HKCPsych PART II EXAMINATION

Paper

1. There is one paper.

2. The paper shall consist of two hundred questions. There are multiple choice questions (MCQs) and extended matching items (EMIs).

3. The MCQs are stem questions of five items, among which the best item is chosen. No marks will be deducted for incorrect responses.

4. The EMIs are stem questions of several items, answers to which are to be chosen from a list of options. No marks will be deducted for incorrect responses.

5. The candidate is given three hours to answer the paper.

6. Separate answer sheets will be provided.

7. Candidates must return all question books with the answer sheets.

8. All questions carry equal marks

9. Candidates are strictly forbidden to take any books, calculators, notes, writing paper, coats, handbags, cases, any piece of electronic, computer or other equipment into the examination room. Any breach of the regulations will lead to disqualification. The senior organizer will provide a place for storage. The examination centre will not be responsible for any loss.

10. In the unlikely event of a candidate falling ill during the examination, the senior organizer should be notified.

11. Candidates are responsible for keeping the Chief Examiner informed of any changes of address or telephone number after the application for examination is made.

Clinical Examination

INDIVIDUAL PATIENT ASSESSMENT

1. The clinical examination, which consists of two parts, the Individual Patient Assessment and the Patient Management Problems, is the most important part of the examination. Unless a candidate passes the clinical, they must fail the whole examination, however good the performance in all other parts. In view of this, the

clinical examination must be approached with the utmost care by candidates and examiners.

2. Each candidate will have one hour to examine a patient and five minutes afterwards to organise their thoughts. They are not required to produce any written material to hand to the examiners.

3. The interview with the examiners is scheduled to occupy thirty minutes. Discussion will generally cover the following topics:

   a) Assessment - the candidate's overall view of the case deriving from salient features in the history and the findings on examination of the mental state; the diagnosis and differential diagnosis; the supposed aetiological factors.

   b) Management - further enquires and investigations; treatment, short-term and long-term (including the part that would be played by other members of the psychiatric team, and by the family etc.).

   c) Prognosis - review of the possible outcomes.

   The examiners may raise general clinical or scientific questions stemming from consideration of the particular case.

4. Each candidate should be required to interview their patient in the presence of the examiners unless exceptional circumstances make this procedure inappropriate for the patient.

5. Candidates are expected to make a physical assessment; the accompanying notes give further guidance on this part of the examination. The necessary instruments and facilities will be available. Candidates will be asked routinely to give an account of whatever findings that may have elicited by physical examination.

6. Prior to their clinical examination, candidates should not visit the hospital to which they have been allocated, either to see patients or for any other purpose relevant to their forthcoming examination. Any queries concerning this should be addressed to the Board of Examiners.

INSTRUCTIONS FOR THE CLINICAL EXAMINATION INDIVIDUAL PATIENT ASSESSMENT

With these instructions, you will receive a schedule of your examination. **Parking spaces are NOT available at examination centre.**

Arrive at the clinical centre 15 minutes before designated examination time.

Please ensure that you arrive at the clinical centre on the day and time specified. *CANDIDATES WHO ARRIVE LATE WILL MISS THEIR ALLOCATED SLOT AND WILL NOT BE ACCOMMODATED*. The senior organiser and examiners have been asked not to make any allowances.

It is strictly forbidden to take any books, calculators, notes, writing paper, overcoats, handbags, cases, any piece of electronic, computer or other equipment into the interview room with the patient. Any breach of the regulations will lead to disqualification.

The senior organiser has been asked to indicate an area for you to deposit your coats and cases. However, you should note that the clinical centres cannot be held responsible for any loss.

Interview with the patient

You will be taken into the interview room and introduced to the patient. You have 60 minutes with the patient. The organiser will knock five minutes before the end of the 60 minutes interview. At the end of the interview, the patient will be taken out of the room. You will then have five minutes to gather your thoughts before you are taken to meet the examiners.

In the unlikely event of a candidate falling ill during the examination, the senior organiser should be notified.

Candidates are responsible for keeping the Chief Examiner informed of any changes of address or telephone number after the application for examination is made.

PATIENT MANAGEMENT PROBLEMS

1. There will be two examiners.

2. Each examiner will ask two to three questions on patient management. The questions will be shown to the candidates in typewritten form. The questions can touch on any aspect of management which will tap onto the candidates' ability to reasonably treat patients in a variety of clinical situations.

3. In the allotted time only up to five questions can be asked.

INSTRUCTIONS FOR THE CLINICAL EXAMINATION PATIENT MANAGEMENT PROBLEMS

With these instructions, you will receive a schedule of your examination. **Parking spaces are NOT available at examination centre.**

Arrive at the clinical centre 15 minutes before designated examination time.

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THE PLACE OF THE PHYSICAL ASSESSMENT IN THE HKCPSYCH EXAMINATIONS

A physical assessment is a series of observations made by the doctor, beginning with visual observation, and possibly, although not always proceeding to examination utilising touch and other senses, and in some cases appropriate instruments. Many physical observations can be made without requiring the patient to undress, and in the examinations, undressing will only be necessary in exceptional cases.

There are important practical reasons why a physical examination should have a defined place in the HKCPsych

i. The accurate appraisal of physical symptoms and signs associated with primary psychiatric conditions.
ii. To provide a basis for informing and if necessary reassuring patients regarding their physical health.
iii. To enable the psychiatrist to be satisfied that there is no physical disorder present, either aetiologically or fortuitously related to the psychiatric presentation.
iv. To ensure that psychiatrists remain competent in physical examination of a patient and to check the findings of other doctors.
v. In order that psychiatrists should know when to refer to another medical specialist, and to make proper referral including information on abnormal physical findings.
vi. To encourage competence in the initiation of investigations and management of physical symptoms, thus avoiding the necessity to refer all non-psychiatric complaints to other medical departments.

A physical assessment, as defined above, is mandatory. The necessary instruments and facilities will be available but candidates should consider whether there may be advantages in bringing their own apparatus with them.

If time or other constraints prevent candidates from conducting as complete an examination as they consider ideal, they must be prepared to justify such omissions as have been made. In every case, examiners will assess the accuracy of the physical assessment and the candidate's judgement with respect to its scope. They may also, on occasion, wish to explore what further observations and investigations would be appropriate, and may require the candidate to undertake the examination suggested.

EVALUATION OF AETIOLOGICAL FACTORS IN THE HKCPSYCH EXAMINATIONS

IMPORTANCE OF PSYCHOLOGICAL FACTORS IN THE CLINICAL EXAMINATION

INTRODUCTION

In both Part I and Part II clinical examinations the candidate should be able to discuss aetiological issues be they social, psychological, biological or organic. This paper addresses the issue of psychological factors. It is not intended, in any way, to detract from the importance of other aetiological factors.

It is felt that every candidate, particularly in Part II, should be able to address the question "*Why has this patient developed this disorder at this point in their life?*", and that in many cases the candidate would need to describe the psychological factors involved. The Notes of Guidance set out below are not suggesting that every candidate should produce a separate psychological formulation, but that s/he should be able to place psychological factors in the context of a general understanding of the patient. Candidates should be able to discuss all possible aetiological factors. In some patients it may be just as important to state clearly that psychological factors are not involved in a major way.

NOTES OF GUIDANCE for examiners, tutors and candidates

1. Candidates should be able to give a concise summary of the psychological factors which may have led to the disorder or illness in the patient they have examined.

2. This would normally be integrated into the discussion of other aetiological factors e.g. organic, family history, life events, social circumstances etc., so that the candidate could attempt to answer the question *Why has this patient developed this disorder at this point in their life, in this particular form and with this particular content to their mental state?* This would involve considering predisposing, precipitating and perpetuating factors.

3. Clearly the degree to which such psychological factors play a part will vary markedly from case to case, and the better the candidate, the more he or she will be able to place appropriate weight on such psychological factors. Candidates should be able to address the relative appropriateness of various frames of reference, e.g. psychodynamic, behavioural/cognitive or family systems formulations.

4. In the Part I examination, the examiners should be looking for evidence that the candidate can appreciate that psychological factors may play a part and make some assessment of the weight that should be given to such factors, considering the most likely diagnosis of the patient they have seen.

5. In the Part II examination, the examiners might expect more detailed coverage of the aetiological factors in general, including psychodynamic factors. Candidates would be expected to be able to give a more sophisticated psychological explanation, and be able to describe some of the different models available, with an indication of which model they were employing and why. In considering aetiological factors, candidates may be able to comment on the implications for treatment and management.

6. POINTS THAT MIGHT BE COVERED IN A BEHAVIOURAL ASSESSMENT:-

   The commonest form of behavioural analysis uses the simple A, B, C model (antecedents, behaviours, consequences). A candidate would not be expected to adhere formally to that model but might be expected to mention some of the following points:

   (a) To what extent there has been faulty early learning
   (b) To what extent the current behaviour is being rewarded and therefore maintained
   (c) To what extent avoidance is playing a part

7. EXAMPLES OF POINTS THAT MIGHT BE COVERED IN A PSYCHODYNAMIC ASSESSMENT:-

   i. Early experience.
   ii. The current psychological mechanisms that are being used and the purpose that such mechanisms might appear to have for that individual.
   iii. The part that such factors have played in symptom formation and the maintenance of the disorder. The interplay between enduring personality traits and the current symptomatology.

8. POINTS THAT MIGHT BE COVERED IN A COGNITIVE ASSESSMENT:-
   (Concepts <u>underlined</u> are the most important factors)

   a) Identification of <u>underlying dysfunctional beliefs</u> derived from early learning experiences. Themes (e.g., need for approval, perfectionism) rather than the actual assumptions might be identified in a single interview.

b) A recent critical incident that may have activated the underlying belief, e.g., in depression, loss, rejection or failure to attain goals; in anxiety, perceived threats.
c) Current symptom profiles described either:

   i. In cognitive (reported automatic thoughts or images), behavioural, affective and biological components or
   ii. The patient's identified problem list

   and how (i) and (ii) may relate to underlying beliefs.

d) Identification of biases in information processing in terms of the negative cognitive triad (view of self, world and future) and\or a description of the most common types of distortion shown by the patient (e.g., over-generalisation, all or nothing thinking).

CLASSIFICATION OF DISEASES

Knowledge of DSM IV will be expected of candidates.

You are reminded that candidates are expected to know the principles of classification, to have a working knowledge of ICD-10 and to have a more detailed knowledge of either ICD-10 or DSM-IV.

PSYCHIATRIC HISTORY

I. Patient's age, sex, marital state (area of residence)

II. Presenting complaints

III. Family history

IV. Personal history

V. Previous personality

VI. Previous medical history

VII. Previous psychiatric history

VIII. Current (or most recent) work and domicile (including composition of household)

IX. History of present illness: its management

X. Present functioning: sleep, appetite, weight gain or loss, daily routines

The ORDER of eliciting and/or presentation of (III) - (IX) may be varied.

Cross-references are important.

In Part I, candidates will be expected to present a detailed history, bearing in mind time constraints.

In Part II, candidates will be expected to present an assessment, giving salient positive and negative aspects of the history, as it is expected that they will have been able to demonstrate their skill in obtaining a psychiatric history in Part I. They should be prepared to expand on any aspect of the history, if asked to do so by the examiners.

QUALITIES OF A GOOD CLINICAL HISTORY

I. Systematic: use of appropriate headings

II. Comprehensive: but not over-inclusive

III. Coherent and internally consistent

IV. Has an appropriate sense of priorities and clinical relevance. Avoids unnecessary detail

V. Multidimensional in approach: physical, psychological, social

VI. Distinguishes appropriately between various categories of data: fact/opinion

description/explanation

direct/indirect

V. Accurate: good communication with patient

VI. Due attention paid to problem of reliability e.g. need for collateral data

In the Part I examination, candidates will not be expected to have explored aspects of the history in the same depth as in Part II and they will not be expected to show EVIDENCE OF DETAILED THEORETICAL KNOWLEDGE e.g. disease incidence in relatives; detailed biochemical theories of disease; theories of psychological development.

MENTAL STATE

I. Appearance and behaviour

II. Talk: amount and form

III. Thought content

IV. Mood

V. Abnormal beliefs, delusions

VI. Perceptual disorders

VII. Obsessional and compulsive phenomena

VIII. Cognitive function

IX. Insight: attitudes to illness and its treatment

Candidates in both parts of the examination will be expected to be aware of definitions in descriptive psychopathology. In Part I these may be at a basic level; in Part II more detailed knowledge will be sought by the examiners. In both examinations, candidates should show their knowledge of variations in the manifestation of psychiatric symptoms.

ASSESSMENT OF MENTAL STATE

I. Systematic: use of appropriate headings

II. Comprehensive

III. Coherent and internally consistent

IV. Appropriate sense of priorities and clinical relevance

V. Multidimensional

VI. Phenomenology: definitions, range of manifestations, significance

VII. Psychodynamics: defence mechanisms, symbolism, content

VIII. Appropriate in method: e.g. how to test for memory; assess suicide risk; elicit Schneider's first rank symptoms

IX. Distinguishes between various categories of data

fact/opinion

description/explanation

direct/indirect

X. Accurate

In Part I, a thorough basic knowledge is expected, and a possession of more detailed knowledge will be anticipated in Part II.

CLINICAL SKILLS

Technique:

Systematic

Comprehensive

Flexible (in form and content)

Goal-directed (but not a check-list approach)

Sensitive control of interview (but not interrogational)

Patients are allowed to talk

Listens appropriately

Appropriate form of questions (open rather than leading)

Objective use of summary statements and clarifications

Candidate's qualities:

Tactful

Considerate

Sensitive to patient's problem and mental state

Empathic

Self-controlled (tolerant of frustration, anxiety, provocation, ambiguity, uncertainty)

Self-awareness

Objective (able to explore all relevant theories without premature closure of options)

Self-confident - awareness of priorities

Safe

DIAGNOSTIC SKILLS

APPROPRIATE EVALUATION OF DATA FROM CLINICAL ASSESSMENT

Direct/Indirect
Descriptive/Explanatory
Reliability/Validity
Cause/Effect relationships
Integration of all available data

APPLICATION OF CLASSIFICATION SYSTEM

Understand and describe (in outline only) the basis of International Classification of Disease 10 (ICD 10) and Diagnostic and Statistical Manual IV (DSM-IV).

Appropriate multidimensional approach.

Concept of natural history of syndromes and disease.

Basic knowledge of explanatory theories:
endogenous/reactive, psychological, interpersonal, social.

In Part I, candidates will not be expected to know detailed statistics of each diagnostic classification.

Candidates in Part II will be expected to have some knowledge of the literature and statistics of either ICD 10 or DSM IV.

CLINICAL AND PSYCHOLOGICAL INVESTIGATIONS

Name of investigation

Rationale

Indication for its use

What it entails:

how it is done
discomfort
risks

Effectiveness:

validity
reliability
cost

Candidate's judgement in use of investigation:
(exercise discrimination appropriate to each clinical problem)

Nursing observations

Social investigations

In Part I examination, candidates are expected to have basic knowledge of all commonly used investigations including EEG and CT scan. They will not be expected to know the theoretical or practical minutiae.

Candidate entering Part II examination will be expected to know the theoretical basis of commonly used investigations and to have some knowledge of investigations that are performed more rarely (for example, at present, MRI and SPECT).

RESULT ANNOUNCEMENT AND FEEDBACK

Examination results will be announced within one month after the examination (except for reassessment results for conditional pass candidates in the Part III examination, which may take about two months). Candidates will be informed of the results individually by mail.

Request for feedback

Candidates who have failed will also receive a feedback request form. A candidate may request feedback on his/her examination performance by completing the form and returning it to the Secretary of Board of Examiners within one year after the examination. Requests made after one year will not be entertained.

Appeal

Candidates who wish to appeal against their examination results may raise their concerns to the Review Committee of the College within three months after the announcement of results. The examination papers, answer books and copies of dissertations submitted to the Board of Examiners for the Fellowship Examinations of that year would be kept for another 36 months, after which they will be destroyed.

An appeal fee equivalent to the examination fee will be charged. The fee will be refunded if the appeal is substantiated.