professions, or society is necessary

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
5.2.1 respect and promote the human rights of people with mental disorders and collaborate with user and carer associations and advocacy groups			MSAP
5.2.2 empower people with mental disorders and their carers			MSAP
5.2.3 recognise and address prejudice, stigma and discrimination associated with mental disorder and its treatment			MSAP DOP
5.2.4 use strategies to enhance patient's self-management and autonomy		ASCE	DBD
5.2.5 actively oppose the use of psychiatry for political repression	WE		
5.2.6 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

Psychiatrists engage in a lifelong pursuit of mastery of their domain of professional expertise. They recognise the need for continuing professional development (CPD). Through their scholarly activities, they contribute to the appraisal, collection and understanding of healthcare knowledge and facilitate the education of their students, colleagues, patients and others.

Competencies
The psychiatrist is able to:

6.1 develop, implement and document a personal 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	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 apply the principles of critical appraisal to sources of medical information

	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			DOP
6.2.2 integrate critical appraisal conclusions into clinical care			DBD

6.3 facilitate learning in students, trainees and health professionals

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
6.3.1 understand the principles of learning and the ethics underpinning medical education including mentoring	WE OE		
6.3.2 work with others to identify respective learning needs			MSAP
6.3.3 select teaching strategies based on best evidence			MSAP DOP
6.3.4 recognise that one's own clinical behaviour can be a model for the learning of others			MSAP DOP
6.3.5 teach, present and reflect on feedback			MSAP DOP

6.4 demonstrate appropriate use of assessment, appraisal and feedback

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessment DBD DOP MSAP
6.4.1 recognise and apply the principles of assessment including the difference between formative and summative assessment	WE		DOP

6.4.2 recognise and apply the principles of appraisal	WE		DOP MSAP
6.4.3 give feedback in a timely and constructive manner showing respect and confidentiality			DOP MSAP

6.5 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
6.5.1 recognise the principles, methodology and ethics of research and scholarly inquiry	WE OE		
6.5.2 formulate a research question and conduct a systematic search for evidence	WE OE		DOP
6.5.3 select and apply appropriate methods to address the question	WE OE		DBD DOP
6.5.4 analyse, interpret and report the results	OE		DBD DOP
6.5.5 appropriately disseminate and utilise the findings of a study			DBD DOP MSAP

7 Professional

Definition
Psychiatrists have a body of knowledge, skills and attitudes dedicated to improving the mental health and well being of others. Psychiatrists are committed to the highest standards of excellence in clinical care and ethical conduct, and to continually perfecting mastery of their discipline.

Competencies
The psychiatrist is able to:

7.1 deliver the highest quality of professional care

	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 relate to co-workers in a professional manner

	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 recognise the needs of other professionals 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

	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			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

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.

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

To date, very little work has been done evaluating the utility of WPBA in psychiatry; an early field trial in the UK indicated that a programme of assessment based on the three main methodologies outlined above was feasible and acceptable to doctors and their assessors and had some positive educational impact (Brittlebank, 2007). All of the reliability and validity data of the methods has come from areas of medical practice outside psychiatry.

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 are undergoing evaluation; 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.

ASSESSMENT VIGNETTES

Here are some vignettes, 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. It is not an exhaustive list.

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 is then reviewed by the appropriate authority in order to make a summative decision about the doctor's progress. Another important feature of workplace assessment is the formative aspect of the feedback obtained. So doctors may use the information from episodes of assessment to inform their learning and continuing development as illustrated by vignette five.

Vignette 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 on, the doctor has asked her 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

Vignette 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 his supervisor to observe his 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). He will be assessed regarding his 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.

Vignette 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 his performance and rate him using the Direct Observation of non-Clinical Skills tool (a form of DOP).
Subsequently he 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.

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

In the past week, he 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 his supervisor to assess him by directly observing him conduct an interview with this patient through an interpreter (Directly Observed Practice, DOP). In this way, he wishes to demonstrate his attainment of the following supporting competencies: 1.1.6, 1.2.0.1, 2.3.4, 3.2.1, 5.1.3.

During his next educational supervision, the doctor requests an assessment of his practice based on his management of this case as documented in the patient's case note (Document Based Discussion, DBD). In this way, he 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 doctor wishes to seek the opinions of other specialists in the department, and arranges to present his patient at a departmental case conference. He wishes to be assessed on his presentation skills, and asks his supervisor to perform an Assessment of Case Presentation (a form of DOP): 2.1.1, 2.3.6, 2.3.7, 6.3.4.

The doctor wishes his peers and allied colleagues to assess his performance in this case, as well as his overall clinical practice. He arranges a Multi-Source Assessment of Performance (MSAP). This would enable him 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.

Vignette five
A senior psychiatrist recently changed jobs, coming from an old age psychiatric ward to an outpatient team specialising in mood disorders. Cognitive Behavioural Therapy (CBT) is a major treatment modality used in the department. The psychiatrist has not practiced CBT for several years. After reading a manual about CBT he treats a patient with this form of psychotherapy.

As part of his routine quality assurance plan he asks a senior clinical psychologist to perform a document based discussion (DBD) to evaluate his ability to perform CBT. This episode of assessment may also be used as evidence to assess competencies 1.2.0.6, 1.2.0.10, 1.2.0.11, 1.4.1, 1.4.2, 2.3.6, 6.1.1 and 6.1.2.

In the discussion of the case they give special attention to his ability to challenge the negative thoughts of the patient and to help the patient to focus more on positive emotions. The outcome of this assessment is that his technique is no longer up to date. The psychiatrist decides to follow a course in CBT in the framework of his continuing medical education.

References

Archer, J, Norcini, J, Southgate, L, Heard s and Davies, H, (2006). Mini-PAT (Peer Assessment Tool): A Valid Component of a National Assessment Programme in the UK? Advances in Health Sciences Education, 13:2: 181-192

Brittlebank, A D (2007). Experience of piloting workplace based assessment in psychiatry. In Bhugra, D, Malik, A and Brown, N (Eds) *Workplace Based Assessments in Psychiatry.* 11, pp 96 – 108 London: Royal College of Psychiatrists

Chisholm, A and Askham, J (2006). What do you think of your doctor? Oxford: Picker Institute Europe

Crossley J, Davies H, McDonnell J, Cooper C, Archer JC, McAvoy P. A district hospital assessing its doctors for re-licensure: can it work? Medical Education 2005; 42: 359-363

Fitch, C, Malik, A, Lelliot, P, Bhugra, D and Andiappan, M. Assessing psychiatric competencies: what does the literature tell us about methods of workplace-based assessment. Advances in Psychiatric Treatment 2008; 14, 122-130

Fletcher, C (2004) Appraisal and Feedback, Making performance review work. London: Chartered Institute of Personnel and Development

Frank, JR (Ed) (2005). *The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care.* Ottowa: The Royal College of Physicians and Surgeons of Canada

Grant, J (2006*) Principles of curriculum design.* Edinburgh: Association for the Study of Medical Education

Holmboe, E S, Huot, S, Chung, J et al (2003) Construct validity of the mini-Clinical Evaluation Exercise (mini-CEX). Academic Medicine, 78, 826-830

Holmboe E S, Hawkins, R E and Huot, S J. Effects of training in direct observation of medical residents' clinical competence. A randomized trial. Annals of Internal Medicine 2004; 140, 878-881

Jolly and Grant, 1997, The Good Assessment Guide. London: Joint Centre for Education in Medicine.

Kogan, J R, Bellini, L and Shea, J A (2003). Feasibility, reliability and validity of the mini-Clinical Evaluation Exercise (mini-CEX) in a medicine core clerkship. Academic Medicine, 78, S33-S35

Malik, A, Fitch, C, Lelliot, P and Bhugra, D. Multi-source feedback for psychiatrists: key evidence and practical lessons. Advances in Psychiatric Practice (2009) in the press

Miller, G E. (1990) The assessment of clinical skills/competence/performance. Academic Medicine, 9, s63-s67

Newble D I and Swanson D B (1998). Psychometric characteristics of the objective structured clinical examination. Medical Education, 22, 325-334

Norcini, J J. (2002). The death of the long case? British Journal of Medicine, 324, 408-409

Roberts, C, Sarangi, S, Southgate, L, Wakeford, R and Wass, V, (2000). Education and debate: oral examinations – equal opportunities, ethnicity and fairness in the MRCGP. British Medical Journal, 320, 370-374

Royal College of Psychiatrists (2006) *Specialty Curriculum for Psychiatry Training.* London: Royal College of Psychiatrists

Royal College of Physicians and Surgeons of Canada (2007) *Objectives of training in Psychiatry.* Ottowa: Royal College of Physicians and Surgeons of Canada

Scheiber SC, Kramer TAM & Adamowski SE (2003). *A Report of the American Board of Psychiatry and Neurology Inc. Core Competencies for Psychiatric Practice: What Clinicans Need to Know*. Washington: American Psychiatric Publishing

Schurwirth, L and van der Vleuten, C (2003). ABC of learning and teaching in medicine: Written assessment. British Medical Journal, 326, 643-645

Swanson, D B, Norman, G R, and Linn R L (1995). Performance-based assessment: lessons learnt from the health professions. Educational Researcher, 24, 5-11

UEMS Section for Psychiatry/European Board of Psychiatry (2003) *Charter on Training of Medical Specialists in the EU (Chapter 6): Requirements for the Specialty of Psychiatry.*

UEMS Secion for Psychiatry (2005) *The Profile of a Psychiatrist*

Van der Vleuten, C.P.M. (1996) The assessment of professional competence: theoretical developments, research and practical implications. *Advances in Health Sciences Education*, 1, 41-67.

Violato, C, Lockyer, J and Fidler, H. (2003) Multi-source feedback: a method of assessing surgical practice. British Medical Journal, 326, 546-548

Wass, V, Wakeford, R, Neighbour, R and van der Vleuten (2003). Achieving acceptable reliability in oral examinations: an analysis of the Royal College of General Practitioners membership examination's oral component. Medical Education, 37: 126-131

Whitehouse A, Hassell A, Bullock A, Wood L Wall D. 360 degree assessment (multisource feedback) of UK trainee doctors: field testing of team assessment of behaviours (TAB). Medical Teacher 2007; 29(2):171-176

Wilkinson, J, Benjamin, A and Wade, W (2003). Assessing the performance of doctors in training. British Medical Journal, 327, S91-S92

Wilkinson J, Crossley J, Wragg A, Mills P, Cowan G, Wade W. Implementing workplace assessment across the medical specialties in the United Kingdom. Medical Education 2008; 42: 364-373