

Brief Research Report

Development and challenge of introducing competency-based medical education in psychiatric clerkship

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ABSTRACT

INTRODUCTION. Competency-based medical education has long been considered the cornerstone of medical education. In psychiatry, structured competence evaluation in students' clerkships has been shown to enhance learning and feedback. This study aimed to develop, introduce and evaluate the use of competence cards in Danish psychiatric clerkships.

METHODS. Adopting Kern's six-step curriculum development model, we conducted questionnaire surveys, observations and interviews with students and faculty to identify learning needs. Three competence cards - psychiatric interview, documentation and coercive measures - were developed and introduced in two hospitals. Students and staff received written and oral instructions. The process was evaluated through interviews, which were analysed thematically.

RESULTS. Only one of the 16 interviewed students had used the competence cards. Three themes emerged: 1) Missing educational scaffolding, 2) Student passivity and perceived guest role, and 3) Barriers to direct supervision. Students observed doctors rather than conducting independent interviews themselves. They reported receiving limited supervision due to staff shortages and experienced uncertainty about their role, rendering feedback difficult to obtain.

CONCLUSIONS. Despite relevant preparation, competence cards were not integrated into psychiatric clerkships. Students requested mandatory implementation due to structural and supervisory barriers. Rethinking the clerkships and faculty development are essential prerequisites to the successful implementation of competence cards.

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TRIAL REGISTRATION. Not relevant.

Competency-based medical education (CBME) has long been considered a cornerstone in graduate medical education. Moreover, in recent years, it has also been introduced in undergraduate medical education [1-3]. Despite its theoretical appeal, implementing CBME is highly context-dependent. One aspect of CBME is evaluating clinical tasks and determining the degree of autonomy students can exercise in performing them, much like the Danish competence cards.

Evaluation of competence in psychiatry clerkships has been shown to facilitate feedback and enhance learning outcomes while improving students' overall educational experience [4].

Hence, we wanted to develop, introduce and evaluate CBME in psychiatry clerkships in a Danish context. Competence cards were chosen as mode of evaluation as it is a tool already known by faculty.

METHODS

We adopted Kern's six-step approach to curriculum development [5].

All participating students were enrolled at the University of Copenhagen, Denmark.

1. Problem identification and general needs assessment

There has been an increasing focus on how to teach Danish medical students all the CanMEDS

roles rather than focusing exclusively on the medical expert role when they enter their clerkships, which aligns with the latest EU roles for medical students [6].

2. Needs assessment of targeted learners

We designed two questionnaires, one for faculty in psychiatric departments and another for medical students who had recently finished their clerkship in psychiatry. We aimed to establish which aspects of the clerkships they felt were not properly covered. Furthermore, we took into account the learning objectives for the psychiatry clerkship and observed students during their clerkships, conducting informal interviews with both students and doctors.

3. Goals and specific measurable objective

We established that the clerkships needed a stronger focus on the patient interview, the psychiatric patient history, coercive measures, communication skills and collaboration.

4. Educational strategies

It was assessed that the learning objectives would be best evaluated via the Danish CBME concept of competence cards as this tool is well known among Danish doctors. The following three competence cards were agreed on:

patient interviews and documentation should be observed by a doctor, psychologist or nurse.

a summary of the patient's journal should be evaluated by a doctor who was familiar with the patient's history.

coercive measures in psychiatry should be evaluated by a doctor and would be case-based.

5. Implementation/introduction

We introduced the competence cards in departments of two Danish hospitals ([see Supplementary material](#)). We tested them throughout two terms. Faculty was instructed both verbally and in writing before each term. There were three groups of students each term, and each group was introduced to the competence cards by a member of the research group.

The students received an email before their clerkship containing information about the project and the competence cards. For the first term, we had a paper version with the competence cards available for assessment in the clinic; for the second term, we also had a supplementary electronic version available [7].

Department management and educational leads were involved prior to implementation; however, it was not possible to appoint a formal local supervisor.

6. Evaluation and feedback

We interviewed the students after each clinical rotation. For the first term, the process was informal and the main points were noted during the interview. These initial interviews prompted us to remove the competence card on coercive measures, as it was not possible to apply it as

intended. More specifically, the students were instructed in coercive cases groupwise, and individual assessment therefore was not feasible. Interviews conducted at the end of the second term were audiotaped, anonymised, transcribed and thematised following Braun and Clarke and including input from the written notes recorded during the first-term interviews.

Trial registration: not relevant.

Results

Among the 16 students interviewed, one had used the competence cards. This student described the card as helpful for clarifying expectations during a patient interview, but experienced it primarily as a summative assessment rather than a formative feedback tool. The analysis revealed three themes explaining the limited use of competence cards.

Missing educational scaffolding

Students described a lack of structural support for assessment. Clerkships were characterised by short rotations across multiple wards, limited continuity with supervisors and limited awareness of the competence cards among doctors. Therefore, competence cards were perceived as optional rather than an integrated part of clinical work. Several students stated that mandatory use or explicit departmental endorsement would have legitimised requests for observation and feedback.

Student passivity and perceived guest role

Students largely occupied a passive, observational role with limited opportunities to conduct independent patient interviews. This varied by ward type, with particularly few opportunities on closed wards. In contrast to somatic clerkships, students felt they contributed little to patient care, making competence assessment seem inappropriate given their limited involvement.

Barriers to direct supervision

Supervision was constrained by both time pressure and student hesitation. Doctors were perceived as overburdened, and students were therefore reluctant to insist on supervision. Supervision, when it occurred, was often brief, making the use of competence cards feel intrusive and poorly aligned with workflows.

Discussion

This study examined the implementation of competence cards in undergraduate psychiatry clerkships. Despite careful development, the cards were rarely used. Our findings suggest that missing educational scaffolding, student passivity and barriers to direct supervision limited their usage.

Competence cards were not embedded in daily clinical routines and relied on individual initiative. In somatic clerkships, similar assessment tools have been implemented more successfully, likely thanks to clearer student roles and more routine supervision [8, 9]. However, studies also found that students may feel uncomfortable requesting observation and feedback, indicating that this is not unique to psychiatry but may become more salient in this context [9].

Students' predominantly observational role was also found in other studies, and this role further undermines their assessment opportunities [10]. Frequent rotation between wards and limited supervisor continuity reinforced a perceived guest role, making competence assessment feel inappropriate. This misalignment between assessment tools and real-life student involvement is consistent with other CBME literature [11-13].

Barriers to supervision reflected both time pressure and students' reluctance to insist that overburdened doctors should provide supervision. Even when supervision occurred, it was often brief and informal. As described by Ahn et al., assessment systems are only as strong as their weakest link; without aligned supervision and feedback structures, new assessment tools risk remaining symbolic [14].

Finally, this study calls for reflexivity regarding the research team's role. Although we were aware of limited supervision resources, we hoped that competence cards would facilitate more direct supervision. In retrospect, stronger departmental anchoring and explicit expectations for supervision may have been necessary to legitimise their use.

This raises the question of whether the current clerkship format in psychiatry can implement CBME tools, such as competence cards. Significant support to the staff's education on CBME would be needed, in addition to a stronger focus on the students' independent interaction with patients under supervision [15]. Furthermore, in light of changes to the educational programme for postgraduate training in Denmark, it seems obvious to consider aligning these changes to support the legitimacy of requesting supervision.

Conclusions

Competence cards were not used in psychiatric clerkships despite extensive introduction. Mandatory structures, fewer internal rotations in the department and explicit supervision expectations appear necessary to underpin undergraduate CBME in psychiatry.

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Supplementary material https://content.ugeskriftet.dk/sites/default/files/2026-03/a11250938_supplementary.pdf

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